Integration of HIV and sexual and reproductive health and rights
Good Practice Guide series

This guide is one in a series of good practice guides produced by the International HIV/AIDS Alliance (the Alliance). This series brings together expertise from our global community-level HIV programming to define and guide good practice in a range of technical areas, including:

- Human rights and GIPA
- HIV prevention
- Sexual and reproductive health and rights and HIV integration
- HIV and tuberculosis
- HIV programming for children
- HIV and drug use
- Programme cycle management

Alliance Good Practice Guides are:

- user-friendly ‘how to’ guides
- targeting HIV programmers working in community settings in developing and transitional countries
- helping to define what is good practice for community-level HIV programmes.

To download Alliance publications, please visit www.aidsalliance.org/publications.

Acknowledgements

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Alliance good practice HIV programming standards – Sexual and reproductive health and rights and HIV integration

<table>
<thead>
<tr>
<th>Good practice standard</th>
<th>Our organisation promotes the linking and integration of sexual and reproductive health and HIV in policies, programmes and services.</th>
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</thead>
<tbody>
<tr>
<td>Good practice standard 2</td>
<td>In collaboration with others, our organisation promotes the sexual and reproductive health needs and rights of all people.</td>
</tr>
<tr>
<td>Good practice standard 3</td>
<td>The people most affected by HIV and sexual and reproductive health problems are meaningfully and consistently involved at all stages of the project cycle.</td>
</tr>
<tr>
<td>Good practice standard 4</td>
<td>Our organisation promotes and/or delivers sexuality education that is comprehensive, increases knowledge, self-esteem and skills, and is socially and culturally context-specific and tailored to people’s needs.</td>
</tr>
<tr>
<td>Good practice standard 5</td>
<td>Our organisation promotes and/or provides information, education and counselling on HIV that is integrated with reproductive concerns and options.</td>
</tr>
<tr>
<td>Good practice standard 6</td>
<td>Our organisation promotes and increases uptake of the essential elements of prevention of parent-to-child transmission.</td>
</tr>
<tr>
<td>Good practice standard 7</td>
<td>Our organisation promotes and/or provides sexually transmitted infection education, diagnosis, and treatment, and condoms.</td>
</tr>
<tr>
<td>Good practice standard 8</td>
<td>Our organisation promotes and refers users to quality, user-friendly services whenever feasible rather than setting up parallel services. We collaborate with and build the capacity of service providers to better meet the needs of our beneficiaries.</td>
</tr>
<tr>
<td>Good practice standard 9</td>
<td>Our organisation works with others to promote and/or implement programmes that address gender and sexuality as an integral component of the SRH and HIV response.</td>
</tr>
<tr>
<td>Good practice standard 10</td>
<td>In collaboration with others, our organisation promotes and/or provides interventions to address gender-based and sexual violence and abuse in its HIV and sexual and reproductive health response.</td>
</tr>
<tr>
<td>Good practice standard 11</td>
<td>Our organisation has a policy and programme to address stigma and discrimination, which undermine protective behaviours and act as barriers to accessing sexual and reproductive health and HIV services and support.</td>
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</tbody>
</table>

Each guide in the Alliance good practice series is accompanied by a set of programming standards. Implementing these is one of the ways that the Alliance, our partners and other organisations can define and promote a unified and quality-driven approach to HIV programming.

This good practice guide contains information, strategies and resources to help programme officers meet the good practice standards for joining up sexual and reproductive health and rights and HIV.

The full programming standards for integrating sexual and reproductive health and rights and HIV are set out in Appendix 2 at the back of this guide.

KEY RESOURCE

The full Alliance good practice HIV programming standards for a range of technical areas can be found at:

- www.aidsalliance.org/Publicationsdetails.aspx?id=451
- www.aidsalliance.org/Publicationsdetails.aspx?id=452
- www.aidsalliance.org/Publicationsdetails.aspx?id=453
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>ART</td>
<td>Antiretroviral treatment</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour change communication</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organisation</td>
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<tr>
<td>GIPA</td>
<td>Greater involvement of people living with HIV</td>
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<td>HPV</td>
<td>Human papilloma virus</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, education and communication</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, newborn and child health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>NSAs</td>
<td>Network Support Agents</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
</tr>
<tr>
<td>PLHIV</td>
<td>Person/people living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>PPTCT</td>
<td>Prevention of parent-to-child transmission</td>
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<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
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<tr>
<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV/AIDS</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Introduction

What is the purpose of this guide?

This is one of a series of good practice guides being developed and disseminated by the International HIV/AIDS Alliance (the Alliance).

There are many online and print resources on sexual and reproductive health and rights (SRHR) and HIV aimed at policymakers and managers which have been generated at international, national and project level. There are tools on how to integrate and implement components of sexual and reproductive health (SRH) and HIV. There are also studies assessing the effectiveness of different approaches. The Alliance itself has wide experience of community-based programmes with most-affected people, namely vulnerable men, women, young people, people living with HIV and key populations (comprising men who have sex with men, sex workers, people who use drugs and transgender people). From this wealth of information, this guide brings together selected good practice experience and resources into an easy-to-use framework that will help users enhance SRH and HIV integration in their programmes.

The aim of this guide is to bring together good practice in four key areas:

1. **Community-based and owned approaches** which put the most-affected people at the centre of the response
2. **Co-ordinating change at multiple levels** to make an impact on HIV and SRH. These levels are:
   - individuals, peers, relationships and households
   - social attitudes, values and beliefs
   - services
   - policies and structures
3. **Joined up approaches to SRHR and HIV**
4. **Working together with the most affected people** and tailoring programmes to address their specific needs.

The guide also aims to:
- provide a ‘road map’ for thinking through what we mean by good practice in integrating SRH, rights and HIV at different levels, assessing where we are now, and researching what further opportunities exist for mobilising communities and affected groups to bring about change
- show how civil society programmes can increase the capacity of communities, alongside government health systems and other partners, to bring about change at the four levels identified above
- share examples and lessons learned of how civil society organisations and community-based programmes from around the world have integrated components of SRH into their programmes
- provide links to other useful resources.
Why have we developed this guide now?

There is growing recognition of the importance of linking SRH, rights and HIV in order to respond more effectively to the HIV epidemic and to individuals’ broader needs. For example, some harm reduction services do not address the SRH needs of women who use drugs or the partners of people who use drugs, and some HIV prevention programmes for sex workers do not include information on contraception. Yet most people think about their sexual and reproductive lives in a holistic way, with HIV as only one aspect.

Sexual and reproductive ill-health and HIV also share common immediate and root causes such as unprotected sexual intercourse; a lack of access to services; poverty; cultural and gender norms; inequality; and social marginalisation.

The United Nations Millennium Development Goals1 will not be achieved unless there is both access to SRH services and an effective global response to the HIV epidemic.2 The level of unmet sexual and reproductive health needs, especially among young women, a population highly affected by HIV and violence, underline the urgency to address Millennium Development Goals 3, 4, 5 and 6 simultaneously. A review of maternal mortality data revealed that HIV-related causes contributed to at least 20% of maternal deaths.3 Recognition of this link by policymakers has resulted in an increase in global funding for these programmes, through the Global Fund to Fight AIDS, Tuberculosis and Malaria for example.

The Millennium Development Goals

Goal 1: Eradicate extreme hunger and poverty
Goal 2: Achieve universal primary education
Goal 3: Promote gender equality and empower women
Goal 4: Reduce child mortality
Goal 5: Improve maternal health
Goal 6: Combat HIV/AIDS, malaria and other diseases
Goal 7: Ensure environmental sustainability
Goal 8: Develop a global partnership for development

Who is this guide for?

This guide is aimed at civil society organisations who want to increase the impact of their SRH and HIV work with communities and vulnerable people. It is relevant for managers, resource mobilisers, implementers, technical support providers, programme officers and directors who may want to link their HIV programmes to SRH programmes, or include HIV interventions in their family planning, maternal health or sexually transmitted infection (STI) programmes.

The guide does not offer exhaustive information about comprehensive SRH and HIV programming, nor does it provide step-by-step details of how to provide specific services. It does, however, bring together good practice, with the ‘key resources’ sections referring readers to further in-depth and technical tools.

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1. ‘Basic facts about the Millennium Development Goals’. Available at: www.unsd.org/mdg/basics.shtml
Let’s introduce you to some users of this guide. These characters will contribute their ideas, questions and tips throughout the chapters that follow.

Jambo! My name is Rahid. I am a married 34-year-old man and I work with the Kenyan National Network of People Living with HIV as a volunteer. I have been living with HIV for three years and I now sit on the National AIDS Control Council with government ministers and very experienced staff from NGOs. The power of sexual feelings and how to talk about them, poor services and the criminalisation of HIV transmission are major challenges for us.

Hello! My name is Sam, and I am from the UK. I am 32 years old and I work in Zambia as a programme officer for an international development organisation. There are quite a lot of bids for integrated sexual and reproductive health and HIV programmes but we are not sure about the best way to go about this.

Hola! My name is Francisco. I am a gay man from Bolivia. I am 41 years old and I work as a programme officer in a technical support organisation in Bolivia. Many of my programmes are focused on the needs of key populations, including people living with HIV, gay men and other men who have sex with men, sex workers and transgender people. I’m experienced in HIV, sexually transmitted infections and rights programmes but need to learn more about other opportunities for integrating sexual and reproductive health.

Hello! My name is Oksana, and I am 27 years old, a former injecting drug user and have been incarcerated many times. I work as a programme officer in a community-based network for people who use drugs, many of whom are living with HIV. Our network partners with many other NGOs and international development organisations who ask for our expertise on working with people who use drugs and who are living with HIV. We include STI prevention in our programmes but we haven’t done much about reproductive health.

Hello! My name is Precious and I’m 17. I lead an organisation of young people, some of them living with HIV, in Swaziland. Young people are now bored with HIV but they still take risks and get pregnant as well. It is so hard to be a young person growing up with HIV and having no money.

Olyotya! My name is Charity. I am living with HIV but my husband Moses is not. We run a non-governmental organisation in Uganda working with families to improve SRH and prevent and treat HIV.

你好 My name is Ming, and I am a young woman from China. I have been working as a programme officer in an international NGO. We support CBOs working with sex workers and drug users. We include STI prevention in our programmes but we haven’t done much about reproductive health for female sex workers and drug users.
Sexual and reproductive health

In this chapter:

- What is sexual and reproductive health?
- What needs to change for good sexual and reproductive health?
- Bringing it all together
- Interventions to bring about change at different levels
- What are risk and vulnerability?
- Who is at risk? Why are they vulnerable?

Good practice programming standards:

- STANDARD 1
- STANDARD 2
What is sexual and reproductive health?

Sexual health

Sexual health is a personal sense of sexual well-being, as well as the absence of disease, infections or illness associated with sexual behaviour. It includes issues of self-esteem, self-expression, caring for others and cultural values.

People enjoy sexual health when they feel good in body, mind and spirit. They feel comfortable about how they experience and express their sexuality in their society. They also understand and accept others who feel and do things differently. They live in enabling environments that value equality and diversity, and respect people whatever their age, gender or HIV status.

Sexuality is central to us as human beings throughout our lives. It includes our gender identification and roles, sexual orientation, eroticism, sexual pleasure, intimacy and reproduction. It influences our thoughts, feelings, interactions and actions, and it motivates us to find sexual pleasure, love and intimacy. It is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. The degree to which we are able to experience or express all of these dimensions is closely linked to our situation and environment. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.4

Reproductive health

The World Health Organization (WHO) defines reproductive health as, “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes”. This definition suggests that people with adequate reproductive health have satisfying and safer sexual lives, and can make a choice as to whether, when and how they would like to have children.5

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5. ‘WHO sexual and reproductive health’. Available at: www.who.int/reproductive-health/gender/sexual_health.html
Sexual and reproductive health also includes maternal, newborn and child health (MNCH) which refers to the health and well-being of women during pregnancy, childbirth and post delivery, and the health of newborn babies and children until the age of five. Every year around eight million children die of preventable causes, and more than 350,000 women die from preventable complications. In order to respond effectively, interventions must ensure that women and children have access to a universal package of family-planning information and services, antenatal, newborn and postnatal care, emergency obstetric and newborn care, skilled care during childbirth at appropriate facilities, safe abortion services (when abortion is not prohibited by law), and the prevention of HIV and other sexually transmitted infections. Interventions should also include: exclusive breastfeeding for infants up to six months; vaccines and immunisation; oral rehydration therapy and zinc supplements to manage diarrhoea; treatment for the major childhood illnesses; nutritional supplements (such as vitamin A); and access to appropriate ready-to-eat foods to prevent and treat malnutrition.6

What needs to change for good sexual and reproductive health?

Working at multiple levels

Sexual and reproductive health is more than simply what individual people experience. Sexual and reproductive health is shaped by factors at different levels of society, such as laws that affect what we do, social factors such as poverty, community norms, and what services are available to us. In order to improve sexual and reproductive health, we need to consider, and act on, the drivers of sexual and reproductive ill health at these different levels. The different levels can be summarised in this way:

- individuals, peers, relationships and households
- community norms, social attitudes, values and beliefs
- services
- policies and structures.

Based on learning from behaviour change and health promotion theory and practice, it is helpful to think about what needs to change at these different levels in order to improve sexual and reproductive health. This helps us to organise our ideas and plans and to increase the effectiveness of our efforts. See Chapter 4 for more details about what changes are needed and actions to bring them about.

The Change Framework and the Ottawa Charter (see box on page 10) acknowledge that the ability of an individual, household or community to change is not always entirely in their own hands but is often influenced by community and cultural norms, access to services and laws, policies and economics. By reflecting on the challenges to health at all the different levels, we can decide what mix of interventions will most effectively bring about the changes we want to see.

A FRAMEWORK FOR HEALTH PROMOTION

The Change Framework is based around the five key areas that the WHO set out in the Ottawa Charter for Health Promotion in 1986:

1. Building healthy public policy that supports those with HIV and removes barriers to the adoption of healthy public policy
2. Creating supportive environments which enable individuals to lead healthy lives and participate in their community and effectively access services
3. Strengthening community action through the use of pre-existing community resources and networks to enable them to set priorities, plan and implement changes
4. Developing personal skills through the provision of information and educational skills to enable individuals to make healthier choices about their lives
5. Reorienting health care services towards prevention of illness and promotion of health rather than focussing on clinical and curative services when people become sick.


Level 1: Change in individuals, peers, relationships and households

At this level the aim is to support individuals, peers and households to make informed choices about their sexual and health-seeking behaviour. Interventions can enable people to understand their health risks; increase their knowledge, self-esteem and skills; motivate people to keep to healthy behaviours; and improve their relationships. People can become more aware of SRH and HIV services, and access these services as well as condoms and a range of contraceptives.

In order to be healthy at this level, people need full and accurate knowledge about:
- their sexual and reproductive organs and how they work
- how sexuality is a healthy and natural aspect of being a human being, although we do not all experience it in the same way. Many of us are attracted to people of the opposite sex, but some are attracted to people of the same sex or to both sexes
- sexual feelings and how to manage, express and enjoy them safely
- the risks of having an unintended pregnancy, getting an STI or acquiring HIV, and their consequences
- how to avoid or reduce these risks; for example, by using a condom and/or other contraceptive
- which services we can use to help avoid or reduce risks, and to get care and treatment if we have a problem.

In order to adopt healthy behaviours we all need motivation, such as:
- fully understanding the benefits of the change and why they are important to us
- feelings of love and care for another person
- sexual pleasure
- belonging to a group which is adopting healthy behaviours
- keeping to our values
- finding new practices enjoyable
- avoiding pregnancy to be able to continue working.

Women living with HIV who are pregnant, often feel worried about informing healthcare providers as they may disapprove of us having a baby. By accessing user-friendly family planning and MNCH services, we can enjoy sex and be able to plan whether or when to have children, and to have healthy children.
Sexual pleasure is a key motivation for sexual activity and a positive approach promotes pleasure as a joy and a right. Sexual pleasure is an important aspect of all safer sex counselling or education. This includes how to make condoms sexy, how different contraceptives affect pleasure, and the possibilities for pleasure without intercourse.7

**Gaining confidence, self-esteem and skills** (sometimes called efficacy) increases our ability as individuals to use and act on our knowledge of good sexual and reproductive health. We are more able to make good choices, negotiate safer sex, avoid violence, put on a condom, plan whether or when to have children, and ask for good health services and a fairer share of resources. With confidence, self-esteem and skills we feel that we have the power to make good decisions and act on them successfully.

<table>
<thead>
<tr>
<th>INTERVENTIONS</th>
<th>RESULTS</th>
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</thead>
<tbody>
<tr>
<td><strong>1. Interpersonal communication methods</strong></td>
<td>Increase in:</td>
</tr>
<tr>
<td>- Counselling</td>
<td>■ knowledge</td>
</tr>
<tr>
<td>- Peer education</td>
<td>■ motivation</td>
</tr>
<tr>
<td>- Working with groups:</td>
<td>■ confidence, skills and self-efficacy</td>
</tr>
<tr>
<td>- giving information</td>
<td>■ communication and life-skills</td>
</tr>
<tr>
<td>- group counselling</td>
<td>■ adoption of healthy behaviours</td>
</tr>
<tr>
<td>- active learning sessions including skills building</td>
<td>■ increased demand for condoms, other contraceptives and lubricants</td>
</tr>
<tr>
<td>- support groups</td>
<td></td>
</tr>
<tr>
<td><strong>2. Using print materials</strong></td>
<td>Increase in:</td>
</tr>
<tr>
<td>- leaflets and booklets</td>
<td>■ knowledge</td>
</tr>
<tr>
<td>- posters</td>
<td>■ awareness</td>
</tr>
<tr>
<td><strong>3. Combining education with entertainment</strong></td>
<td>Increase in:</td>
</tr>
<tr>
<td>- local media – drama, song, dance and local radio</td>
<td>■ knowledge</td>
</tr>
<tr>
<td>- mass media – film, TV and cartoon stories</td>
<td>■ change in attitudes</td>
</tr>
<tr>
<td>- internet and mobile phones</td>
<td>■ motivation</td>
</tr>
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<td></td>
<td>■ skills</td>
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**EXAMPLE: THE REDA COUNSELLING MODEL**

R Rapport: establish a co-operative working relationship.
E Exploration: help the client to understand their problem, and clarify what it means to them and what is important about it.
D Decision: help the client to decide on the options available to them.
A Action: help the client to plan a course of action and start on it, reviewing as appropriate.


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**Level 2: Change in community, social and cultural values and norms**

The values, attitudes and behaviours expected and approved of by the societies we live in can hinder or help us to enjoy good sexual and reproductive health. Gender equality, acceptance of differences in sexuality, respect for people living with HIV and key populations, and willingness to reflect on and change social values and attitudes, all improve health and reduce stigma and discrimination. However, in too many societies people who do not conform to social, cultural and gender norms are rejected, stigmatised and even criminalised. People with same-sex partners, transgender people, people living with HIV, sex workers and people who use drugs are examples of people who are often stigmatised and rejected by their societies. This makes it more difficult for them to have long-term relationships, access services for information, treatment and care, family planning and MNCH and to take measures to protect themselves and others from HIV infection, STIs or unintended pregnancy.

At this next level, our work is aiming to change the attitudes and behaviours that undermine SRHR. Activities are likely to address issues such as gender, sexual and cultural values and behaviours, and the stigmatisation and violation of rights of particular groups. Mobilising communities to reflect on social factors and work for collective change is essential. A supportive social and cultural environment fosters respect and protection. It also promotes SRH and rights for people of any gender and sexuality, and supports gender equality. In an ideal environment we would all have access to the education, services and social support we need to live healthy, fulfilling sexual and reproductive lives.

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**Example: A Support Group in Haiti**

Centre Espoir (CEPOZ) provides a friendly meeting place for around 300 people living with HIV in Port au Prince, Haiti. The programme’s services include HIV testing, STI treatment, economic and nutritional support, help for people experiencing sexual violence, and referral to other service providers. Support groups play an important role in the programme. The groups provide people living with HIV, and affected friends and families, emotional and social support that creates a sense of togetherness and builds self-esteem. They also provide a platform to work against stigma and discrimination. Groups are usually facilitated by a person living with HIV, and each group has a counsellor and invites guest speakers.

**Example: Radio Phone-ins in Cambodia**

Audiences are growing steadily for the BBC World Service Trust’s radio phone-ins on sexual health in Cambodia because they provide an opportunity for vulnerable groups to ask questions anonymously that they might not ask face-to-face. Surveys show that exposure to radio and TV programmes increases knowledge of the benefits of condoms and creates support for discussing and using them. Condom use also increases, but more among men than women, and not between regular partners.


See also ‘Mass media and HIV and AIDS in Cambodia’. Available at: www.bbc.co.uk/worldservice/trust/research/2009/04/090403_cambodia_sentinel_survey.shtml


Available at: www.aidsalliance.org/publicationsdetails.aspx?id=296

This guide provides tools for facilitating interactive drama with communities to increase knowledge of SRH and HIV, build skills and find ways to improve sexual and reproductive health.

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I know how to look after myself. I practise my right to say no to sex with my friends and we support each other. We feel confident to say what we want clearly and even to older men.
EXAMPLE: LEARNING ABOUT SOCIAL VALUES IN TANZANIA AND ZAMBIA

A community in Tanzania was concerned about the high prevalence of HIV infection and early pregnancy in girls aged 15 to 19. When men and women mapped the places where girls might be exposed to risky sex, they realised that the girls were at risk everywhere: in their own homes, at the well, on the road to school, and in school itself. They realised that male attitudes and behaviour around gender and age was putting all girls at risk and making it difficult for them to avoid unwanted sex. Community leaders, parents and girls agreed that these beliefs had to change and took action to bring this about, by creating by-laws for example.

Young people in Zambia were trained to talk to their peers about the things that influence their behaviour. These peer researchers then met with project staff to share and analyse their findings. One finding was that young men listened to both their Chewa cultural teaching, which encourages boys to practise sex for perfection at marriage, and their Christian teaching, which promotes abstinence until marriage. The boys preferred the Chewa teaching because it allowed them more sexual freedom. The project resulted in changes to how young men and women are traditionally socialised at puberty, which in turn altered gender values, attitudes and beliefs.

<table>
<thead>
<tr>
<th>INTERVENTIONS</th>
<th>RESULTS</th>
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<tbody>
<tr>
<td>1. Community mobilisation</td>
<td>Increases understanding of community norms, and influences them to support SRH</td>
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<tr>
<td></td>
<td>Engages most-affected people and stakeholders</td>
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<td></td>
<td>Promotes community ownership of change</td>
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<td></td>
<td>Identifies allies to help spread new ideas</td>
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<td></td>
<td>Strengthens change through collaboration and co-ordination</td>
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<tr>
<td></td>
<td>Uses community skills and resources</td>
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<tr>
<td>2. Understanding social values and attitudes</td>
<td>Leads to change through understanding and analysis</td>
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<tr>
<td></td>
<td>Enables use of information to design social change programmes</td>
</tr>
<tr>
<td>3. Group learning</td>
<td>Increases awareness of community norms and understanding of their impact</td>
</tr>
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<td></td>
<td>Leads to commitments and action plans to strengthen enabling values and attitudes, and change harmful ones</td>
</tr>
<tr>
<td>4. Most-affected people in active and leadership roles</td>
<td>Promotes rights and builds confidence of most-affected people</td>
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<td></td>
<td>Builds respect for most-affected people</td>
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<tr>
<td></td>
<td>Reduces fear and raises hope</td>
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<tr>
<td></td>
<td>Changes attitudes from stigma to appreciation and openness</td>
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<tr>
<td>5. Sensitisation and training of influential groups and opinion leaders</td>
<td>Creates powerful influencers of change who command respect, are listened to and believed</td>
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<tr>
<td></td>
<td>Role models change first, with others following their lead</td>
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<tr>
<td></td>
<td>Creates a large enough group to act together and form a social movement</td>
</tr>
<tr>
<td>6. Use of local and mass media</td>
<td>Reaches large numbers of people in local languages/cultural forms</td>
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<tr>
<td></td>
<td>Influences social values and attitudes by demonstrating the benefits of change</td>
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<tr>
<td></td>
<td>Makes people reflect privately on new ways of thinking and acting and therefore change, especially if combined with group activities</td>
</tr>
<tr>
<td></td>
<td>Creates a favourable climate for social change</td>
</tr>
</tbody>
</table>
The African Transformation programme, based on the successful Arab Women Speak Out project, aims to build self-efficacy, confidence and self-esteem in women and men; improve gender values, attitudes and beliefs; and increase community participation. Operating in Malawi, Nigeria, Tanzania, Uganda and Zambia, it is based on group work and has two main components. First, print, audio and video profiles of men, women and couples who have overcome gender barriers and become role models form the centrepiece of each group session. Second, interactive and participatory exercises enable men and women to examine how gender norms and social roles affect their lives.

Evaluation of the programme in Uganda has shown an increase in women starting a new business, participating in community efforts to improve health care, talking with other women about ways to negotiate with husbands and families, and participating in community meetings. There has also been an increase in women and men taking part in activities to reduce or stop harmful traditional practices. There are higher levels of confidence, self-esteem and skills in women and men, particularly in doing something to stop violence against women and carrying out tasks not traditionally performed by their gender. Both women and men now have higher scores on a gender equity scale.

Sources: Johns Hopkins University Center for Communication Programs (2007), 'African transformation engenders self-efficacy, improves gender norms, and increases community participation', Communication Impact! 23. Available at: www.jhuccp.org/node/636

Level 3: Change in health and support services
The aim at this level is to improve access to, and use of high-quality, welcoming and comprehensive SRH and HIV services. Services are most effective when tailored to meet the specific needs and rights of individuals, particularly the most vulnerable, such as sex workers or young people. Our work can address the barriers to access and use by strengthening partnerships between community workers and health facilities, and by involving users in activities to improve quality and reduce stigma and discrimination.

People need access to many types of services to help them lead healthy sexual and reproductive lives. Services and service providers include facility-based health centres or hospitals, community-based outreach services, traditional services, private facility-based services and projects to market commodities such as condoms. Services can be provided in different places, but they need to be accessible, responsive, affordable, user-friendly, good quality and integrated.

If we want to improve access to high-quality services, it is important to:

- engage and educate the community about services
- help services become more responsive to everyone’s needs
- make it easy to use the services
- join up SRH and HIV services.

We also need to think about our role in relation to users, community groups and the other services in our site, and form partnerships to combine our strengths. These partnerships might be made up of people who are most affected by SRH and HIV problems, local communities and their health and education providers, NGOs, community-based organisations (CBOs) and government and private services.
### A Summary of Interventions and Results at a Health and Support Services Level

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Engaging and educating the community</strong></td>
<td>Ownership of services, better service integration design, and increased collaboration between services and between community and services</td>
</tr>
<tr>
<td>■ Educating people about services</td>
<td>■ Increased demand improves knowledge of services and how to use them</td>
</tr>
<tr>
<td>■ Community advocacy for high-quality, accessible and comprehensive services</td>
<td>■ Improved services, confidence and demand</td>
</tr>
<tr>
<td><strong>2. Helping services to become more responsive</strong></td>
<td>Continuity of care, which responds to needs at all levels</td>
</tr>
<tr>
<td>■ Improving collaboration between services at community, primary and secondary levels</td>
<td>■ Improved service quality, helpful staff, greater levels of trust and confidentiality</td>
</tr>
<tr>
<td>■ Technical capacity-building and training</td>
<td>■ Increased use of services</td>
</tr>
<tr>
<td>■ Reducing service-related stigma</td>
<td></td>
</tr>
<tr>
<td><strong>3. Improving accessibility</strong></td>
<td>Increased service accessibility and use</td>
</tr>
<tr>
<td>■ Providing services nearer to users</td>
<td></td>
</tr>
<tr>
<td>■ Making journeys to the facility easier</td>
<td></td>
</tr>
<tr>
<td>■ Making services affordable for the poorest people</td>
<td></td>
</tr>
<tr>
<td>■ Making services affordable and friendly</td>
<td></td>
</tr>
<tr>
<td><strong>4. Joining up SRH and HIV services</strong></td>
<td>Increased access to comprehensive SRH and HIV services</td>
</tr>
<tr>
<td>■ Assessing and designing joined-up services</td>
<td></td>
</tr>
<tr>
<td>■ Identifying the challenges to joined-up services and addressing them</td>
<td></td>
</tr>
<tr>
<td>■ Joining up services at community level</td>
<td></td>
</tr>
<tr>
<td>■ Joining up facility-based services</td>
<td></td>
</tr>
</tbody>
</table>

People working in the community have a vital role to play in integrating HIV and SRH services, both directly and through referral:

- They can integrate different components of SRH and HIV services such as counselling on dual protection, providing condoms, emergency contraception and oral pills, and referral for other contraceptive methods

- Outreach workers can visit homes to help people take their medicines correctly and supply condoms and pills

- Peer educators can facilitate interactive learning activities on SRH and HIV, helping people to use services and to ask for better quality and improved access

- Traditional healers and birth attendants can provide services such as syndromic STI treatment, basic antenatal and postnatal care, and referral for HIV testing, treatment and safe delivery

- Private practitioners or sales outlets can provide joined-up services such as syndromic care, clean needles and contraceptives. Some people may prefer to talk about their needs privately with a pharmacist rather than queue up at the hospital.
Sex workers in Kenya do not use mainstream health care services because of stigma, poverty and the illegal, invisible nature of sex work. In response, Alliance Linking Organisation KANCO has set up a centre for sex workers to help reduce the level of unprotected sex and the risk of HIV infection. KANCO also wants the centre to increase access to services, including HIV testing and counselling, STI and opportunistic infection treatment, and access to antiretroviral treatment (ART).

The centre offers the following services: information; condom education and provision; family planning; HIV testing and counselling; STI screening and management; opportunistic infection management; referral for ART; tuberculosis (TB) screening and referral; PAP smears for cervical cancer; breast examination; and group empowerment activities. The centre trains sex workers to reach their peers where they work and socialise, hold weekly peer group meetings in different areas, give out pamphlets and cards, and invite their peers to the centre.

Up to 300 sex workers now access services. They have established a support group for people living with HIV and registered self-help groups to set up income-generating activities. Sex workers report that they have reduced their risk practices and there is greater uptake of HIV testing and other health services. Sex workers also refer their regular clients and partners for STI and HIV services, and recognise their role in preventing the spread of HIV.

A key piece of learning from the programme has been that service delivery has to be flexible and adaptable as sex workers are very mobile and have unpredictable working hours. Programmes must also have medical, psychosocial and behavioural components, and friendly, non-judgmental attitudes among staff are essential.

There are many opportunities for joining up SRH and HIV services in existing facilities, directly or through referral. We can directly integrate components into existing services, for example by creating a one-stop shop (when a provider offers SRH and HIV services at the same place in one session), by referring people from one service to another, or by piloting new integrated services.

Level 4: Changes in policy, laws and other structural factors
Our lives are influenced by the public policies and laws that govern us. These policies and laws affect how funding for health and social support services is spent, and whether the human rights – and sexual and reproductive rights – and dignity of people of any age, sex, sexual orientation, ethnic group, religion or wealth are supported and promoted. Laws that treat HIV transmission as a health problem rather than a crime have a positive impact on SRH. Policies that make provision for health services that support, treat and meet the needs of the whole community are also likely to have a positive impact on SRHR.

Advocacy for laws and policies that support SRHR and protect people from harassment and abuse are particularly important where existing policies and laws violate human rights or stigmatise and discriminate against people living with HIV and key populations, such as men who have sex with men, sex workers or people who use drugs. Advocacy can change or improve policies and laws to ensure health services are adequately funded, welfare systems are improved, and access is increased to integrated HIV and SRH services.
## A Summary of Interventions and Results at Policy, Legal and Other Structural Levels

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and analyse the impact of laws and policies, and make a case for change, a new policy or better implementation</td>
<td>Provides evidence of the impact of a law or policy</td>
</tr>
<tr>
<td></td>
<td>Sets out the benefits of the changes we are proposing</td>
</tr>
<tr>
<td></td>
<td>Sets out what we and our organisation or coalition think should happen – our position.</td>
</tr>
<tr>
<td>Study human rights agreements and gather evidence and case studies on the abuse of these rights, and on alternative, successful approaches</td>
<td>Provides essential evidence to promote rights and defend people whose rights are being violated</td>
</tr>
<tr>
<td>Publish position paper or briefing note</td>
<td>Helps coordinate common public statements amongst allies</td>
</tr>
<tr>
<td></td>
<td>Provides useful information for policy makers, journalists, directors, leaders and others</td>
</tr>
<tr>
<td>Form a coalition</td>
<td>Builds support for change. Demonstrates a range of interests all coming together in support of change</td>
</tr>
<tr>
<td>Working from inside influential organisations</td>
<td>Direct contact with a known person can give more influence</td>
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<tr>
<td></td>
<td>It is easy to strengthen the capacity of allies within the organisation</td>
</tr>
<tr>
<td>Lobbying or face-to-face meetings</td>
<td>Gives an opportunity to present the ‘human face’ of the issue and build relationships</td>
</tr>
<tr>
<td></td>
<td>Most-affected people can present case directly</td>
</tr>
<tr>
<td>Presentations of evidence and the benefits of change</td>
<td>Is an opportunity to present an issue in a controlled way. This includes testimonies by people affected by the problem and those whose lives have improved after change</td>
</tr>
<tr>
<td>Drama or video to show the negative impact of existing policy or law and the benefits of change</td>
<td>Can influence targets and reach more people by engaging feelings as well as providing facts</td>
</tr>
<tr>
<td>Press release</td>
<td>Useful for gaining public support, to launch a campaign or provide a quick reaction to opposition</td>
</tr>
<tr>
<td>Media interview</td>
<td>Same as for press release, but also provides a human face</td>
</tr>
<tr>
<td>Press conference</td>
<td>Same as for press release</td>
</tr>
<tr>
<td></td>
<td>Good for presenting evidence, case studies and examples</td>
</tr>
<tr>
<td></td>
<td>Useful to launch a major campaign or react to serious opposition or major developments</td>
</tr>
<tr>
<td></td>
<td>Can easily involve most-affected people and allies, and give them public recognition</td>
</tr>
<tr>
<td>Toolkits and guidelines</td>
<td>Enables policy-makers and programmers to implement good SRH and HIV policies and laws</td>
</tr>
</tbody>
</table>
**EXAMPLE: HARMFUL CRIMINAL LAWS**

Criminalising the transmission of HIV, or sex between consenting adults, can make people highly vulnerable to SRH problems and HIV. It can violate rights and affect access to services. For example, sex between men, anal sex, drug use and sex work are illegal in many countries. This creates many barriers to these people accessing information and services, and exposes them to rights violations. Laws that criminalise the transmission of HIV from mother to child violate the human right to have a child and result in fewer people seeking an HIV test. Criminalisation of HIV transmission also reduces peoples’ willingness to be open about their HIV status. These laws put all the responsibility for prevention of HIV transmission onto the person living with HIV.

**CASE STUDY: THE IMPORTANCE OF NETWORKS IN ADVOCACY WORK**

RedLacTrans is a regional network of transgender people covering 16 countries in Latin America and the Caribbean. It was established to distribute information, take action and provide a platform for reporting human rights abuses such as hate crimes and the social rejection of transgender people.

In 2008, advocacy work with heads of government and civil servants working on health led to greater representation of transgender people in regional decision-making forums and influenced policies to raise their visibility and integrate their priorities into health policy and legal reform.

In Guatemala, RedLacTrans and local organisation Reinas de la Noche used the media to publicise the hate murders and disappearances of transgenders that were occurring, and took part in a national demonstration to stop violence against women. However, this made the situation worse: “As a result of those actions there were more attacks, more threats. I was attacked and someone tried to kill me,” said RedLacTrans director, Johana. When hate and violence originate in the police force and a public ministry it is difficult to protest for justice. So transgender organisations now go to the Office of Human Rights to denounce and publicise hate crimes. RedLacTrans are also working to gain a hearing before the Inter-American Court of Human Rights to apply pressure at the international level. “My responsibility as an activist, as a champion of human rights in the transgender community, is to carry on,” said Johana.

**KEY RESOURCES**

UNFPA (2009), ‘UNFPA framework for action on adolescents and youth. Opening doors with young people: 4 keys’.


This framework for action contributes to the comprehensive development of adolescents, not only through SRH education and services but also through their livelihoods, participation and leadership.
Bringing it all together

It is helpful to analyse these four levels separately when we are assessing problems and designing programmes. But, to make the most impact we need to join them up so that interventions at each level reinforce and support interventions at the other levels.

The case study (below) describes an integrated programme to address gender-based violence at all four levels.

CASE STUDY: WORKING AT MULTIPLE LEVELS IN INDIA

The violence that female sex workers in India experience from criminals, partners, pimps, madams, and the police increases the risk of HIV transmission. Violence results in sex workers being less able to negotiate condom use or to access health services. They are also less likely to adopt health-seeking behaviour and take action to promote their health and well-being.

In order to address this, the Gates Foundation-funded Alliance project has been building the capacity of community organisations, and female sex workers themselves, to provide protections from violence, and to sensitise the perpetrators and hold them to account. The project works from the principle that an individual woman is less likely to take action on violence than groups of women working together, so it is helping female sex workers to form support groups for protection, sensitisation and advocacy work.

The key interventions are advocacy training for female sex workers, creating crisis response teams formed of female sex workers and community organisations, and raising awareness in the media and the police on the rights of female sex workers.

Although the response has been broadly positive, it is difficult to assess how far advocacy has reduced violence towards female sex workers because their reporting of violent incidents is low, due to loyalty or fear of reprisals. The police force is the only organisation that can be publicly held to account, and it is here where advocacy has been most clearly successful. The project worked with senior officers to influence police behaviour, and reinforced this with a media campaign to ‘name and shame’. Awareness raising has been the best advocacy strategy for the other perpetrators and the community. As a long-term, collaborative effort, the project focuses on building the capacity of female sex workers and community organisations well beyond the life of the project itself.

The project has called for more emphasis to be placed on security because women who are less intimidated by the threat of violence are more able to avoid it. Women in the state of Manipur claimed that the biggest contribution to reducing violence was the opening of a night shelter in Imphal that allowed them to hide from criminals and police. Female sex workers at the shelter can also advise on protection options.

In Andhra Pradesh women described confidence as the greatest form of protection. Female sex workers who were trained as outreach workers almost eliminated violence from their lives, and they attributed this to feeling more able to stand up for themselves. It is important to design monitoring tools that can gather qualitative data on how empowered female sex workers feel to protect themselves against violence.

However, the most effective way to monitor community-led responses to violence may be to measure our own performance as lead organisations and donors supporting these responses. This can tell us how well our own approaches are working, remind us of our own accountability, and empower female sex workers to control the type of support they need.

Interventions to bring about change at different levels

Set out below are some examples of the kinds of interventions we can implement to bring about change at the different levels. These categories are not fixed and some actions can bring about change at multiple levels. We need to choose the actions that are most likely to have the effect we want to achieve. It is helpful to analyse the levels separately when we are assessing problems and designing programme, but to make the most impact we will also need to join them up so that each level reinforces and supports the others.

## A summary of interventions and results at all levels

<table>
<thead>
<tr>
<th>INDIVIDUAL, PEER AND HOUSEHOLD INTERVENTIONS – ADDRESSING HEALTH SEEKING BEHAVIOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Counselling for mental health, sex and relationships, and family planning</td>
</tr>
<tr>
<td>* Health information and education</td>
</tr>
<tr>
<td>* Improving risk perception and increasing health seeking behaviour</td>
</tr>
<tr>
<td>* Peer education</td>
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<tr>
<td>* Community outreach</td>
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<tr>
<td>* Working with groups:</td>
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<thead>
<tr>
<th>SERVICE LEVEL – IMPROVING SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Training healthcare workers about the rights of individuals living with HIV, understanding and challenging stigma, and the benefits of integrating SRH and HIV services</td>
</tr>
<tr>
<td>* Training peer outreach workers to increase demand for services and to provide education and services in the community directly and by referral</td>
</tr>
<tr>
<td>* Supporting government services to address a range of SRH and HIV needs</td>
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<tr>
<td>* Using opportunities to influence training curricula for health care and social workers</td>
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</table>

<table>
<thead>
<tr>
<th>COMMUNITY ACTION INTERVENTIONS TO ADDRESS SOCIAL FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Mobilising community members to educate and inform their communities about sexual and reproductive health, maternal, newborn and child health (MNCH) and HIV</td>
</tr>
<tr>
<td>* Community education about HIV and SRH including MNCH</td>
</tr>
<tr>
<td>* Facilitating group reflection and action</td>
</tr>
<tr>
<td>* Encouraging most-affected people including key populations into active and leadership roles</td>
</tr>
<tr>
<td>* Using local and mass media such as drama and radio to raise awareness of SRH, MNCH and HIV, and to challenge existing social norms</td>
</tr>
<tr>
<td>* Training and sensitising influential people and opinion leaders</td>
</tr>
<tr>
<td>* Local advocacy with police and other officials to bring about implementation of supportive policies and laws</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>POLICY AND STRUCTURAL INTERVENTIONS – CHANGING LAWS AND POLICIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Advocacy for policies and laws that promote access to integrated SRH and HIV health services and help people to realise their rights</td>
</tr>
<tr>
<td>* Advocacy for appropriate health spending on integrated SRH and HIV services for people living with HIV and key populations</td>
</tr>
<tr>
<td>* Supporting the implementation of policies and laws through strategic plans, implementation protocols and guides</td>
</tr>
</tbody>
</table>
What are risk and vulnerability?

Some people are less able to manage their exposure to STIs, HIV or unintended pregnancy than others. This can put them at greater risk of HIV infection and other SRH problems. Our aim should be to identify and reach those who experience the most difficulties.

**Risk** refers to the probability or likelihood that a person will become infected with HIV and encounter other SRH problems. Particular behaviours, such as unprotected sex and sharing injecting equipment, increase risk. The degree of risk depends on many factors, such as the HIV status of a person’s sexual partners, and genital health.

**Vulnerability** refers to the range of factors that reduce a person’s ability to avoid risk. For example, sexual feelings and needs, gender norms, poverty, lack of access to services and commodities such as peer education, condoms or other contraception, all increase our vulnerability to HIV and other SRH problems. Stigma, discrimination and other human rights violations increase our vulnerability to HIV by making us more likely to be poor, criminalised, excluded from society or secretive about the sex we have.

### EXAMPLE

In Jamaica, different vulnerabilities among the population have led to varying rates of HIV infection. The overall infection rate in the population is 1.3%. However, among sex workers it is 9% and among men who have sex with men it is estimated to be as high as 25–30%.


### Who is at risk? Why are they vulnerable?

We all have a number of risks and vulnerabilities around SRH and HIV that operate at different levels. It is not possible to make a list of interventions that will meet all the needs of a specific group because we all have a number of identities, behaviours and vulnerabilities. People may not identify themselves as belonging to one key population group, especially if they belong to a number of different groups or if they have been stigmatised.

Young people, people living in remote areas, and those who are stigmatised or criminalised, such as people living with HIV and key populations, often lack the knowledge and skills to maintain good sexual and reproductive health. If some sexual practices are stigmatised or criminalised, it is more difficult for people to get information about their risk or how to enjoy sex safely. For example, young people, gay and heterosexual couples and sex workers may all practice anal sex, but they do not have the information they need to ensure safer anal sex and prevent HIV and anal STIs. Everyone needs information about all the sexual practices they might enjoy.

### REMEMBER

We all have attitudes or experiences that can make us vulnerable to risk-taking. People with both high risk and high vulnerability experience the most SRH and HIV-related problems. It is important that the most affected people play a major role working with programmes so they can understand and meet their needs. Most-affected people are sometimes called ‘key populations’ or ‘most-at-risk populations’ (MARPS).
Services
Women who sell sex or use drugs also need family planning and maternal, newborn and child health services, as well as specific interventions to promote safer sex with clients and intimate partners, and harm reduction services such as access to clean injecting equipment and opiate substitution treatment.

Social situations
Many people face stigma, for example, married women with HIV, pregnant schoolgirls, men with anal STIs, boys who are attracted to boys, sex workers, or people who use drugs. Stigma is always painful, is a barrier to accessing services and information, and lowers self-esteem. It can also result in violence, the inability to earn a living or stay within the family, or even death. Criminalised behaviour such as same sex relationships, sex work and drug use can lead to arrest and further rights violations.

Gender issues
Gender inequality plays a significant role in increasing vulnerability to HIV and other SRH-related problems and limiting access to health care services and information. In many societies, men and women are expected to follow gender rules and are punished if they break them. Men have more power than women but can lose this power if they are seen to be feminised, for example by having sex with other men, or by changing their gender. Men are often stereotyped as violent perpetrators. This, of course, is not always the case, but some men do see themselves as entitled to use violence against women or others who do not behave in a masculine way. Poor boys and men are often unable to gain respect or sustain long-term, approved relationships with girls and women.

The table, on the following pages, highlights some of the SRH and HIV vulnerabilities that certain groups of people face and what needs to change to address the causes of risk and vulnerability for each group.
Who is at risk and what needs to change?

<table>
<thead>
<tr>
<th>GROUP</th>
<th>KEY SRH VULNERABILITIES</th>
<th>WHAT CHANGE IS NEEDED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV</td>
<td>Many people do not know that they have HIV and do not access safer sex and treatment services</td>
<td>Increased access to HIV testing, safer sex information, and treatment services</td>
</tr>
<tr>
<td></td>
<td>Many people suffer blame and violence upon disclosure of their HIV status, particularly women, who are often diagnosed first at antenatal clinics</td>
<td>Counselling on partner violence integrated into HIV and couples/family counselling</td>
</tr>
<tr>
<td></td>
<td>Stigma and discrimination can lead to loss of partner, children and home; poor access to services; poor quality care; isolation; and lack of work and housing</td>
<td>Reduction in stigma and discrimination</td>
</tr>
<tr>
<td></td>
<td>Lack of financial resources to access services and commodities</td>
<td>Access to ART and other treatment resources for better health</td>
</tr>
<tr>
<td></td>
<td>People share ART and food with children and partners</td>
<td>Comprehensive information and services to allow a healthy and satisfying sexual life</td>
</tr>
<tr>
<td></td>
<td>Some people disapprove of people living with HIV engaging in sexual activity and having children, leading to stigma and discrimination</td>
<td>Choice about contraception, safe abortion and whether or not to have children</td>
</tr>
<tr>
<td></td>
<td>Reluctance of health workers to give reliable contraceptives to people living with HIV because of the fear that they will stop using condoms</td>
<td>Ability to reduce risk of HIV transmission to children</td>
</tr>
<tr>
<td></td>
<td>Health providers may lack knowledge of safer methods of conception for people living with HIV and on ART</td>
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</tr>
<tr>
<td></td>
<td>In some parts of the world, it is difficult for HIV-positive women to assert their right to have a safe abortion. Other women are pressured to have an abortion because of their HIV status</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased risk of STIs, cancers and maternal mortality</td>
<td></td>
</tr>
<tr>
<td>People who use drugs</td>
<td>Women who use drugs and female partners of men who use drugs lack services</td>
<td>Friendly SRH services for drug users, linked to harm reduction services. SRH and other health services must ensure they don’t exclude active drug users</td>
</tr>
<tr>
<td></td>
<td>Focus on preventing HIV transmission via injecting omits SRH needs</td>
<td>STI diagnosis and treatment services alongside or integrated into harm reduction services</td>
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<tr>
<td></td>
<td>Babies may be abandoned at birth because of fear of arrest and because of poor access to opiate substitution treatment in pregnancy and labour</td>
<td>Drug user-friendly pregnancy and maternal health services for women who use drugs, including PPTCT and opiate substitution treatment</td>
</tr>
<tr>
<td></td>
<td>Childbearing is disapproved of and children taken into care</td>
<td>Drug user-friendly contraception, dual protection, emergency contraception and safe abortion services. Women who use drugs may find longer acting contraceptives such as implants more acceptable than the pill</td>
</tr>
<tr>
<td></td>
<td>Multiple causes of stigma</td>
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</table>

For more information please see the Good Practice Guide on HIV and drug use.
### Young people

- Growing up and managing emerging sexual feelings
- Lack of comprehensive sexuality, life skills and rights education, and services for SRH and HIV
- Negative cultural attitudes to young people’s sexuality, resulting in stigma and discrimination
- Unequal power relations with adults leading to abuse
- Poverty and lack of employment
- Some gender norms and practices increase HIV risk and sexual health problems
- Young women, who are biologically more susceptible to HIV than men, also often have older male sexual partners, who are more likely than younger men to be infected with HIV  
- Sexual abuse, violence, exploitation and early marriage
- Orphans and other particularly vulnerable children are at higher risk of abuse and exploitation
- Violations of rights, including a lack of participation in decisions that affect them
- Screening for HIV and treatment for young children is not widely available

### Women

- Cultural and gender norms that expect women to submit to men’s sexual needs and control their own sexual behaviour
- Inequality between men and women affecting decision-making, choice and access to resources
- Economic dependence on men
- Cultural and gender norms that accept violence towards women
- Women’s ability to use sexuality to earn higher income than other available work may increase risk of infection
- Biologically, HIV is transmitted twice as easily from men to women as from women to men
- Low contraceptive use, high maternal mortality and high HIV prevalence are found in the same countries and groups, along with poor access to services
- Men are expected to make decisions about how many children to have and their spacing. They may not allow their partners to use contraception
- Women may enjoy sexual activity less because of fears of pregnancy, infection or violence

### What change is needed?

- Comprehensive sexuality and life skills education and services tailored to their needs
- Acceptance of young people’s sexuality
- Protection from sexual abuse and exploitation
- Promote economic independence from older men
- SRH education
- HIV treatment and care for children and young people living with HIV
- Equality in sexual and reproductive decision-making
- Equal access to an equal share of resources
- Promote economic independence for women
- Address gender-based violence
- Access to choice of contraceptives and condoms
- Access to comprehensive SRH services

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<table>
<thead>
<tr>
<th>GROUP</th>
<th>KEY SRH VULNERABILITIES</th>
<th>WHAT CHANGE IS NEEDED?</th>
</tr>
</thead>
</table>
| Female sex workers    | In addition to the above:  
- Sex workers experience stigma and discrimination demonstrated through physical and verbal abuse, and often criminalisation  
- The focus on HIV/STI prevention omits other SRH needs such as family planning and MNCH  
- The home life of sex workers, including their regular partners and children, is ignored  
- Only 21% of countries have anti-discrimination laws that protect the rights of sex workers  
- Social attitudes result in moralistic or punitive approaches to stop sex work rather than meet the SRH and HIV needs of sex workers  
- Emotional, psychological and physical violence is common and is exacerbated when sex work is forced underground e.g. selling sex in more hidden, unfamiliar areas; limiting the ability to develop solidarity with other sex workers to build support and social capital, and negotiate with health and social service providers  
- Lack of legal protection from the police and judiciary, even where sex work is legal due to societal attitudes or related activities such as soliciting for clients being illegal, making sex workers less likely to make a complaint to the authorities if they have experienced violence  
- Lack of understanding of sex workers’ rights  
- Limited participation and prioritisation of sex workers in SRH and HIV responses  
- A large proportion of sex workers are invisible and difficult to reach | - Counselling on preferred contraceptives, condoms and other safer sex methods (inhastruterine devices alone may increase risk of HIV/STI infection)  
- Discussion of the impact of hormonal pills, injections or implants on menstrual bleeding  
- Counselling for sex workers who want to conceive but ensure that their lover is the father  
- Counselling on sex work during pregnancy and reducing the risk of STIs and HIV for the mother and foetus  
- Discuss anti-violence strategies with sex workers, support collectivisation and creation of safe spaces and link up with sex-worker friendly legal, health and support service providers  
- Support the mother to attend antenatal care, and plan for where she will deliver, costs and care for the baby after it is born |
| Women who have sex with women | Lack of disclosure of sexual orientation  
- Many women also have sex with men due to their preference or because they are unable to live according to their sexuality, due to pressure to conform to gender norms and expectations to have children. In those instances, they face a degree of risk for HIV and HPV from unprotected sex with men, using drugs, sharing sex toys, oral sex and genital contact, especially during menstruation  
- Many women who have sex with women believe that they are not at risk of HIV, STIs or unintended pregnancy so they do not access information about safer sex  
- Same-sex activity not seen as sex or significant  
- May use untested semen to get pregnant  
- Stigma and discrimination  
- Violence and rape aimed at ‘correcting’ lesbian behaviour  
- Poor access to SRH services  
- No legal rights to keep children | - Trained, non-discriminatory medical staff to take a sexual history without making assumptions about identity or sexual behaviour  
- Teachers trained to include same-sex behaviour in sex education  
- Screening, testing and care for HIV  
- Screening for breast cancer, HPV and STIs  
- Family planning, artificial insemination and adoption  
- Services for addiction to alcohol or drugs  
- Support services for violence and disclosing sexual identity |

11. International HIV/AIDS Alliance (2008), ‘Sex work, violence and HIV. A guide for programmes with sex workers.’ Available at: www.aidsalliance.org/includes/Publication/Sex_%20work_violence_and_HIV.pdf
<table>
<thead>
<tr>
<th>GROUP</th>
<th>KEY SRH VULNERABILITIES</th>
<th>WHAT CHANGE IS NEEDED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>Cultural and gender norms that encourage lack of control over sexual desire, multiple sexual partners, risky sex, domination of women and having many children</td>
<td>Opportunities to reflect on gender values, attitudes and behaviour and contribute to actions to improve gender relations</td>
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<tr>
<td></td>
<td>Men are expected to know about sex and not to ask for help</td>
<td>SRH services accessible to boys and men</td>
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<tr>
<td></td>
<td>Men who do not conform to gender norms and behaviours are stigmatised</td>
<td>Participation in all aspects of improving SRHR for men and women</td>
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<tr>
<td></td>
<td>Some men are unable to maintain regular relationships with women or marry because they cannot compete with older, richer men</td>
<td>Information about reproductive health including fertility, how to avoid STIs and HIV transmission to female partners and children, and PPTCT</td>
</tr>
<tr>
<td></td>
<td>Better-off men are able to attract more sexual partners</td>
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<tr>
<td></td>
<td>Lack of male-friendly reproductive health education and services</td>
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<td></td>
<td>Focusing on women’s vulnerability gives men the idea that they are not vulnerable</td>
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<tr>
<td></td>
<td>Men may be stigmatised as irresponsible and promiscuous, rapists and women beaters, and not respected for their ability to be part of the solution</td>
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<tr>
<td></td>
<td>Migrant men are more likely to have multiple and overlapping partners</td>
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<tr>
<td>Male and transgender sex workers</td>
<td>Multiple layers of stigma related to sex between men, sex work, gender identity and HIV status</td>
<td>Information on the risks of all sexual practices and how to reduce them</td>
</tr>
<tr>
<td></td>
<td>Social attitudes result in moralistic or punitive approaches to stop sex work rather than meet sex workers’ SRH and HIV needs</td>
<td>Services for anal and oral STIs</td>
</tr>
<tr>
<td></td>
<td>Sex between men and sex work is criminalised in many countries</td>
<td>Learning sessions and counselling on reproductive health, fertility, protection of female partners and children, and PPTCT</td>
</tr>
<tr>
<td></td>
<td>Less attention is given to male and transgender sex workers in the HIV and SRH response</td>
<td>Interventions to increase self-esteem and reduce stigma</td>
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<tr>
<td></td>
<td>Male sex workers who also have female partners and children find it difficult to talk to them about their work and HIV risk</td>
<td></td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>Stigma, discrimination and criminalisation of same-sex relationships</td>
<td>Specific information and services; for example, related to anus and rectum damage, oral and anal gonorrhoea, hepatitis and anal cancer</td>
</tr>
<tr>
<td></td>
<td>Lack of information on a range of sexual practices, including anal sex, and how to make them safer</td>
<td>Comprehensive information on the risks of sexual practices and how to make them safer</td>
</tr>
<tr>
<td></td>
<td>Lack of user-friendly services able to respond to the specific needs of men who have sex with men such as anal STIs</td>
<td>Information about reproductive health including fertility, how to avoid STIs and HIV transmission to female partners and children, and PPTCT</td>
</tr>
<tr>
<td></td>
<td>Lack of information and services on reproductive health, including protecting fertility and preventing HIV transmission to female partners and children</td>
<td>Positive role models to tackle issues around self-esteem</td>
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<tr>
<td></td>
<td>Difficulty disclosing HIV risk to female partners due to stigma and social inequality</td>
<td></td>
</tr>
<tr>
<td>GROUP</td>
<td>KEY SRH VULNERABILITIES</td>
<td>WHAT CHANGE IS NEEDED?</td>
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<tr>
<td>Men who have sex with men (Continued)</td>
<td>41% of countries reported laws, regulations and policies that hinder the delivery of effective HIV-related services for men who have sex with men¹²</td>
<td>Discreet services to help avoid stigma, such as trained, non-judgmental doctors  Work to reduce stigma is vital</td>
</tr>
</tbody>
</table>

| Male to female transgender and transsexual people | Multiple causes of stigma, discrimination and criminalisation  Violence, rape and murder  Persecution by the law and state  Police abuse and imprisonment  Rejected by society, school and workplace and forced into sex work  Poverty  Prejudice, violence and discrimination by health service providers  Lack of comprehensive information and services to meet SRH and HIV needs  Unsafe surgery and hormone injections. Misuse of silicone and oils as implants  Low self-esteem and depression  Use of drugs and alcohol | Health care workers trained to treat transgender people with respect (using their preferred name, allowing the use of female toilets and being non-judgmental)  Acknowledge geographic and social isolation and potential trauma history  Counselling and learning sessions on accepting being female  Provision of safer alternatives to prosthetic and implant materials  Vaccinations for hepatitis A and B  Information on STIs and timely treatment  Small condoms for neo-penis and urgent consultation if condoms slip or break.  Lubrication for neo-vaginas  Information on possible interaction between ART and hormones |

| Disabled people | Assumption that they are not and should not be sexually active or have children  Lack of services that recognise disability and adjust interventions to meet users’ needs. These needs include accessible locations, communication and protection strategies¹³  Vulnerability to sexual abuse and exploitation  The global literacy rate for adults with disabilities is 3%, and only 1% for women with disabilities. Literacy is vital to understanding HIV messages and translating them into individual behaviour change¹⁴ | Recognition of the right to a pleasurable and safer sexual life  Comprehensive SRH education, counselling and services that reach people with different disabilities  Support for disabled people to find ways to enjoy their sexuality safely, meet potential partners if they wish, and access services  Non-stigmatising environments where they are able to enjoy equal and long-term sexual relationships |

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Joining up HIV and sexual and reproductive health and rights

In this chapter:
- Why join up HIV and sexual and reproductive health and rights?
- Which components can we join up?
- What are the benefits?
- What are the challenges?

Good practice programming standards:

- STANDARD 1
- STANDARD 2
- STANDARD 4
- STANDARD 5
- STANDARD 6
- STANDARD 7
- STANDARD 11
Why join up HIV and sexual and reproductive health and rights?

Most HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. The risk of acquiring and transmitting HIV can also be increased by the presence of certain STIs.

Sexual and reproductive ill-health and HIV also share root causes: lack of access to information and services; poverty; harmful gender norms and inequality; cultural norms; and social marginalisation or criminalisation of key populations.

Most people think about their sexual and reproductive lives in a holistic way with HIV as only one aspect. Working for broader sexual and reproductive well-being opens up many more opportunities to prevent HIV infection and provide care for people with HIV, as well as improving sexual and reproductive health in its own right.

Integrated SRHR and HIV programmes can also strengthen and expand work to promote rights, address the root causes of vulnerability and reduce stigma and discrimination. Joined-up community activities such as peer outreach, interactive learning groups, drama and local advocacy can help bring about changes in gender and cultural norms.

**TYPES OF HIV EPIDEMICS**

In high-prevalence settings around 40% of HIV transmission occurs in long-term concurrent relationships and around 40% in sex workers, men who have sex with men and people who inject drugs. Everyone is at risk of HIV infection, and many babies are born with HIV.

In this situation it makes sense to integrate the promotion of healthy sexual behaviour and to optimise connections between HIV testing and all SRH services. It is also sensible to join up HIV, STI, and MNCH services.

In concentrated epidemics the most affected people include people living with HIV and key populations of sex workers, men who have sex with men, transgender people and people who use drugs. Here it may be more effective to integrate SRH services into HIV programmes and services that have already been designed for people living with HIV and key populations.

What type of HIV epidemic is happening in your district?

When we are looking at joining up SRH and HIV programmes, we need to make sure we understand the type of HIV epidemic in our country, district and community as well as the sexual and reproductive health situation.
Which components can we join up?

The diagram below shows the main components of SRH and HIV services and the key linkages. Chapter 4 gives more information on the interventions we can use.

A framework for priority linkages

- **Increase access to high quality HIV testing** through a range of HIV and SRH services. This enables more people to know their HIV status and access HIV prevention, care and treatment services for themselves and their children. Work should also aim to reduce barriers to testing such as stigma and criminalisation. For example, expand access to HIV testing for pregnant women at antenatal clinics and ensure timely provision of ART for mothers and babies through MNCH services. (See interventions 3, 8, 9 and 10, page 49.)

- **Promote safer sex that protects individuals from HIV, STIs and unintended pregnancy** (dual protection). Provide individuals with the knowledge, attitudes, skills and confidence to enjoy safer, healthier and happier sexual lives. At the levels of social change, services and policy, create enabling environments for SRHR and HIV education and broader poverty reduction. For example, facilitate comprehensive sexuality and life-skills sessions with young people and work with community leaders and parents to support healthy behaviour. (See intervention 2, page 51.)

- **Optimise connections between HIV and STI services**. STI diagnosis and treatment reduces HIV transmission and infection. It also provides opportunities to reach men as well as women with HIV testing and counselling on safer sexual behaviours. For example, the integration of antenatal screening services for syphilis and the provision of syndromic management for other STIs can improve pregnancy outcomes for mothers and newborns. (See intervention 11, page 61.)

- **Promote dual protection** through the use of condoms together with a more effective contraceptive method or emergency contraception in case

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**KEY RESOURCES**


This document sets out the rationale and evidence for integrated approaches, how to make the case effectively, and examples of eight HIV interventions in which SRH can make a difference.
of condom failure. This approach can increase condom uptake because it responds to people who may be more concerned about HIV, infertility or unintended pregnancy. It may also be easier to ask someone to use a condom to prevent pregnancy than to prevent HIV. Messages targeting condoms at people at higher risk of HIV can stigmatise condoms and those who use them. Promoting them as a value-free device that anyone can use to plan their families and protect each other from infection is likely to help reduce this stigma. (See intervention 1, page 50.)

- **Join up HIV services with MNCH services.** The four pillars of PPTCT can keep mothers healthy and reduce the number of orphans and babies born with HIV. (See interventions 8, 9 and 10, page 49.)

**CASE STUDY: REFERRAL FROM ONE SERVICE TO ANOTHER**

Alliance India has established community sexual health services called Mythri clinics in Andhra Pradesh that advocate good treatment for their clients. These integrated community services reach thousands of the most marginalised men and women, supplying high-quality services. They provide individual health promotion, condoms, and STI diagnosis and treatment. They also mobilise communities and train peer outreach workers to help female sex workers and men who have sex with men gain the confidence, self-esteem and skills to practise safer sex and get prompt treatment for STIs. The clinics refer clients for HIV testing, ART and other support services such as networks of people living with HIV. Plans are underway for the clinics to be taken over by the Indian government.

**Four pillars of prevention of parent-to-child transmission**

1. **The prevention of HIV infection in young men and women as they are growing up and before they conceive**

2. **The prevention of unintended pregnancies in all girls and women, whatever their status**

3. **HIV testing and counselling for all pregnant women, with fast referral to ART, care and support; antiretroviral prophylaxis; safer delivery; and safer infant feeding. Testing of partners and safer sex promotion are also important because the risk of HIV transmission is very high if a partner is recently infected**

4. **Long term ART for mothers and children living with HIV. Ensure that mother and child get long-term support with nutrition, prevention of infections, treatment and care**

**Sources:**
What are the benefits?

Evaluations show that SRH and HIV linkages can bring important benefits at public health, socio-economic and individual levels (see key resource opposite).

**Improved access and uptake**

Joining up SRH and HIV interventions and services can increase access to and uptake of both components. It also enables us to tailor our programmes to the needs of different groups.

**People living with HIV** have a range of SRH and HIV needs. They may face stigma in some facilities and difficulties travelling to separate services. Home-based care programmes can incorporate SRH education, services and referral for the whole family, tailored to everyone’s needs. In Uganda, the Alliance trained people living with HIV to work as Network Support Agents to create linkages between communities, people living with HIV, and health and other services at facility and community level. Through the project, people living with HIV were counselled and educated about SRH and HIV. They were also given condoms and referred to family planning, PPTCT and STI services. (See case study on next page.)

**Young people** are best served through integrated programmes to prevent pregnancy, STIs and HIV. Evidence shows that countries with strong, youth-friendly, comprehensive SRH education and health services have lower rates of early pregnancy, abortion and STIs. Whether they are first reached through family planning, sexual health clinics, sexuality education or HIV education, young people need and have the right to comprehensive information and services. Adolescent orphans and vulnerable children particularly need access to SRH and HIV information and services because they are significantly more likely to be sexually active at younger ages. This is related to abuse, the need for transactional sex and lack of parental guidance and protection.

Reproductive health services can reach **groups perceived to be at low risk of HIV** with HIV testing and services; these groups include married women, older women and people in regular concurrent partnerships. In generalised (high prevalence) epidemics, these groups may have high numbers of new infections. Postnatal services and post-abortion services can provide an opportunity to counsel on HIV and STIs, and provide HIV testing and contraceptives.

Linking SRH and HIV can enable **key populations** to access services tailored to their needs. For example, sex workers may prefer to get family planning at HIV centres to avoid stigma but would also like to get treatment and PPTCT from the hospital if it provides non-stigmatising services to sex workers.

**Better care**

Joining up services can improve quality of care by providing a comprehensive service in one place; increasing providers’ communication skills; taking account of all SRH needs when helping clients to make a decision on safer sex or family planning; and reducing the stigma particular groups face, such as people living with HIV who want to have children.

**Greater efficiency**

Joining up services can result in increased effectiveness and efficiency, and less duplication of effort and competition for resources. It can also lead to better use of human and material resources for health.
A project to expand the role of networks of people living with HIV in Uganda aimed to improve access to HIV prevention, treatment, care and support services for households with people living with HIV, and increase service use. The project trained groups of people living with HIV to offer community-based palliative care, adherence counselling, HIV prevention activities and material support for orphans and vulnerable children. Some individuals were also trained to become Network Support Agents (NSAs), referring people with HIV to services, including family planning, PPTCT and STI diagnosis and treatment.

The project increased access to home- and community-based services, referrals to health facilities and the involvement of people with HIV in service delivery. NSAs mobilised people with HIV to use existing government services and comprehensive community-based, wrap-around services. They also compensated for staff shortages at health facilities, where they directed and counselled clients; for example, identifying ARV defaulters and referring them back to the facility or informing staff why they no longer attend. Since NSAs lived openly and positively with HIV, they helped to reduce the stigma that deterred people from getting testing and seeking care. They also encouraged those who tested positive to disclose this to partners and family members. However, they required on-going training on issues such as TB and the analysis and use of monitoring data, and their allowances struggled to be sufficient to cover expenses.

The project learned that community ownership provides an opportunity to increase the involvement of local authorities and civil society organisations in community activities sponsored by groups of people living with HIV. District partnerships need to be maintained through advocacy, attendance at district health team meetings and routinely sharing reports. It was important to strengthen the programme in initial districts, using supervision and mentoring of the groups to ensure quality, before expansion. More staff and capacity were essential as the project was scaled up.

The groups of people living with HIV developed strong partnerships and felt a sense of ownership. Supporting them to play an active role in management, policy-making and strategic planning also strengthened their involvement further. They moved from a passive role as patients to an active role as service providers, making this a rare example of putting the principle of greater involvement of people living with HIV (GIPA) into practice in a systematic way on a countrywide basis.


MAMTA Health Institute for Mother and Child joined up with the Swedish Association for Sexuality Education (RFSU) to develop a network that could provide training in gender, sexuality, rights and advocacy skills for young people. The group also researched the best ways to engage their stakeholders. This led them to develop an advocacy kit (translated into Hindi) and handbook, a film about rights aimed at young people, briefings on working with policy-makers and the media, working papers, and evidence of the actions that stakeholders could carry out at various levels. They also developed young people as partners (peer educators, community workers and animators).

The group met with parliamentarians to get to know the information they needed on young people’s SRHR, and went on to develop written materials for them and make recommendations to programme planners. They met with stakeholders at district level to gather data on local community values, attitudes and customs relating to young people’s issues. They also worked closely with the media to highlight young people’s SRH needs and rights. As a result, an evaluation found stigma had been reduced in the community, young people readmitted to school, and some girls returned to the community. There had also been key changes in the criminal justice system on child trafficking.

For more information on the project: www.mamta-himc.org/srijan_net.htm
Challenging social norms
Joining up programmes can strengthen and broaden the coverage of activities aimed at understanding and changing harmful social, cultural and gender norms. They can also address the root causes of vulnerability. Activities include collective action, reinforcement of key messages and joint advocacy.

Reducing stigma
Integrating services in different ways to suit specific needs can reduce HIV-related stigma and discrimination. Programmes that meet people’s SRH needs in a more holistic and positive way, rather than simply focusing on HIV infections, may be more attractive and less stigmatising. Integrating family planning into HIV services may protect people with HIV from stigmatising attitudes at a general clinic. Attending a dedicated HIV service may expose people to more stigma than attending a broader, unmarked service.

People working with existing HIV services can train SRH providers to understand the needs of the most affected people such as people living with HIV, key populations and young people and challenge their own and other people’s stigmatising attitudes. If SRH and HIV outreach workers are covering the same communities, they can co-operate in providing counselling, facilitating participatory learning groups, and developing drama to reduce both self-stigmatising and community-stigmatising behaviour.

Strengthening rights, policies and laws
Joining up SRH and HIV advocacy work on rights, policies and laws can increase impact. SRH and HIV civil society organisations can work on improving legal and policy frameworks. They can gain a better understanding of the full range of rights that are relevant to SRH and HIV. Joining up increases the number of advocates and the collective strength of advocacy efforts.

CASE STUDY: KEY POPULATIONS IN MADAGASCAR MAKE POWERFUL ADVOCATES

The Alliance has supported sex workers in Madagascar to become national advocates. There are high concentrations of sex workers and mobile populations in urban areas. A participatory needs assessment showed that they had a high risk of STIs and HIV, were denied basic human rights, and were subjected to abuse and stigma. The Alliance worked with them to reduce their vulnerability to infection and empower them to advocate for their rights.

The programme worked with FIMIZORE, a network of sex worker organisations concentrated in Madagascar’s largest cities, to build its capacity through training in peer education, STI and HIV prevention, advocacy, leadership, financial management, and anti-stigma and discrimination work. Key interventions included researching and documenting the laws and decrees affecting sex work and HIV in Madagascar, and using the findings to inform sex workers of their rights. The programme also documented evidence of abuse and violence, and presented this to health and law enforcement departments; lobbying decision-makers and leaders; and negotiating for service improvements and a protective legal framework for sex workers.

These interventions led to solid networks working together to defend sex worker rights and address the causes of their vulnerability. Advocacy on human rights, closer relations between sex workers and the community, and access to health services have resulted in significant improvements. Sex workers gained the respect of stakeholders nationally and are now invited to meetings and have access to decision-making bodies. The language of human rights has proved to be a strong tool for building their confidence and preventing STIs and HIV.


KEY RESOURCES

This tool can be used to assess HIV and SRH linkages at policy, system and service delivery levels, identify gaps and contribute to action plans.

What are the challenges?

Linking SRH and HIV policies and services presents many challenges to those on the frontline of health care planning and delivery. These challenges include:

- ensuring that integration does not overburden existing services in a way that compromises service quality, and that integration actually improves health care provision
- managing the increased workload for staff who take on new responsibilities
- allowing for increased costs initially when setting up integrated services and training staff
- combating stigma and discrimination from and towards health care providers, which has the potential to undermine the effectiveness of integrated services no matter how efficient they are in other respects
- adapting services to attract men and young people who tend to see SRH, and especially family planning, as ‘women’s business’
- reaching those who are most vulnerable but least likely to access services, such as young people and key populations such as, sex workers and men who have sex with men
- providing the special training and ongoing support required by staff to meet the complex SRH needs of HIV-positive people effectively
- motivating donors to move from parallel to integrated services, and sustaining support for integrated policies and services.

Key questions for assessment and design are:

- What SRH and HIV problems do different groups of people face?
- What are the causes and consequences of these problems?
- What SRH and HIV services are available in the site?
- How well do they address the problems of different groups?

**Key resources**


This guide defines integration and provides evidence that it makes a difference to HIV outcomes. It outlines what policies and programmes could be integrated in country contexts, what is needed for successful integration, and makes proposals to monitor and evaluate integration.
3 Approaches

In this chapter:
- How human rights, public health and development shape our work
- Gender and sexuality
- Partnerships for change
- Community mobilisation and participation

Good practice programming standards:

☑ STANDARD 2
☑ STANDARD 3
☑ STANDARD 9
☑ STANDARD 10
When we have problems in our community related to HIV and sexual and reproductive health, it is important to acknowledge that change needs to happen. The way we go about making this change is influenced by a range of ideas, values, principles and methods – which make up our approach. In this chapter we explore the approaches that can guide the way we respond.

**How human rights, public health and development shape our work**

Our work responding to HIV and SRHR is informed by human rights, public health and development approaches.

**Rights-based approaches**

Human rights principles and practices influence all our beliefs and values and consequently our actions. They are enshrined in the United Nations Universal Declaration of Human Rights and many other international human rights instruments such as the International Covenant on Economic, Social and Cultural Rights.\(^{15}\) They apply to all human beings, whatever their age, sex, sexual orientation, ethnic group, religion or wealth. The following human rights apply especially to integrated SRHR and HIV work:

<table>
<thead>
<tr>
<th>HUMAN RIGHT</th>
<th>USE THIS RIGHT TO PROTECT:</th>
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<tbody>
<tr>
<td><strong>The right to life and security of the person</strong></td>
<td>Women at risk of genital mutilation, or subject to forced pregnancy, sterilisation or abortion. All people from criminalisation and imprisonment for their sexual or gender orientation, occupation or drug use. The rights of men and women to have autonomy over their bodies at all stages of their lives.</td>
</tr>
<tr>
<td><strong>The right to equality and to be free from all forms of discrimination</strong></td>
<td>The right of all people, regardless of race, colour, sex, sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, economic status, birth, HIV or other status, to enjoy a safe and pleasurable sexual life founded on self esteem and mutual respect, respectful, safe and equal access to information and services related to development and SRH.</td>
</tr>
<tr>
<td><strong>The right to privacy</strong></td>
<td>The right of all clients of SRH information, education and services to privacy, and confidentiality regarding personal information given to service providers.</td>
</tr>
<tr>
<td><strong>The right to information and education</strong></td>
<td>The right of all people to access full information on the benefits, risks and effectiveness of all methods of protection against STIs and HIV infection and fertility regulation, so their decisions are made with full, free and informed consent.</td>
</tr>
<tr>
<td><strong>The right to health care and health protection</strong></td>
<td>The right of all people to the highest possible quality of health care, and the right to be free from traditional practices that are harmful to health.</td>
</tr>
</tbody>
</table>

Often, governments, police or other authorities, and the social and cultural norms of their society, will deny people human rights that affect their sexual and reproductive health and HIV status. In some societies, for example, women are at risk of genital mutilation, forced pregnancy, sterilisation or abortion. In others, the right to enjoy a safe and pleasurable sexual life founded on mutual respect and self esteem, and to have safe and equal access to information and services in relation to SRH and HIV, is not available to everyone, regardless of their race, sex, sexual orientation, drug use and HIV status.

When faced with human rights abuses in relation to SRHR and HIV, a human rights-based approach advocates for the defence of people’s rights, in particular their right to health. A human rights-based approach to programming differs from providing for people’s basic needs, such as food and shelter, by recognising the existence of rights, and by focusing on the duty of governments (and other duty bearers) to respect, protect and guarantee these rights.

In the programmes and services the Alliance supports, for example, it does not discriminate against people living with HIV and key populations, despite the fact that many of these groups are criminalised for their actions such as selling sex, having male to male sex or using drugs. The Alliance promotes the meaningful participation of affected communities in the way it plans, delivers and evaluates its programmes and services. This is part of a rights-based approach.\(^{16}\)

\[\text{How do we make our rights-based approach real when the government says that we have no rights?}\]

In our project, we actively participate in naming our problems, looking at their causes, designing an action plan, carrying it out and monitoring and evaluating our progress. Knowing our rights strengthens our confidence to advocate for what we need and to change attitudes.

\[\text{We support one network that defends the right of all transgender people to express their gender identity and sexuality without fear of discrimination or arrest. The network members work with lawyers, administrators and health services to advocate for access to services enforced through a new law against discrimination.}\]

\(^{16}\text{Adapted from IPPF (2003), ‘IPPF charter guidelines on sexual and reproductive rights’. Available at: www.ippf.org/en/Resources/Guides-tools/IPPF+Charter+Guidelines+on+Sexual+and+Reproductive+Rights.htm}\]

**CASE STUDY: THE IMPACT OF ADVOCACY INITIATIVES WITH KEY POPULATIONS IN BOLIVIA**

Alliance Linking Organisation Instituto para el Desarrollo Humano has been working in Bolivia since 2005 to strengthen the participation of key populations (people living with HIV, sex workers, men who have sex with men, and transgender people) to improve their access to non-discriminatory, quality services from public health providers.

Key population activists were supported to acquire skills in advocacy, leadership, planning and implementation. These skills increased their visibility, and positioned and strengthened their organisations. The activists also carried out participatory research and concluded that health care was “deficient for the key populations, violating not just the right to health care but also fundamental rights such as identity, integrity, dignity and life”. During this process, national ‘working tables’ were set up, each with members from the four key populations. These have now established themselves as key reference points in the national HIV response.

This advocacy work played a key part in getting Resolution 688 passed, which incorporated amendments to the Bolivian constitution making it mandatory for health programmes and services to provide comprehensive health care and show respect for the dignity and rights of key populations. A provision was also made for the penalisation of discrimination on the grounds of sexual orientation or gender identity to be included in the new constitution. Other achievements included passing Law 3729 for the Prevention of HIV/AIDS and creating a national health plan.

The national working table wanted to find out whether health service providers were applying Resolution 688 and whether key populations were exercising their rights. So in 2008 it set up a Citizen Observatory to compile information on discrimination against key populations in health care centres, and to monitor the implementation of policies that protect citizens’ rights and improve their quality of life. This showed very low levels of awareness of Resolution 688 and Law 3729 among health service providers and key populations. The data the Citizen Observatory has gathered provides reliable evidence that can be used to analyse the new legal context in Bolivia and political changes in the country. The new political constitution, the issue of municipal autonomy and the promotion of social involvement have led to many opportunities to lobby for universal access to health care. Regional forums are continuing to analyse the current situation for key populations, and are identifying barriers to service access and ways to reduce them. Key population leaders liaise with allies and other stakeholders as they vote together on proposed resolutions, publish them in a national newspaper and send them to the ministry of health.

The Citizen Observatory has achieved a strong commitment among national key population leaders to partnership work. This has led to agreements between the national working table and other key population organisations, as well as ties with the ministry of health and other key government bodies, such as the National AIDS Committee and the Global Fund Country Coordinating Mechanisms. The programme is now also being implemented in Equador, Colombia and Peru.

**Public health approaches**

Public health principles are also central to an effective approach as they enable us to understand and address individual health needs as well as the determinants of ill health. Public health research has provided strong evidence on which interventions work well, and this can help us to prioritise approaches that will best improve the health of communities. A public health approach focuses on interventions that reduce vulnerability to infection and disease, and promote healthy public policy. For public health approaches to work, human rights have to be placed at the centre, as highlighted in the previous section. The field of public health has shown the importance of focusing on pragmatic interventions that rely on scientific research, and that have been proven to be effective. For example, research shows that it is more effective to provide young people with information on SRH issues before they need to use it, in order to prepare them for the future.17

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17. WPF and STOP AIDS NOW! (2009), ‘Evidence and rights based planning & support tool for SRHR/HIV prevention interventions for young people’. Available at: www.wpf.org/documenten/OVC_E-PAT_tool_UK.pdf
CASE STUDY: EFFECTIVE REFERRAL PROCEDURES IN TANZANIA

Researchers from Tanzania and the UK have collaborated with local stakeholders to design and assess a referral system to link people diagnosed at a voluntary counselling and testing (VCT) clinic in a rural district in northern Tanzania with a government-run HIV treatment clinic in a nearby city. The new procedures include:

- a two-part referral form that facilitates access to the HIV clinic and monitors attendance
- transportation allowances and a ‘community escort’ from a local home-based care organisation for patients attending the HIV clinic
- supportive counselling services provided by the VCT counsellors and home-based care volunteers.

As a result of the new system, referral uptake at the HIV clinic averaged 72% among men and 66% among women during the first three years of the national ART programme, and gradually increased with the introduction of transportation allowances and community escorts. Most patients reported that the new system made it easier to access the HIV clinic, although they would prefer HIV treatment services to be nearer to their homes. The referral forms proved an efficient and accepted method for assessing the effectiveness of the clinic as an entry point for ART.

Source: Nsigaye, R. et al. (2009), ‘From HIV diagnosis to treatment: evaluation of a referral system to promote and monitor access to antiretroviral therapy in rural Tanzania’, Journal of the International AIDS Society, 12(31). Available at: www.jiasociety.org/content/12/1/31

Development approaches

It is important that development principles and practices inform our work because we are working in resource-poor settings with people who are living in poverty. Informed by human development practice, a development approach uses participatory methods, builds capacity to strengthen vulnerable people and communities to ensure sustainable programmes and organisations, and focuses on those most in need or vulnerable to HIV and other SRH problems. This means that addressing poverty and inequality, and developing and adapting programmes so that they are culturally and socially acceptable, will be central to our policy and practice.

CASE STUDY: A PARTICIPATORY TOOL FOR PLANNING EFFECTIVE SERVICES

The health journey is a participatory methodology based on the journey that we all go through when we realise that we have a health problem. We think about our options. We could do nothing and hope that the problem will go away. If we decide to do something about it we think about what to do, where to go and who to ask. We think about how we can make sure that we get the help we need. The picture on the right shows a journey that a woman living with HIV made when she realised that she was pregnant.

The tool is useful because the person with the problem is at the centre of the picture and it is based on their real-life experience. It highlights the connections between affected people, services and environments. It focuses on the strengths and challenges of what actually happens rather than of what ought to happen.

By analysing health journeys it becomes clearer what people’s real needs are and what is helpful to them. The journeys also show the wide range of people that influence those with health problems. Used with a mixed group, the health journey encourages greater sharing of knowledge and provides an impetus for analysis, planning and implementation of more effective services and policies.

Recognising and responding to gender and sexuality issues is central to the Alliance’s approach because the Alliance’s values state that the lives of all human beings are of equal value. Slightly more than half of all people living with HIV are women and girls. In sub-Saharan Africa, more women than men are living with HIV. and young women aged 15–24 years are eight times more likely than men to be HIV positive. It is an important principle that everyone, regardless of gender and sexuality, has a right to health and whatever they need to achieve this. In our programmes, we can work with those who are affected to analyse the positive and negative impacts of gender and sexuality in the local context. These impacts may relate to both gender and sexual inequality, and to the way that gender and sexual values, attitudes and practices affect men and women throughout their lives.

In this guide, we use the term ‘sex’ to mean whether we are male, female or intersex, determined by our genitalia and genes. We use ‘gender’ to mean the socially constructed roles, behaviours and characteristics that a given society considers appropriate for men, women and, in some societies, transgender people. Gender identity is how a person sees themselves along a continuum from male to female, rather than their biological sex.

In many societies, the majority of people believe that individuals are either male or female and should follow their ‘natural’ roles in life, with marriage and sexual relations only appropriate with someone of the opposite sex. These values and attitudes discourage people from accepting or expressing gender in different ways and lead to stigma. Some cultures have separate social roles for certain types of transgender people, such as those for the hijra communities of India and Pakistan.

These beliefs lead to hetero-normative lifestyles (behaviours, values and attitudes towards social relations, consumption, entertainment and dress that make sense to oneself and others in a specific time and place). This discourages people from crossing or mixing gender roles, or from creating alternative forms of gender expression. It also underpins some of the prejudices that stigmatise those who live outside a society’s prescribed gender boxes.

This means that it is important to develop leadership that supports gender as a central issue in SRH and HIV programmes, and to access funding specifically for the integration of gender issues. When we are planning our programmes, we need to think about how to take gender into account. It can be helpful to think about responses to gender in four categories.

1. **Do no harm**

At the very least our programmes should not make gender inequalities or relationships worse. For example, the term ‘prevention of mother-to-child transmission (PMTCT)’ suggests that women are responsible for preventing (and by implication causing) HIV transmission to their babies. This may lead to increased stigma and partner violence towards women, and exclude male partners from information, services and responsibility. By using the term ‘prevention of parent-to-child transmission (PPTCT)’ or ‘vertical transmission’, and by providing counselling for couples, services can support gender equality and more effectively prevent vertical transmission.
2. Gender sensitive
This means SRH and HIV services taking account of the different needs of women, men and transgender people, whatever their sexual orientation. This includes recognising their physical vulnerabilities and the impact of their gender and sexual orientation on their options for safer sex and use of services. For example, women often find it difficult to negotiate contraceptive use with their partners. So services might need to reach couples or men and women separately with counselling and information, and provide women with male and female condoms and contraceptive hormone injections in private. Service providers need to ensure they do not make any assumptions about gender orientation or sexual behaviour, and that users are not stigmatised. For example, men and women may enjoy anal sex whatever their sexual orientation.

3. Gender transformative
The transformative approach supports gender equity for people of all orientations. It seeks to change the conditions that create inequity including the dominant definitions of femininity and masculinity, and prejudice towards gender and sexual diversity. Men, women and transgender people are seen to be equally important in addressing HIV and SRH problems. Methods for this approach include participatory group work to analyse the gender system and the impact it has on HIV and SRHR, and to plan ways to change negative aspects.

4. Empowering
Empowerment programmes aim to equalise the balance of power between the genders. This can reduce the vulnerability caused by a lack of power, usually experienced by girls, women, transgender people and people with same-sex partners. As well as providing information, skills and services, these programmes advocate economic and political equality.

In sexual and reproductive health work it can be all too easy to get into the habit of talking about sex and sexuality only in terms of problems, such as too many children, disease and violence. But sexual pleasure is a key motivation for sexual activity, and a more positive approach that promotes pleasure as a joy and a right can engage people more effectively.

We can promote sexual pleasure by: 18

- **addressing exploitation and inequality** as the basis for promoting consensual sexual relations
- **empowering and affirming**. Women for Women’s Human Rights (WWHR) in Turkey uses modules on sexual pleasure in its human rights training for women, even in conservative areas
- **promoting pleasure in safer sex interventions**. The Pleasure Project has mapped 27 initiatives around the world that use pleasure as the primary motivation for promoting sexual health, including programmes that eroticise condoms. They also work with churches to improve sex among married couples.

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Partnerships for change

It will only be possible to achieve access to high-quality programmes for everyone if those who are affected, communities, and different types of government and civil society organisations combine their strengths in partnerships.

What are the roles that different groups need to play?

People who are most affected by SRH and HIV, including **people living with HIV and key populations**, have experience dealing with their difficulties and using services – and they often know best what would help to meet their needs. They are central to analysing the situation, shaping the response at different levels, providing education and services to their peers, campaigning for services, and advocating for social and policy change.

**Our organisation doesn’t know any people living with HIV or key populations. Stigma is too great and they are not open in the community. How can we involve them in integrated programmes if they are not here?**

**The more we create spaces for people living with HIV and key populations to participate, the more we will reduce stigma and discrimination and others will feel safe to come and work with us on their SRHR needs.**

**Government sectors** can reach people nationwide with services, education and livelihoods, at community, district, provincial and national levels. Government sectors are essential for scaling up services, training staff, allocating resources, and formulating policies, implementation plans and standards.

**NGOs and CBOs** play a major role in:

- mobilising communities around a problem or issue
- educating people to understand how services can benefit them and how to use them
- contributing to making services responsive to people’s needs and reducing stigmatising attitudes in service providers and users
- increasing access by providing services in the community and ensuring access to key populations
- helping to join up SRH and HIV services
- mobilising key populations to demand and use services.

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**KEY RESOURCES**


Assess your organisation and the potential barriers to participation for diverse groups of people living with HIV and key populations. Then work to develop a partnership with organisations of people living with HIV and key populations. Our reputation will develop as people learn that your organisation is an open and safe environment that is willing to work in a participatory way.
Private sector partners may play a major role in increasing access to services for people who are unwilling or unable to access government services because of distance, fear of stigma or poor quality of care. For example, people seeking condoms or STI treatment may prefer to use pharmacies or small drug stores. The private sector may also provide workplace education and services.

Community mobilisation and participation

What is a community?
A community is a group of people who feel they have something in common. They might live in the same village, work together, have the same problems or share the same interests.

People usually belong to more than one community at the same time. For example, a person living with HIV might identify herself as part of the wider community where she lives, as a member of the CBO she works with, as a wife and as a mother. People living with HIV might form a community group to respond to their challenges or to socialise and spend time together. It is important to understand how people identify themselves, rather than how others identify them. We also need to recognise how different sectors of communities overlap and interact. We can support communities to develop CBOs that help integrate SRH and HIV. These CBOs can promote safer sex to prevent HIV, STIs and unwanted pregnancies, provide home-based care, educate young people, build partnerships, and access resources.

What is community mobilisation?
Community mobilisation is a process that catalyses individuals, groups and organisations to assess, plan, carry out, monitor and evaluate activities on a participatory and sustained basis to improve their health and lives. Communities can mobilise on their own initiative or be stimulated by others.

Community mobilisation is central to influencing social values because it allows us to:

- learn about the culture and norms of the community and how they affect the SRH of different groups. Joint naming and analysis of social values is an important step towards achieving change
- be open about what we are doing and work with different groups in the community, including those who promote social values, such as church leaders, and those who are affected by them; such as unmarried mothers or same sex partners
- encourage community ownership of the need to change some social values, and ownership of what needs to be done to achieve this. This reduces the risk that people feel their culture is under attack and that they need to defend it against outsiders
- nurture relationships with powerful people or opinion leaders who are supportive of changes in harmful social attitudes and who can spread innovation
- build collaboration so different interventions can be co-ordinated and have a greater impact than single interventions. For example, drama and radio can bring about a change in attitudes that is strengthened by participatory group activities with peers. The combined activities can result in a social movement for change
- use the skills and resources in the community; for example, popular forms of cultural communication.


To start the process, community members and others often use a series of participatory activities to identify problems related to SRHR and HIV, the causes of vulnerability, and those who are most vulnerable. These activities can also identify resources that are available to meet specific needs or gaps, develop a plan, and create a sense of ownership, commitment and support for the plan in the community.

The process should ensure that those most affected by SRH and HIV-related issues, including those living with HIV, play an active, ongoing and influential role in shaping and implementing an effective response. It also means that community members take responsibility for addressing the problems of SRH and HIV themselves.

The participation of the most-affected people, such as people living with HIV and key populations, is both a right and an effective approach to bring about change because:

- they have expert knowledge of the problem
- they can suggest workable solutions based on their own experience and an insider’s perspective
- they are often highly motivated
- people living with HIV have been central to the significant progress made in the HIV epidemic
- they will gain more skills and confidence
- it reduces stigma towards those most affected.

It is good practice to work in partnership with those most affected by harmful social attitudes and practices, including people living with HIV. This partnership can provide learning for all sides, and may lead to training and support for some individuals to become leaders and actively engage in interventions.

Working with most-affected people, who are actively addressing their community’s problems, builds respect for their knowledge, skills, and sense of responsibility and care. It can also change social attitudes towards them from disapproval and exclusion to appreciation as valued members of society, friends and colleagues.

Most-affected people, including those living with HIV, might choose to:

- shape and implement an effective response to the issues their community faces
- use the Stigma Index to gather evidence of people’s experience of stigma and use it for campaigns and advocacy to change attitudes and policy
- become workplace advisors
- facilitate participatory group learning to help different groups understand and challenge stigma in themselves and others
- train health workers and religious leaders on the facts about HIV and stigma
- speak at public forums and events
- form networks to gain collective strength and become more visible and familiar.
An example of the mobilisation of married couples to prevent and treat HIV in parents and babies

<table>
<thead>
<tr>
<th>STAGE</th>
<th>QUESTIONS</th>
<th>WHAT HAPPENED IN THE PROJECT</th>
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</thead>
<tbody>
<tr>
<td>1. Starting together</td>
<td>What is the problem we want to address?</td>
<td>Although 40% of HIV transmission was occurring in adult married couples, HIV programmes were focusing on young single people. Marriage was promoted as a safe behaviour</td>
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<td>Who will take part?</td>
<td>Couples were getting sick and having babies who did not thrive</td>
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<td>A partnership of affected people and an NGO brought together leaders, providers, married men and women, and young people to explore the problem and make an action plan</td>
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<td>2. Assessing together</td>
<td>Who is most affected?</td>
<td>Community members, married couples and NGO staff worked together to explore the problem and find the causes and consequences</td>
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<td>What are the causes of the problem?</td>
<td>They mapped available resources and barriers</td>
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<td>What are the consequences?</td>
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<td></td>
<td>Where are we in addressing the problem?</td>
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<td>3. Designing and planning together</td>
<td>What changes do we want?</td>
<td>Based on the assessment findings, the community and NGO agreed on strategies to bring about change at all levels, including:</td>
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<td>How shall we achieve them?</td>
<td>- counselling and participatory learning in peer groups to promote communication between couples, awareness of risk and how to reduce it, HIV testing, safer sex, ART and PPTCT. This involved traditional teachers, religious leaders, service providers and peers</td>
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<td>Who will we reach?</td>
<td>- interactive drama, radio soap operas and phone-ins on HIV, SRH and married couples; how to reduce risk to partners and babies; the impact of stigma, gender practices and violence; and change needed</td>
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<td>- trained health workers and peer outreach workers to encourage couples to go for HIV testing, treatment and PPTCT</td>
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<td></td>
<td>- advocacy for testing and treatment of babies of HIV-positive mothers and a constant flow of commodities</td>
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<tr>
<td>4. Implementing together</td>
<td>Co-ordinating the work</td>
<td>The project built the capacity of service providers, peer outreach workers and community leaders to advocate for change and implement the programme. Project partners co-ordinated and carried out the plans, resolved difficulties and stayed motivated</td>
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<td></td>
<td>Building capacity</td>
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<td></td>
<td>Carrying out activities</td>
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<tr>
<td>5. Monitoring together and adapting</td>
<td>How well are we performing?</td>
<td>Monitoring showed that fewer men and couples living on remote farms were reached with education. Couples who were in conflict did not come for HIV testing</td>
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<td>Are we using resources well?</td>
<td>The project identified venues and times when men were free and trained farmers as peer outreach workers, with bicycles to reach the remote farms. Marital conflict was addressed as a major issue in group sessions, counselling and drama/radio. Traditional mediators and religious leaders were trained to support couples more intensively</td>
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<td>How are the most affected people responding?</td>
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<td>How do we need to adjust our project?</td>
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<tr>
<td>STAGE</td>
<td>QUESTIONS</td>
<td>WHAT HAPPENED IN THE PROJECT?</td>
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| 6. Evaluating together | - Are we doing the right activities well?  
- What differences are we making?  
- Are we reaching our aims and objectives?  
- What do we need to change? | - Married couples had better knowledge and more positive attitudes and communication skills. HIV testing for couples increased ten-fold over the period of the project and HIV-discordant couples were increasingly accessing condoms, ART and PPTCT services  
- People recognised that married couples might acquire or already have HIV. Stigma and discrimination reduced and disclosure to partners became less likely to result in violence or divorce  
- Challenges included couples not continuing with condom use after six months; intermittent stock-outs of condoms and ART drugs; attitudes among some young people who thought it best not to marry; and the omission of widowed, unmarried and divorced people who have high rates of HIV infection |
| 7. Adapting the design in the light of the evaluation |  | - Peer couples explored why they stopped using condoms and ways to keep using them. They designed messages and communicated them through counselling, drama and radio. Project members followed up couples regularly with condom supplies and suggestions for variations in safer sex. Peer groups of widowed and divorced people, and young people were established providing learning sessions and support |
| 8. Scaling up | - Has our project worked well enough to expand to new activities, areas or groups?  
- How shall we go about this? | - The evaluation showed the project had many benefits but was costly to sustain. The team and ministries reviewed the cost-effectiveness of the project and streamlined processes. They decided to support a team of key implementers from the initial villages to catalyse the process in new communities; reproduce training and IEC materials and media for national usage, second trainers from the project to national training schools; and reproduce the drama and radio programmes |
Sexual and reproductive health and HIV interventions

In this chapter:
- Key sexual and reproductive health and HIV interventions

Good practice programming standards:

- STANDARD 5
- STANDARD 6
- STANDARD 7
Key sexual and reproductive health and HIV interventions

This chapter provides more detailed information on 14 integrated SRH and HIV interventions. It emphasises reproductive health and MNCH interventions because these may be less familiar to people working in HIV programming.

The tables describe the intervention (what), the rationale for the intervention (why), key activities (how), and key reference material.

The interventions are:
1. Safer sex promotion to prevent STIs, HIV and unintended pregnancy
2. Activities to support a satisfying sexual life
3. Increasing access to HIV testing and counselling
4. Joining up family planning and HIV services
5. Safe abortion and post-abortion care
6. Protecting and enhancing fertility
7. HIV treatment (ART)
8. Preventing HIV transmission to babies during pregnancy, delivery and after birth
9. Improving maternal and newborn health
10. Treatment of HIV-positive children
11. Optimising integration between STI and HIV services
12. Male circumcision
13. Prevention, diagnosis and treatment of SRH-related cancers
14. Addressing gender-based violence

Interventions aimed at changing individual behaviour, social values, policies and laws are described in more detail in Chapter 1.
### Safer Sex Promotion to Prevent STIs, HIV and Unintended Pregnancy

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<tr>
<td>Safer sex strategies that aim to prevent both the transmission of HIV, STIs and hepatitis C, and unintended pregnancy, are called dual protection strategies. Dual protection strategies include:</td>
<td>Condoms, when used correctly and consistently, are an effective technology to prevent the sexual transmission of HIV, most STIs, and pregnancy</td>
<td>Listen to users in the design, implementation and monitoring of condom promotion programmes, using the principle of ‘nothing about us without us’ or similar community participatory approach</td>
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<td>- the use of male or female condoms alone</td>
<td>- Using condoms for family planning, STIs and HIV prevention reduces stigma and motivates condom use</td>
<td>- Promote male and female condoms for pregnancy and STI/HIV prevention</td>
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<td>- combining two methods:</td>
<td>- Dual protection strategies give people more choices in the type and level of protection they require. Condoms are less effective as a contraceptive than hormonal and medical methods. Some people may not be able to use condoms consistently and correctly with all partners</td>
<td>- Include individual/couple STI/HIV risk assessment in protocols for family planning</td>
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<td>- condoms plus another contraceptive method</td>
<td>- Pregnancy prevention and STI/HIV prevention needs are often inseparable so it makes sense to address them together. Meeting needs for dual protection improves quality of care</td>
<td>- Dual protection means more than just providing condoms. Address the different motivations for using condoms and the different people who need dual protection, such as married and discordant couples, people who use drugs, young people, men who have sex with men, and sex workers</td>
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<td>- condoms plus emergency contraception if condom fails</td>
<td>- selectively using condoms and another method (for example, using the pill with main partner, but the pill plus condoms with others)</td>
<td>- Include contraceptive counselling in HIV services (or refer people to it) on a routine basis</td>
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<td>- contraceptives plus emergency contraception if condom fails</td>
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<td>- Train providers to remove biases favouring either condoms or more effective contraceptive methods</td>
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<td>- Work with clients on condom use and negotiation skills</td>
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<td>- Budget for any increased costs in providing dual protection</td>
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<td>- Involve men in counselling and education, and address their concerns about condoms</td>
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<td>- Erectile condoms, produce different shapes and sizes, give instructions for use and adapt these for the local context – know your users and community</td>
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<td>- Help clients to think through the potential consequences of their decisions, barriers to carrying them out, and ways to overcome them, such as. helping them to practise negotiating condom use</td>
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<td></td>
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<td>- Provide full information on how to use condoms successfully</td>
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### Key References

### Activities to Support a Satisfying Sexual Life

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<tr>
<th>WHAT?</th>
<th>WHY?</th>
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<tr>
<td>Promote the right of everyone, including people living with HIV, to a safe and satisfying sexual life</td>
<td>Sexual pleasure is a major reason why people have sex but is often ignored in sexual health programmes</td>
<td>Address exploitation and inequalities as the basis for promoting consensual sexual relations</td>
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<tr>
<td>Provide positive sexuality education that includes a range of possibilities for safer sexual pleasure, and builds self-esteem and communication skills</td>
<td>Talking about sexuality and sexual pleasure in a positive way in safer sex promotion may be more engaging, motivating and empowering than basing education on fear</td>
<td>Promote sexual pleasure as empowering and affirming, and promote the right of everyone, including people living with HIV and key populations, to a safe and satisfying sexual life</td>
</tr>
<tr>
<td>Include sexuality and pleasure in counselling on safer sex and contraception, and address sexual problems</td>
<td>People living with HIV may experience sexual problems for a number of physical, metabolic and emotional reasons. Some people may experience depression, anxiety, anger, guilt, low self-esteem, changed body image, and fear of infecting others. This can result in a loss of sexual desire and drive</td>
<td>Provide health workers with an opportunity to explore their own values, feelings and experiences related to sexuality, and discuss how to avoid allowing these to influence their work</td>
</tr>
<tr>
<td>Consider the effect of ART drug interactions or hormones on libido and change if appropriate</td>
<td>Health programmes that focus on preventing further HIV transmission may add to these difficulties, even suggesting that people living with HIV should not have a sex life at all</td>
<td>Train peer outreach workers, educators and health professionals in empathetic approaches to sexual issues. This includes taking a sexual history without making assumptions or judgments, and providing accurate and easily understood information</td>
</tr>
<tr>
<td>Facilitate peer support groups and learning sessions to share positive sexual experience, provide mutual support, and reduce anxiety</td>
<td>Loss of sexual desire and sexual relationships can increase depression and anxiety, and reduce quality of life and self-esteem</td>
<td>Facilitate positive sexuality learning sessions to all those who need them, including young people, married couples, people living with HIV and key populations. Provide information on the risks of all sexual activities and ways to make them safer and pleasurable</td>
</tr>
<tr>
<td>Provide or refer people to sex therapy if needed</td>
<td>Key populations may experience sexual problems because of anxiety, self-stigma, the need to hide their identity or behaviour, low self-esteem, and a lack of information on sexuality tailored to their needs</td>
<td>Talk about sexuality, pleasure and sexual problems in counselling by:</td>
</tr>
<tr>
<td>Consider concurrent medical conditions other than HIV that may affect sexual ability such as diabetes and address them appropriately</td>
<td>ARVs may affect sexual drive in men and women, and cause erectile and ejaculatory problems in men</td>
<td>giving clients permission to talk about sensitive issues</td>
</tr>
<tr>
<td>Specific contraceptives, including condoms, may have an impact on sexual drive and pleasure</td>
<td>Fear of HIV, STIs, unintended pregnancy and violence constrains desire and pleasure</td>
<td>providing basic information about sexuality</td>
</tr>
<tr>
<td>Services that do address sexual problems often focus on men and neglect women’s sexual satisfaction. This reflects gender expectations of sexual pleasure</td>
<td>Making specific suggestions, such as the use of lubricants to make sex more comfortable</td>
<td>making specific suggestions, such as the use of lubricants to make sex more comfortable</td>
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<td>discussing the effects of ART and hormones on libido and suggesting changes as appropriate</td>
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<td>providing medications and sex therapy (or referrals)</td>
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<td>supporting people to take actions that address the causes of problems and improve their sexual lives</td>
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<td></td>
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<td>training peer educators to facilitate learning on sexuality and the exchange of helpful experiences and tips in support groups</td>
</tr>
</tbody>
</table>

### Key References

- The Pleasure Project (www.pleasureproject.org) has mapped 27 initiatives around the world that use pleasure as the primary motivation for promoting safer sex and epidemic health, including programmes that eroticise condoms and work with churches to improve sex among married couples.
### Increasing Access to HIV Testing and Counselling

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<thead>
<tr>
<th>WHAT?</th>
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<tr>
<td>Family planning, antenatal and postnatal care services, STI clinics and primary health services have successfully integrated HIV testing and counselling directly or through referral</td>
<td>HIV testing and counselling provides an opportunity for risk assessment and discussion of options for safer sexual behaviour</td>
<td>Mobilise the community to talk about the benefits and challenges of HIV testing, the best ways to provide it, and the benefits to SRH</td>
</tr>
<tr>
<td>HIV testing services have successfully integrated family planning, STI diagnosis and treatment, and maternal health into their services directly or through referral</td>
<td>Knowing our HIV status enables us to make informed decisions about our sexual and reproductive lives to avoid re-infection or infecting our partners or children. It gives us access to ART, care, and advice on how to protect our health, and well-being</td>
<td>Pay particular attention to people who only get an HIV test when they are already ill as ART is then less effective. Find out the barriers to testing, such as fear of stigma and arrest, and how to overcome them</td>
</tr>
<tr>
<td>There is evidence that a number of models of community-based HIV testing greatly increase coverage of quality HIV testing</td>
<td>Using HIV testing and counselling as an entry point into SRH services in different settings increases access for women, men, young people, people living with HIV and key populations, and is less stigmatising and more effective</td>
<td>Build rapport with users and providers, and map SRH and HIV testing and counselling services. Assess the services, their users and their satisfaction. Together, look for opportunities to improve quality and access, and join up services, either directly or through referral</td>
</tr>
</tbody>
</table>

#### Key References

- Population Council (2008), ‘The balanced counseling strategy plus: a toolkit for family planning service providers working in high HIV/STI prevalence settings’. Available at: www.popcouncil.org/publications/books/2008_BalancedCounselingStrategyPLUS.asp
  This toolkit sets out an interactive, client-friendly approach for improving counselling on family planning and prevention, detection, and treatment of STIs and HIV.

- IPPF and UNFPA (2004), ‘Integrating HIV voluntary counselling and testing services into reproductive health settings: stepwise guidelines for programme planners, managers and service providers’. Available at: www.unfpa.org/upload/lib_pub_file/245_filename_hiv_publication.pdf
  Outlines the rationale for integrating HIV testing and counselling into SRH programmes; details an assessment process; describes factors to consider when planning an integrated service; and covers specific implementation issues, monitoring and evaluation. The appendices contain checklists, sample monitoring tools and references.

  A summary of evidence-based models for community-based HIV testing and counselling, including home-based HIV testing: couple testing; community mobilisation; provision of HIV counselling and testing; post-test counselling; work-based and mobile testing.
## JOINING UP FAMILY PLANNING AND HIV SERVICES

### WHAT?
- Ensures that people at risk of, or living with HIV are able to access and choose from the full range of effective contraceptive methods to prevent unintended pregnancy, and can also obtain information and commodities to prevent HIV and STI infection (see intervention 1)
- Integrate family planning education and services into HIV programmes, such as HIV testing or treatment services; or integrate HIV education, testing, counselling and treatment into family planning programmes, directly or through referral

### WHY?
- Increases the number of people who know their HIV status and are able to make informed choices about whether or when to have a child. This reduces the number of unintended pregnancies and enhances maternal and child health and prevents transmission from parent to child in a cost-effective way
- Provides comprehensive services and dual protection
- Uses available resources more effectively
- Decreases stigma associated with using HIV and STI services
- Makes it easier to provide partner testing and treatment

### HOW?
- Mobilise the community and engage users at all stages of the project cycle
- Address stigma towards most-affected people
- Integrate family planning with HIV testing. Counsel women and men about their reproductive options on a regular basis and refer as needed
- Set up HIV testing and counselling at family planning clinics
- Train all service providers on family planning, HIV and rights, non-stigmatising attitudes, and counselling skills
- Provide joined-up counselling on family planning, STIs and HIV in HIV and SRH services
- Provide family planning at HIV care and treatment centres, and through postpartum follow-up and home-based care
- Refer from HIV services or family planning services as appropriate
- Most contraceptives are safe for women and men living with HIV. They should be offered the whole range, including condoms and emergency contraception
- TB treatment, antibiotics, certain ARVs and methadone reduce the effectiveness of hormonal contraceptives and providers need up-to-date information on this
- Screen or treat women for a possible infection before inserting an IUD
- Like others, people living with HIV should have access to sterilisation, but with full information and free from coercion
- Think about the specific needs of different groups. For example, people who are very mobile or use drugs may prefer to use an injectable contraceptive or implant, or may prefer the contraceptive pill.
- Advocate for the rights of different groups to have access to full range of reproductive and contraceptive options and document instances where certain groups are denied access to family planning services and counselling.

### KEY REFERENCES
- This tool is designed to help health workers counsel people living with HIV on sexual and reproductive choices and family planning.
- The latest technical guidance on contraceptive provision for people with HIV to help programme managers and policy makers develop programme strategies for integration and train health care providers to offer contraceptives to their clients with HIV.
- WHO, USAID and FHI (2009), ‘Strategic considerations for strengthening the linkages between family planning and HIV/AIDS policies, programs, and services’. Available at: www.fhi.org/en/RH/Pubs/booksReports/FP-HIV_Strategic_Considerations.htm
- The document is designed to help programme planners, implementers, and managers make appropriate decisions about pursuing the integration of family planning and HIV services.
### SAFE ABORTION AND POST-ABORTION CARE

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<tr>
<td>Surgical and medical abortion is safe for all women, including those living with HIV, and this should be an option, without coercion, to the extent that the law allows. Abortion services can be integrated into SRH services and HIV services directly or through referral, particularly family planning and contraceptive counselling services. It is also important to reduce post abortion complications including infections by providing appropriate medications.</td>
<td>Reduces complications and death from unsafe abortions. Saves the lives of mothers and reduce the number of orphans and babies born with HIV. The Barcelona Bill of Rights includes the right to safe pregnancy and legal abortion. Pressure or coercion to have an abortion and denial of a safe abortion are both violations of rights.</td>
<td>Review national policy, law and rights documents about abortion to be clear about whether there are any situations where abortion is legal, including a diagnosis of HIV, and whether there are procedural barriers to women accessing a legal abortion. Provide women and service providers with this information. Identify and work with allies such as service providers who provide safe abortions or post-abortion care. Look for entry points for safe abortion in existing reproductive health services. Vacuum extraction before 12 weeks and medical early abortions have a safety record of around 99% and can be carried out by mid-level health care providers without a surgical facility. Provide training on manual vacuum aspirations or extractions. More research is needed on the interaction between medical abortion drugs and ARVs. Work with maternal health services and community workers to improve the care and follow-up of women who have had an unsafe abortion. This can reduce complications and deaths, and help them to use an effective contraceptive until they want to conceive. Advocate for the rights of women including those living with HIV and/or from key populations to make their own reproductive decisions, including safe abortion, based on full information by: researching and analysing the impact of anti abortion laws; working with allies from influential organisations; develop policy position papers and directly lobbying policy makers; conducting media campaigns to gain public support and raise awareness of key issues.</td>
</tr>
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</table>

### KEY REFERENCES

## Protecting and Enhancing Fertility

### WHAT?
- Infertility is the inability to produce children after 12 months of unprotected sex at the frequency of three times per week. Infertility affects both men and women and can happen even if they have had a child in the past. Miscarriage or stillbirth is a form of infertility.
- Fertility can be reduced by certain STIs, reproductive tract infection, and mumps after puberty in men; anatomical, endocrinal, genetic and immune system problems; aging; and medical procedures that bring infection into a woman’s upper reproductive tract.

### WHY?
- The ability to have children is highly valued and is a human right. Integrating interventions that help people to protect their fertility, and to conceive if they have difficulties, increases service quality and user satisfaction, and reduces stigma.
- The promotion of condoms to protect fertility can increase the number of people motivated to use them.
- Services can help discordant couples who wish to conceive to reduce their risk of infecting each other and their baby.

### HOW?
- Mobilise communities around the protection of fertility throughout the life cycle as an important aspect of SRH.
- Promote safer sex and condoms to prevent infections, and early diagnosis and treatment of STIs (and HIV).
- Promote key points in counselling on infertility:
  - encourage couples to come for counselling
  - assess psychosocial factors and be empathetic
  - if counselling and examinations show a likely cause for infertility refer for investigation
  - advise couples to have intercourse two or three times a week, stop smoking and reduce alcohol intake
  - advise on nutrition if appropriate. Very low or very high body weight reduces fertility in women
  - review prescription and recreational drugs as they can impair fertility
  - review occupational history
  - provide psychosocial support during referral
  - consider adoption

In discordant couples:
- if the woman has HIV, prevent infection by insemination of the partner’s semen
- if the man has HIV, reduce the viral load to an undetectable level with ART, aim to conceive at the most fertile time to minimise unprotected sex, and use PEP to further reduce risk
- if both have HIV, reduce viral load with ART and time conception to prevent new strains of virus.

### Key References
  Articles and links to further resources.
  Discusses the causes of infertility and the potential of community-based services to promote actions to protect fertility, maximise chances of conception, refer for treatment and provide psychosocial support.
### HIV Treatment – Antiretroviral Treatment

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<tr>
<td>ART is a combination of drugs that can reduce or stop the ability of HIV to reproduce in the body. The level of virus becomes so low that it can no longer be detected. This means that the body’s immune system is no longer under attack. The number of CD4 cells gives us a measure of how well the immune system is functioning. On ART, the number increases and the person recovers their health.</td>
<td>Delays the progression of HIV illness for many years. People are restored to health. They can return to work, recover their interest in sex, and live a normal life with a manageable illness.</td>
<td>ART can be integrated into SRH services, or SRH services into HIV services, either directly or by referral.</td>
</tr>
<tr>
<td>ART is most effective if it is started before CD4 counts drop below 350 cells/mm³.</td>
<td>On ART, the low level of HIV in the body makes people less infectious so the risk of HIV transmission to partners and children is greatly reduced.</td>
<td>Community engagement is essential to support adherence and link people on ART to SRH services and vice-versa. People living with HIV can help others to adhere to ART.</td>
</tr>
<tr>
<td>ART does not completely remove HIV from the body, and people need to take the pills correctly, at regular intervals, for the rest of their life. If they stop, the virus quickly increases and CD4 cells decrease.</td>
<td>The return to health has a huge impact on individuals, those close to them and the household economy. It reduces poverty and allows children to continue in school and receive the care they need, as well as reducing the number of orphans.</td>
<td>Encourage people, especially those most vulnerable, such as young women, men and key populations, to go for HIV testing and counselling early when ART is most effective.</td>
</tr>
<tr>
<td>Delays the progression of HIV illness for many years. People are restored to health. They can return to work, recover their interest in sex, and live a normal life with a manageable illness.</td>
<td>The return to health has a huge impact on individuals, those close to them and the household economy. It reduces poverty and allows children to continue in school and receive the care they need, as well as reducing the number of orphans.</td>
<td>Do not make judgments about who is capable of adhering to ART regimens. Evidence shows that with support and motivation, everyone can adhere to drugs which restore their health.</td>
</tr>
<tr>
<td>The importance of a community focus for ART uptake and adherence in collaboration with formal health settings. Provides a curriculum and activities for participatory training on comprehensive support for ART.</td>
<td>Use participatory assessment, counselling and support group discussions to understand the barriers to access and adherence for particular groups, and find ways to address them.</td>
<td></td>
</tr>
</tbody>
</table>

### Key References

- Includes self-assessment guides, a client interview guide and other materials for identifying and solving on-site problems that compromise the quality of services designed for HIV care and treatment.
- The importance of a community focus for ART uptake and adherence in collaboration with formal health settings. Provides a curriculum and activities for participatory training on comprehensive support for ART.
- Examines antiretroviral delivery within a sexual and reproductive health setting, using a case study demonstrating transition from a traditional to pioneering role.
## Preventing HIV Transmission to Babies During Pregnancy, Delivery and After Childbirth

**What?**
- Promote safer sex to all women and their partners, whether HIV positive or negative, during pregnancy and breastfeeding
- Provide HIV testing and counselling for all pregnant women and CD4 counts for all HIV-positive pregnant women
- If the CD4 count is below 350, start all individuals on ART immediately or their own health. If it is more than 350, give the mother ARVs to prevent transmission to her infant.
- Encourage all HIV-positive mothers to deliver in a health facility that can provide:
  - ART prophylaxis to mother and baby during delivery
  - delivery in a way that minimises risk of HIV infection
  - counselling on infant feeding to reduce the risk of HIV transmission to the baby. This is either exclusive breastfeeding from birth to six months, followed by complementary feeding until 12 months with no need for abrupt weaning, or formula feeding from birth

**Why?**
- In 2009, 370,000 children were infected with HIV. Almost all of these infections occur in low-income countries, and more than 90% were the result of mother-to-child transmission during pregnancy, labour, delivery, or breastfeeding. Without intervention, there is a 20-45% chance that a baby born to an HIV-infected mother will become infected.
- Most infant HIV infections can be averted, yet few of the world’s pregnant women are being reached by PPTCT services or adequate antenatal and postnatal services.
- To achieve wide coverage, PPTCT programmes must be integrated into existing public health systems, with services provided by all antenatal and delivery clinics. So far, only a few low-income countries have achieved this goal. There is abundant evidence that PPTCT programmes are feasible, cost effective and a necessary part of maternal, newborn and child health.
- To break down barriers such as inaccessible services; too few mothers being tested for HIV; fear and distrust; disclosure and discrimination; the side-effects of drugs and adherence; cost; feasibility of exclusive breastfeeding; and lack of male involvement
- Long-term combination therapy for the mother keeps her healthy and this improves the health of all her children, whether infected with HIV or not

**How?**
- Comprehensive continuity of care – from pre-conception counselling for positive or discordant couples to antenatal care, institutional delivery and postpartum care – is key to reducing mother-to-child HIV transmission. Many mothers and fathers are lost to the programme at each stage. Many programmes provide one or two components only.
- Community mobilisation and participatory assessment and planning with families increases understanding of the barriers at each stage and context-specific ways to address them. One example is giving single-dose Nevirapine to mothers to take home.
- Anti-stigma education is key to enable mothers and fathers to disclose their HIV status and get family and community support for treatment adherence, institutional delivery and safer infant feeding practices. Anti-stigma activities, and in some cases discreet separate services, are especially important for key populations or single young people.
- PPTCT services are usually provided through antenatal and child health services at community, primary care and district level. With task-shifting, community and primary-level workers can counsel and refer mothers and fathers to the appropriate facility. They can do community HIV testing and ART support, Nevirapine or ART adherence, safer infant feeding and postpartum care. Research shows that peer education programmes such as ‘mothers2mothers’ in South Africa, or networks of support agents living with HIV can increase use of the full range of PPTCT services.
- The involvement of fathers and families is key to supporting PPTCT activities. HIV testing and counselling for couples is now routine in antenatal services in Rwanda, while in Zambia there is a special clinic with incentives for couple testing at the weekend. Counselling can help mothers to disclose their HIV status to their partners.
- Counselling couples on safer sex during pregnancy and lactation is essential, particularly if couples are discordant or likely to have sexual relations outside the partnership.
- If not provided, advocate for pregnant mothers living with HIV to have access to long term ART and comprehensive MNCH services to ensure the long term health and well being of mothers and children. Promote the rights of mothers from key populations to access comprehensive PPTCT services.
8 PREVENTING HIV TRANSMISSION TO BABIES DURING PREGNANCY, DELIVERY AND AFTER CHILDBIRTH

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<tr>
<td>- Counsel the mother to take care of her nipples and breasts, and any sores in her baby’s mouth. After delivery give the baby:</td>
<td></td>
<td>- Nevirapine for six weeks if the mother is breastfeeding and taking ART for her own health</td>
</tr>
<tr>
<td>- Nevirapine from birth up to one week after breastfeeding ends if the mother is taking ARV to protect her baby</td>
<td></td>
<td>- Nevirapine from birth up to one week after breastfeeding ends if the mother is taking ARV to protect her baby</td>
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<tr>
<td>- Nevirapine for six weeks if babies are being formula-fed</td>
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<td>- Nevirapine for six weeks if babies are being formula-fed</td>
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<tr>
<td>- follow up mother and baby for HIV testing, treatment and care, and counselling on adherence, infant feeding, immunisation, healthy living, family planning and safer sex</td>
<td></td>
<td>- follow up mother and baby for HIV testing, treatment and care, and counselling on adherence, infant feeding, immunisation, healthy living, family planning and safer sex</td>
</tr>
</tbody>
</table>

**KEY REFERENCES**

  A useful summary of the 2010 updated WHO guidelines and links to other materials. Details of recommended ARV combinations and dosage levels.


- AVERT (online), ‘Preventing mother to child transmission (PMTCT) in practice’. Available at: www.avert.org/pmtct-hiv.htm
  A summary of why so many mothers drop out of PMTCT programmes and what can be done to improve this.

  A study showing that peer psychosocial support programmes play an important role in providing continuity of care for HIV positive women and infants, and helps them to adhere to medical recommendations.
### Improving Maternal and Newborn Health

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<tr>
<td>The following interventions have a major impact on maternal, newborn and child health, and reduce mortality:</td>
<td>Every year around eight million children die of preventable causes, and more than 340,000 women die from preventable complications related to pregnancy and childbirth.</td>
<td>Mobilise communities and families to understand the factors that cause the deaths of mothers and babies, and what needs to change to reduce them.</td>
</tr>
<tr>
<td>- access to a choice of contraceptives to avoid unintended pregnancies</td>
<td>- access to safe abortion and post-abortion care</td>
<td>- Antenatal care to establish a relationship with the mother; identify and manage problems; make a delivery plan; implement prevention, diagnosis and treatment of HIV, syphilis and other STIs; and provide vitamin A, folic acid, anti-malarials and immunisation.</td>
</tr>
<tr>
<td>- access to quality antenatal care, including HIV testing</td>
<td>- at least three visits to quality antenatal care</td>
<td>- Manage delivery in a clean place using sterile equipment; for example, using safe delivery kits for skilled birth attendants and midwives.</td>
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<td>- delivery by a skilled attendant using sterile equipment</td>
<td>- delivery by a skilled attendant using sterile equipment</td>
<td>- Refer women with complications for emergency obstetric care early. Design strategies to deal with delays in deciding on referral and transport to the facility.</td>
</tr>
<tr>
<td>- access to emergency obstetric services</td>
<td>- long-term ART for all eligible women</td>
<td>- Train health workers to provide high-quality services during and after pregnancy and childbirth. Train community providers to carry out essential tasks.</td>
</tr>
</tbody>
</table>

### Key References

- UNFPA and Guttmacher Institute (2009), ‘Adding it up: the costs and benefits of investing in family planning and maternal and newborn health’. Available at: www.unfpa.org/public/site/global/pid/4461
- See also Pinkham, S. et al. (2008), ‘Women, harm reduction and HIV’, Reproductive Health Matters, 16 (31).
WHAT?  |  WHY?  |  HOW?
---|---|---
- Provide quality health care to infants in postpartum and child health clinics, including immunisation, nutrition, growth monitoring, prevention of malaria and diarrhoea, and ART treatment  |  - There are currently two million children living with HIV, with 370,000 new infections each year  |  - Follow up all mothers and infants after delivery with post-natal care, including immunisation, nutritional support, prevention of malaria and diarrhoea, HIV testing and ART for mother and baby  
- Test and identify babies born with HIV as early as possible  |  - If children with HIV are not identified early, half will die before their second birthday. Early diagnosis and treatment greatly reduces illness and death in children with HIV  |  - Scale up paediatric ARV treatment by building the capacity of community-based programmes to monitor and support ART adherence, nutrition, cotrimoxazole prophylaxis, intensive TB case finding, Isoniazid preventive therapy, adherence to TB-DOTS, routine immunisations, and provide appropriate referrals  
- Provide babies and children with paediatric ART as early as possible  |  - In 2008, only 8% of children born to HIV-positive mothers were tested for HIV before two months of age. Many mothers are lost to follow-up and few laboratories have the capacity to identify infected children. 200,000 children are currently on ART, three times more than in 2005, but far lower than the coverage of adults  |  - Encourage early identification through testing and referral of HIV-infected children from PPTCT programmes. Teach carers the symptoms of HIV in children and where they can get a test. Be more proactive at antenatal, postpartum and child health clinics so infants get diagnosed and treated as early as possible  
- Provide psychosocial support, comprehensive sexuality education and SRH services to children living with HIV, tailored to their current and future needs  |  - Challenges to working with children include how to help them to express themselves, dependence on adults for their care, being fearful, and requiring more time to open up during counselling. Some caretakers find it difficult to disclose the HIV status of their children and may be elderly, sick and poor. There is often a lack of ARVs and support services for children, and limited space  |  - Look for ways to make testing and treatment accessible for poor families  
- Follow up all mothers and infants after delivery with post-natal care, including immunisation, nutritional support, prevention of malaria and diarrhoea, HIV testing and ART for mother and baby  
- Scale up paediatric ARV treatment by building the capacity of community-based programmes to monitor and support ART adherence, nutrition, cotrimoxazole prophylaxis, intensive TB case finding, Isoniazid preventive therapy, adherence to TB-DOTS, routine immunisations, and provide appropriate referrals  
- Encourage early identification through testing and referral of HIV-infected children from PPTCT programmes. Teach carers the symptoms of HIV in children and where they can get a test. Be more proactive at antenatal, postpartum and child health clinics so infants get diagnosed and treated as early as possible  
- Look for ways to make testing and treatment accessible for poor families  
- Address the special needs of infants and adolescents with HIV, including issues of disclosure, sexual abuse, psychosocial support and treatment adherence. Identify the barriers to child adherence through counselling and focus groups, and look for ways to reduce them. Provide home-based care  
- Create child-friendly environments and support groups  
- As children grow up living with HIV, provide sexuality and life-skills education, and provide or refer to appropriate HIV and SRH services  
- Provide additional, standardised training for health professionals, including upgrading nurses’ skills in working with children and counselling on sensitive issues  
- Standardise treatment protocols and referral guidelines  
- Improve drug procurement and supply channels

KEY REFERENCES
- AVERT (online), ‘Treatment for children with HIV and AIDS’. Available at: www.avert.org/hiv-children.htm
- Excellent summary of evidence-based practical information on providing ART to children.
- This descriptive study explores the challenges of providing HIV counselling and testing services to children in Uganda.
OPTIMISE INTEGRATION BETWEEN STI AND HIV SERVICES

**WHAT?**
- STI prevention and treatment services include safer sex, condom and early treatment promotion, screening for STIs, and syndromic treatment of adults and care of infected newborns
- STI prevention should be a component of all HIV prevention interventions
- STI counselling, screening and treatment should be integrated into family planning services, antenatal and postpartum care, and HIV testing, treatment and support services.
- People with HIV need access to quality STI prevention and treatment services

**WHY?**
- There are one million new cases of STIs every day. Prevalence of STIs is 12% in Africa, 7% in Latin America and 5% in Asia
- In low-income countries STIs rank among the top five diseases for which people seek care. They cause acute and chronic illness and have serious consequences
- Untreated STIs have been shown to increase the risk of HIV transmission, so prompt treatment reduces risk of HIV infection. For example, the presence of untreated genital herpes and ulcers increases the risk of contracting HIV between 50 and 300 times per intercourse
- STIs are the main preventable cause of infertility, particularly in women. They can cause pelvic inflammatory disease, ectopic pregnancy and genital cancers
- Untreated STIs such as gonorrhoea, syphilis, chlamydia and herpes can cause infections in unborn and newborn children, and cause miscarriages, stillbirths, perinatal death and blindness
- STIs are transmitted through sexual contact in the same ways as HIV, so safer sex behaviours will prevent both STIs and HIV

**HOW?**
- Mobilise the community and stakeholders to promote STI prevention and treatment, and reduce stigma
- Map, build rapport and assess local STI treatment services. Work with providers to improve readiness, accessibility and quality, and reduce stigma. Identify possibilities for integration; for example STI services in family planning clinics, HIV testing centres, support and treatment centres, home-based care, and primary health care clinics, and HIV testing and counselling in STI services
- Train community and outreach workers to provide education on STI symptoms, prevention and treatment, including adherence education on STIs. Refer and encourage partner treatment, and provide relationship counselling
- Promote safer sexual behaviours and ensure access to quality condoms and lubricants at affordable prices at all service points
- When taking a sexual history, do not make assumptions about sexual orientation or practices. Include all risky sexual practices such as oral and anal sex
- Promote early treatment based on STI signs and symptoms for individuals and their partners. If possible, take a sexual history and screen asymptomatic clients for chlamydia and syphilis – at antenatal clinics, for example. Provide syndromic treatment for people with a high-risk history
- Ensure correct treatment for STIs: a full dose of correct and effective medicines, treatment of sexual partners, education and advice
- Expand vaccines for hepatitis B and human papilloma virus (HPV)
- Design specific services for groups at risk of STIs, such as men who have sex with men, sex workers or young people who are stigmatised at local services. Train and sensitise who providers might include traditional healers, private practitioners or pharmacists
- Prevent and care for syphilis and conjunctivitis in babies
- Advocate for comprehensive STI diagnostic and treatment guidelines to include anal and oral STIs

**KEY REFERENCES**
  Available at: www.who.int/mediacentre/factsheets/fs110/en
  Covers the global health burden of STIs, types of STI, signs and symptoms, complications, their relation to maternal and child health, prevention and treatment.
  Available at: www.who.int/hiv/en/hiv_aids_2001_01.pdf
  Recommendations for a syndromic approach to the management of patients with STI symptoms and the treatment of specific STIs. Also includes information on the notification and management of sexual partners and on STIs in children and adolescents.
  Available at: http://data.unaids.org/publications/IRC-pub07/jc1212-hivpreveasterneurcentrasia_en.pdf
  Highlights the experiences of five organisations that developed effective practices and implemented HIV/STI prevention programmes for sex workers.
Male circumcision involves the removal of the foreskin from the penis.

The operation needs to be carried out safely and hygienically.

Men should not have sexual intercourse for at least six weeks after the operation or until the wound is healed. Sex before this puts the man at higher risk of HIV.

Male circumcision is different from female genital cutting, which has no health benefits and can cause serious health problems and difficulty in sex and childbirth.

Male circumcision reduces the sexual transmission of HIV from women to men by about 60%.

It does not provide complete protection, and men should continue to use safer sex methods such as condoms.

We do not know if male circumcision protects women directly, due to insufficient evidence at present.

We do not know whether male circumcision protects men who have sex with men.

The greatest benefit is seen in epidemics with over 15% prevalence, mainly heterosexual spread and more than 80% of men not circumcised. There is also good benefit in similar epidemics with 3-15% prevalence.

Adolescents, young men and older men at high risk of HIV should be prioritised.

Provide counselling, information and group learning sessions. Use culturally sensitive language and reach men and women. Emphasise the need for safer sex and delaying sex until healed.

Community engagement is essential to introduce or expand circumcision. Include traditional and health service practitioners. Learn about the cultural and religious factors that help or hinder circumcision. How many are circumcised and who does it?

Address gender issues around male circumcision. Promote shared decision-making, gender equality and improved health for men and women.

Be aware of the possible impact of male circumcision on sexual behaviour and risk taking in particular. Some men may believe that they are no longer at risk and that has a direct impact on women’s abilities to negotiate condom use.

Provide circumcision alongside broader SRH services to reduce stigma and promote reproductive health and relationship skills.

Train service providers to carry out high-quality, sterile circumcision with informed consent, and follow up until healed.

Make sure that communities, men and parents have full information about the benefits and risks of male circumcision.

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**Key References**

  Summarises the review of current models and practice for male circumcision service delivery. Identifies who should be prioritised in the roll-out, defines a minimum package of services and outlines key roll-out strategies.

  Designed for teaching traditional surgeons/circumcisers and attendants about safe male circumcision practices and how to talk to initiates about social and sexual responsibility during the ceremonial rites of initiation into manhood.
### Prevention, Diagnosis and Treatment of SRH-Related Cancers

<table>
<thead>
<tr>
<th>WHAT?</th>
<th>WHY?</th>
<th>HOW?</th>
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<tbody>
<tr>
<td>Increase awareness of the risk of cancer and promote key prevention messages, awareness of early symptoms, screening services and the importance of early treatment</td>
<td>People living with HIV, hepatitis C and HPV are at increased risk of a number of cancers, including SRH-related cancers, such as cervical cancer. HPV affects up to 80% of sexually active men and women, and people living with HIV have more persistent HPV, increased risk of pre-cancer and faster progression to invasive cancer. 16% of women living with HIV in one study had pre-cancerous anal lesions. Breast cancer poses a risk to many women, including women living with HIV. Kaposi’s sarcoma and non-Hodgkins lymphoma are HIV-related.</td>
<td>Provide information on ways to prevent different cancers, recognise early symptoms and promptly use services for screening and treatment. Map existing cancer services and link them to health care services for most-affected people. Provide cervical screening for women living with HIV at the time of HIV diagnosis and regular pelvic exams and HPV screening. Educate all women on how to perform self breast examination. Cervical cancer prevention strategies can include visual inspections with acetic acid and pap smears. Screening HPV-positive people for pre-cancerous anal cells will allow for early diagnosis and treatment.</td>
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<tr>
<td>Train health workers to understand the importance of timely diagnosis and the prevention and treatment of different cancers</td>
<td>This intervention includes education, early diagnosis through knowledgeable clients and screening and prompt treatment and care.</td>
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</table>

### Key References

## WHAT?  
Community mobilisation of women and men to promote gender equality, to understand the harm caused by gender-based and intimate partner violence, and to take action to reduce it

Mobilise communities and leaders to reduce stigma and violence towards people with same-sex partners, transgender people, single women, people living with HIV and sex workers

Facilitate learning sessions to improve communication and sexual relationships

Integrate the issue of violence into HIV counselling to reduce the risk of violence on disclosure and support those who face it

Provide counselling and care after a person has experienced violence

### Care after rape

Provide initial counselling to calm the person down and if possible, identify a relative or friend to provide immediate support

Provide the following:

- a pregnancy test and emergency contraception
- syndromic treatment of STIs
- HIV testing and counselling on first visit
- PEP on first visit with 28 days supply and anti-emetics
- collect forensic evidence for a court case
- link and refer to ongoing counselling, police and legal services

link HIV and intimate partner violence in HIV testing and counselling

**Gender-based violence and HIV are overlapping epidemics, each driving the other and acting as a major barrier to prevention, treatment and impact mitigation**

People may experience gender-based or intimate partner violence in heterosexual, same-sex or transgender sexual relationships. Violence is frequently experienced by those stigmatised and criminalised for their sexuality

Violence and the threat of violence can hamper women’s ability to adequately protect themselves from HIV infection and/or assert healthy sexual decision-making. In addition, women living with HIV are more likely to experience violence due to their HIV status.

To raise awareness about the damage caused by gender-based violence on individuals, families and the community

To reduce the risk of intimate partner violence on disclosure of HIV status

To mitigate the immediate impacts of sexual violence, such as mental and physical trauma, unintended pregnancy, STIs and HIV

To refer the survivor to services that can continue to support them and bring the perpetrators to justice

### Mobilise the community to address gender violence and support survivors. Create a community awareness campaign

#### Services for rape survivors

Integrate the service into SRH and HIV services at district hospital level, linking to primary and community level. Establish a sexual violence advisory committee at the hospital and institute a hospital policy for rape management. Spell out the roles and responsibilities for comprehensive care and follow up

Design treatment protocols and training modules

Train community workers, clinicians, police, and social workers on post-rape care

Centralise and co-ordinate post-rape care through a designated outpatient room. Have a 24-hour service because prophylaxis works best when started early

Design policies to manage young, male or transgender survivors as well as women

Make links with and sensitise police, legal and counselling services

Invite survivors and their allies to set up support groups to provide support and healing

### Integrating the issue of violence into HIV counselling

Provide entry points for clients to speak about partner violence if they wish in pre- and post-test HIV counselling

Address fear of violence as a barrier to having an HIV test; how to disclose HIV status; making decisions in risk-reduction counselling, and post-test support needs

Discuss the possibility of couple or family counselling and mediated counselling to reduce the risk of violence

Advocate for the rights of women and key populations to have legal recourse for violence perpetrated against them, based on full information by: researching and analysing the impact of existing laws on incidence of violence and HIV; working with allies from influential organisations, developing policy position papers and directly lobbying policy makers; conducting media campaigns to gain public support and raise awareness of key issues in relation to violence and HIV

### Integrating the issue of violence into HIV testing and counselling

Advocate for the rights of women and key populations to have legal recourse for violence perpetrated against them, based on full information by: researching and analysing the impact of existing laws on incidence of violence and HIV; working with allies from influential organisations, developing policy position papers and directly lobbying policy makers; conducting media campaigns to gain public support and raise awareness of key issues in relation to violence and HIV

## KEY REFERENCES

- International HIV/AIDS Alliance (2008), ‘Sex work, violence and HIV. A guide for programmes with sex workers.’ Available at: www.aidsalliance.org/includes/Publication/Sex_%20work_violence_and_HIV.pdf

## INTEGRATION OF HIV AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS
**Appendix 1**

**Glossary**

**Advocacy** is a process aimed at changing the attitudes, policies, laws and practices of influential individuals, groups and institutions for the betterment of people affected by the issue.

**Antenatal screening** for sexually transmitted infection and HIV is the assessment of a pregnant woman’s likelihood of being infected with an STI or HIV. It may include testing for HIV and STI diagnosis.

**Bisexual** describes a person whose emotional and sexual attraction is to people of both sexes and who identifies as such.

**Community** means a group of people linked and interacting in some way; for example, by location (living in a village), kinship (family and tribe), occupation (peer educators) or by having a common problem (HIV). People may belong to several different communities at any one stage of their lives.

**Concurrent multiple partners** can mean having regular sexual relationships with more than one person over a particular period of time. This differs from serial monogamy, where an individual has a monogamous sexual relationship for a time, stops and then has a new monogamous relationship with a different person. It also refers to people having casual sexual partners over the same period of time.

**Counselling** is using good communication skills to listen actively; help people to talk about their needs, concerns and situation; think through the possibilities for change; give them information and advice on available methods and services; help them to come to their own decision and support them to act.

**Culture** describes what we learn, think, feel and do as individuals and what our society considers important. Our culture reflects our history and is based on our social, economic and environmental situation. It is learned from our family and society, who provide us with guidelines on how to behave as men and women, how to raise children and how to live. Messages from different sources also influence our culture. All societies change to take account of new knowledge and situations. We can belong to many different sub-cultures.

**Development** is the process and mission aimed at raising the standards of living and quality of life for people around the world.

**Discordant partners** are those where one partner is HIV-positive and the other is HIV-negative. In concordant partners, both are HIV-positive.

**Discrimination** is when, in the absence of objective justification, a distinction is made against a person that results in them being treated unfairly or unjustly on the basis of belonging, or being perceived to belong, to a particular group.

**Dual protection** is the use of the same method (for example, condoms) or more than one method (for example, condoms and contraceptive pill) of contraception to reduce the risk of pregnancy and STI or HIV.

**Evaluation** is the periodic assessment of the relevance, performance, efficiency, results and impact of work in relation to its stated objectives.

**Family planning** is the planning of whether and when to have children, and the methods, including contraceptives, that are used in order to implement plans.

**Gay** describes a man or woman whose primary emotional and sexual attraction is to a person of the same sex and who chooses to identify themselves as such. Gay women may refer to themselves as lesbians.

**Gender** refers to the socially constructed roles, behaviours, activities and attributes that a society considers appropriate for men and women. It dictates the status of men and women and who has more power. Gender varies from place to place and can change over time and between generations.

**Heterosexual** describes a man or woman whose primary emotional and sexual attraction is towards the opposite sex.

**Homosexual** is a medical or scientific term for a man or woman whose primary emotional and sexual attraction is to a person of the same sex. Many men and women prefer to describe themselves as gay or lesbian.

**Human rights** are universal legal guarantees for all human beings, set out in international standards, protecting human dignity and fundamental freedoms and privileges. Human rights cannot be waived or taken away.

**Impact** refers to the longer-term effects produced by a development intervention, directly or indirectly. For example, it may refer to a rise or fall in incidence and/or prevalence of HIV.

**Indicators** are markers used to measure the results of an intervention, project or programme.

**Integration** refers to different kinds of sexual and reproductive health and HIV interventions and services that can be joined together to enhance outcomes. For example, this could involve referrals. It is based on the need to offer comprehensive services.

**Intersex** describes a person whose genitalia and/or chromosomes are not clearly male or female.

**Intervention** is an action aimed at changing or interrupting a specific aspect of a problem; for example, a behavioural intervention aimed at changing people’s adoption and use of condoms.
Linkages are the policy, programmatic, services and advocacy synergies between SRH and HIV. It refers to a broader human rights approach, of which integrated services are one component. Linkages can happen between core HIV interventions and core SRH interventions. Linkages also involve addressing the social and structural issues that make people vulnerable to sexual and reproductive ill-health and HIV.

Men who have sex with men describes any man who has sex with another man regardless of how he sees his identify. For example, a man may describe himself as heterosexual but occasionally have sex with men.

Monitoring is the systematic and continuous assessment of the progress of an activity or programme over time, which checks that things are going to plan and enables us to make adjustments in a well-thought-out way.

Most-affected people are those who experience high risk of exposure to HIV or sexual and reproductive ill-health and have limited ability to reduce their vulnerability to that risk. They may be referred to as ‘key populations’ or ‘most at risk groups’. For example, where same sex practice is illegal, men who have sex with men have limited access to information or services on safer sex. The involvement of the most-affected people is key to the response to these problems.

Outcomes are the results of an intervention. Outcomes may include increased service coverage and utilisation or behavioural changes.

Outputs are the results of programme activities; the direct products, services, capital goods or deliverables, such as the number of counselling sessions completed, people reached materials distributed.

Outreach services connect SRH and HIV prevention, support and treatment services to individuals or communities who may have problems accessing them by normal means. This includes meeting individuals with information and services, follow-up visits and education activities in remote villages.

Participatory approaches refer to the active involvement of people affected by a problem, together with those who are concerned about it, in assessing, planning, implementing and evaluating programmes. They help to empower marginalised groups within the wider society. They also contribute to projects tailored to local needs and resources, and a sense of ownership that increases their chance of success.

Polygamist is the term used for people who have long-term ‘pair-bond’ sexual relationships with more than one person over the same period. For example, polygamy and polyandry is when a man has more than one wife or a woman more than one husband respectively.

Postpartum care refers to the services a child needs during the risky period immediately after a woman has given birth – typically six weeks. HIV-related postnatal services include interventions to reduce the possibility of HIV infecting the child through breast milk. It is also a good opportunity to talk about family planning.

Poverty is the condition where basic human needs are lacking. These include lack of access to food, water, nutrition, healthcare and clothing. The World Bank defines extreme poverty as a person subsisting on less than US$1 a day.

Programme refers to an overarching national or sub-national systematic response to a health problem, and may include a number of projects and interventions.

Project is a particular endeavour with a beginning and an end. It is aimed at achieving specific measurable objectives that are part of an overall programme objective.

Project cycle refers to the stages that a project goes through while it is active. It includes assessment, planning, implementation, monitoring, evaluation and adjustment and/or scaling up.

Prophylaxis is a public health intervention designed to prevent a person becoming infected with a disease. Antiretroviral treatment can have a prophylactic effect by reducing an individual’s viral load, lessening the chance of sexual partners or babies being infected.

Public health aims to address the factors that make people vulnerable to poor health and prioritises approaches that help to improve the health of communities as well as individuals. Public health research provides evidence on which interventions work so that we can plan our programmes based on science rather than opinion.

Risk refers to activities that put a person at risk of HIV or STI, unintended pregnancy or other harm; for example, unprotected sexual intercourse.

Safer sex is the practice of sexual activity in a manner that reduces the risk of STI and HIV infection. Methods utilised can include abstinence, sexual activity without intercourse, monogamy and condoms.

Safer delivery means reducing the dangers associated with giving birth.

Sensitisation refers to efforts to change attitudes within a society by providing information designed to increase people’s understanding of a problem.

Sex refers to the biological and physiological characteristics that define men and women.

Sexual and reproductive health refers to physical, emotional, social and spiritual well-being in those areas of life concerned with sexuality and having children. It includes our feelings and desires, sexual relationships and activities, having children, protecting ourselves from infection, and making choices about our sexual and reproductive lives.

Sexuality is how humans express themselves as sexual beings. Sexuality is a complex phenomenon, and numerous definitions and meanings exist.

Skill-based learning refers to an interactive process of teaching and learning that enables learners to acquire knowledge and to develop attitudes and skills. These are often skills that empower them more generally; for example, negotiation skills.
**Social norms** are the values, beliefs, attitudes and behaviours expected and approved of by society.

**Stakeholders** are people with an interest in a project. They include those who will be affected by a project, work on it and fund it.

**Stigma** is the identification that a social group creates of a person (or group of people) based on some physical, behavioural or social trait perceived as diverging from group norms.

**Strategy** is a systematic approach to responding to a particular need.

**Syndromic treatment for sexually transmitted infections** refers to giving treatment based on groups of signs and symptoms of infection rather than laboratory tests.

**Transgender** describes a person who dresses as, acts as and wishes to be (or is) recognised as a member of the opposite sex, usually on a permanent and ongoing basis.

**Transsexual** is a person who feels they are in the wrong biological body and want to change – or has changed – their biological sex, either through surgery, hormone treatment or both.

**Transvestite** is a person who dresses as a member of the opposite sex sometimes. This may be for different reasons, enjoyment, sex or entertainment work or ritual purposes.

**Vertical transmission** refers to the transmission of HIV from parent to child during pregnancy, delivery or during breastfeeding. Efforts to prevent vertical transmission are commonly called prevention of mother-to-child transmission (PMTCT) or prevention of parent-to-child transmission (PPTCT). PPTCT is preferable because it acknowledges the responsibility of both parents to reduce the risk of transmission and is less stigmatising to women.

**Vulnerability** is a measure of an individual’s or community’s inability to control their risk of infection or ill-health.
Appendix 2

Alliance good practice programming standards – SRH, rights and HIV integration

What are good practice programming standards?
Programme standards define quality and good practice. The standards also define our approach to HIV programming and conducting research. They define what users or beneficiaries of our programmes can expect.

At the intervention level, we refer to tools that define good practice for specific intervention types.

These programme standards do not define reach and scope. Targets for reach and scope are set by people closer to the specific programmes, according to local epidemiology and context.

Why develop programming standards?
- To define and promote good practice in community-based HIV programming. Definitions of good practice and quality are based on evidence and programme learning, and are shaped by the Alliance’s values.
- To support assessment and evaluation of programme quality.
- To influence programme design.
- To build an evidence base for quality programming.
- To shape the provision of technical support provided through the Alliance’s Technical Support Hubs.

Who is involved?
- Alliance Linking Organisations and their implementing partners (community- and faith-based organisations), and Alliance’s Technical Support Hubs, their users and beneficiaries, will use programming standards to design, implement and evaluate HIV programmes.
- Users or beneficiaries of Alliance services and programmes can use programming standards to understand what our programmes are for, and to help evaluate Alliance programmes.
- Alliance programme officers and programme managers will use programming standards to assess, design and evaluate programmes (using a self-assessment tool).
- Alliance resource mobilisation staff will use programming standards to develop high quality proposals.
- Funders of Alliance programmes have an interest in programming standards. Alliance standards illustrate that our programmes are shaped by a culture of quality and good practice, are informed by evidence, and are monitored and evaluated according to a set of standards.
- Other civil society organisations are interested in quality standards for their community level programmes. Alliance programming standards can influence and guide good programming in other civil society organisations.
Linking SRH and HIV is important as it ensures the synergies between the two play a meaningful role in the design and implementation of our policy work and rights approach, as well as programme and services.

The integration of SRH and HIV refers to the joining up of sexual and reproductive health and HIV services, either directly or through referral.

Linkages and integration enable programmes to reach more people, especially key populations, to respond more fully to their needs and reach both HIV and SRH goals more effectively. Linkages strengthen programmes aimed at addressing root causes of sexual and reproductive ill-health, including HIV.

Linkages between SRH and HIV also involve addressing the social and structural issues that make people vulnerable to sexual and reproductive ill-health and HIV, e.g. gender inequality, poverty, stigma and discrimination, rights violations and legal issues.

Our organisation promotes the linkages and the integration, when possible, between core HIV interventions (prevention, treatment, care and support) and core SRH interventions (family planning, maternal and newborn health, prevention and management of sexually transmitted and reproductive tract infections, promotion of sexual health, prevention and management of gender-based violence, prevention of unsafe abortion and provision of post abortion care). [IPPF, UCSF, UNAIDS, UNFPA, WHO (2008) Sexual and reproductive health linkages: Evidence review and recommendations.]

A rights-based approach is used in relation to activities and programmes on SRH and HIV integration.

Map existing linkages and integration between SRH and HIV in policies, programmes and services.

Identify strengths, weaknesses and gaps, including organisational capacity.

Review ways to optimise synergies between HIV policies and programmes and SRH policies and programmes.

Develop an integration plan for SRH and HIV activities, and allocate financial and human resources to implement it.

Adapt or develop protocols and guidelines to support integrated activities.

Conduct staff training in SRH and HIV linkages.

Offer to support the government to establish SRH and HIV linkages, for example, with training.

Develop an advocacy strategy to promote integration of services within the public health system.

Documents are available on, and staff are able to describe, the following indicators of SRH and HIV integration:

- findings from assessment of existing SRH and HIV linkages and integration and resources for integration
- the potential for strengthening linkages and linkages in the strategic plan
- budgets and work plans
- protocols and guidelines
- training materials, reports and outcome
- monitoring and evaluation protocols, records and reports
- advocacy strategy which includes SRH and HIV integration and rights.

**Materials and Resources**

### Standard 2

**Our organisation promotes and advocates for the sexual and reproductive needs and rights of all people**

- The violation of human and sexual and reproductive rights is a root cause of HIV risk and sexual and reproductive ill-health. It often forms a ‘make or break’ obstacle to efforts to build capacity, promote safer sex, achieve universal access to services and change social norms, especially for the most vulnerable people.

- Sexual and reproductive rights include being able to make decisions about who we have sexual relationships with; live our lives free of sexually related stigma and discrimination; enjoy pleasurable sexual relationships free of coercion and violence; choose whether and when to marry and have children; protect ourselves from STIs and HIV and access health care and information. These are our rights whether we are young or old, rich or poor; men, women or transgender, have same or opposite sex partners and living with HIV.

- As the most effective way to address rights depends on the local context, our organisation promotes partnerships and collaboration with partners involved in policy, rights, law and justice.

- We promote skills training in advocacy and SRH rights which can strengthen the confidence and social support of marginalised population groups. Advocacy efforts also help people to identify and recognise violations of human rights and their impact.

### Implementation Actions

- Our organisation forms strategic partnerships with networks and organisations promoting sexual and reproductive rights.

- Examples of work with partners include:
  - Identify human rights commitments ratified by the government related to SRH
  - Review, promote and monitor their implementation at all levels
  - Gather evidence and use to challenge harmful policies and laws, e.g. criminalisation of HIV transmission, sex work or same sex practice
  - Use evidence in advocacy with key targets at community, district and national level
  - Measure and document changes in attitudes, laws and policies and their enforcement.

### Markers of Progress

- Documents exist that set out the collaboration plan, outputs relevant to each stakeholder and roles and responsibilities.

- A report of assessment and analysis is available and staff can describe their response to the findings.

- The work plan/budget includes rights-based activities.

- Advocacy tools designed for different groups are available.

- The advocacy strategy includes sexual and reproductive rights and universal access to services.

### Materials and Resources


### Standard 3

<table>
<thead>
<tr>
<th><strong>Description</strong></th>
<th><strong>Implementation Actions</strong></th>
<th><strong>Markers of Progress</strong></th>
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<tbody>
<tr>
<td>The participation of the most-affected people is a human right, a means of building confidence, skills and respect and reducing stigma; and an effective approach to bringing about change. Participation fosters community mobilisation.</td>
<td>Most affected people are identified and mobilised to participate in an ongoing process of assessment, objective setting, design and planning, implementation, monitoring and evaluation.</td>
<td>Staff can describe how affected people are involved and what influence they have had on the programme.</td>
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<td>Examples of most-affected people and key populations include people living with HIV, those stigmatised because of their sexuality or gender, women affected by female genital mutilation or rape and single mothers. The most-affected people have expert knowledge of the issue and existing responses and can contribute to workable solutions based on their experience.</td>
<td>Establish networks of affected people linked to stakeholders with access to resources, for example, midwives.</td>
<td>Affected people can describe examples of their involvement in programmes and the ways in which this affects the process and outcomes of the programme. They can describe what they would like to change about their involvement.</td>
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<td>‘Meaningful’ involvement refers to the people most affected being actively engaged in an ongoing way in the programme and project cycle as partners who are listened to and have an influence on decision-making.</td>
<td>Use participatory tools which enable people most affected to express their ideas, talk about their lived experience, analyse their lives and play an active role throughout the life of the programme.</td>
<td>Reports on different stages of the project cycle include names and roles of the most-affected people.</td>
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<td>Our organisation promotes the meaningful participation of key populations and most affected people in all of the stages of a project cycle as an ongoing process (i.e. mobilisation, assessment, planning, implementing, action, monitoring, evaluation, advocacy and scaling up).</td>
<td>Document assessments, plans, guidelines and evaluations in ways that key populations and most-affected people can understand, use and keep in the community.</td>
<td>Peer outreach workers who have experienced the same problems have understanding and empathy for their peers and act as role models for change.</td>
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<td>Build the capacity of the most-affected people to participate meaningfully in an ongoing way.</td>
<td>Most-affected people can have frank conversations with their peers to learn about how they perceive the programme and their suggestions for improvement.</td>
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<td>Carry out mentoring and leadership development of potentially strong and interested spokespeople.</td>
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### Materials and Resources

  http://tiny.cc/0jvxz
  http://tiny.cc/nm7dk
  www.unfpa.org/public/op/edit/publications/pid/1274
<table>
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<tr>
<th>STANDARD</th>
<th>DESCRIPTION</th>
<th>IMPLEMENTATION ACTIONS</th>
<th>MARKERS OF PROGRESS</th>
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<td><strong>STANDARD 4</strong></td>
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<tr>
<td>✔</td>
<td><strong>Our organisation promotes and/or delivers sexuality education that is comprehensive, increases knowledge, self-esteem and skills, and is socially and culturally context-specific and tailored to people’s needs</strong> (continued on next page)</td>
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<td>- Sexuality education is an important intervention for people of all ages, genders and situations. It may be carried out in or out of formal education settings, for example through peer education. Sexuality education is socially and culturally context specific and tailored to people’s needs.</td>
<td>- Engage ministries (for example, education, health or gender) and/or national civil society organisations in the process of curriculum and materials development from the start to ensure support for scale up and quality.</td>
<td>- Process in place for beneficiary and stakeholder participation in assessment to identify learning needs and design of curriculum content.</td>
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<td>- Our organisation promotes sexuality education that is intensive, sensitive and monitored for quality. In order to scale up the numbers reached, we promote the involvement of government and national civil society organisations at the start of the process to get their buy-in for national coverage, insertion into pre-service training and monitoring of quality. Note: This standard refers to the content and methodologies of curricula on sexuality education rather than the modes of delivering the education (for example, in or out of school).</td>
<td>- Engage communities (for example, young people, parents, traditional counsellors, teachers and leaders) in participatory assessment of the needs of the beneficiaries and seek agreement on what they need to learn.</td>
<td>- Documents describing the curriculum and learning sessions demonstrate by using a checklist, the criteria described in the standard.</td>
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<td>- Assess existing curricula and materials with beneficiaries and key stakeholders.</td>
<td>- Observation of learning sessions in action using a checklist demonstrates the criteria for effective sexuality education.</td>
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<td>- Develop or adapt content as needed based on participatory assessment and local situations.</td>
<td>- Learners can describe what they learned and how they were able to use the learning.</td>
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<td>- Use the findings to sensitize communities more widely on the need for sexuality education before starting the programme in new areas. (The ‘community’ may be for example, MSM, transgender people, people living with HIV or sex workers.)</td>
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<td>- Use a curriculum for sexuality education which has the characteristics listed in column two.</td>
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</tr>
</tbody>
</table>
**STANDARD 4**

- Evidence* shows that effective sexuality education:
  - is tailored to the reality of people’s lives, their age, gender and sexual identity, reproductive situation, needs and opportunities, cultural, social and economic environment and rights
  - has clear learning objectives for knowledge, attitudes and skills
  - topics are covered in a series of sessions in a logical sequence, and may include topics such as growing up, relationships, love, pleasure, values, sexuality and gender, life-skills, pregnancy, STIs and HIV, sexual choices and violence depending on needs
  - people are given information and skills before they need to use them, e.g. children learn about conception and that people get HIV before they become sexually active
  - people have opportunities to work in smaller peer groups which allow for trust building and deeper discussions
  - skill-based, interactive learning methodologies are used and based on local situations
  - safety guidelines are developed with vulnerable people, including protection guidelines and confidentiality
  - the curriculum is inclusive – for example, it speaks to people living with HIV and those who don’t know their status, not just people who are negative. Sexual and gender diversity is accepted and celebrated.


- Test the curriculum and learning sessions and get feedback on the process and outcomes. Revise if necessary before scaling up.
- Produce tools and resources for distribution more widely.

**MATERIALS AND RESOURCES**

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<th>STANDARD 5</th>
<th>DESCRIPTION</th>
<th>IMPLEMENTATION ACTIONS</th>
<th>MARKERS OF PROGRESS</th>
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</table>
| **Our organisation promotes and/or provides information, education and counselling on HIV that is integrated with reproductive concerns and options** (continued on next page) | - People need access to full information about their reproductive rights and choices; how to protect themselves from unintended pregnancy and infection; how to protect themselves and their children from HIV during conception, pregnancy, delivery and breastfeeding; how to protect their fertility and maximise the chance of conception and options for managing an unintended pregnancy without physical and mental harm and legal consequences. They also need services related to these issues.  
- Meeting unmet needs for contraception would reduce up to one third of maternal deaths globally. If more women who want to avoid pregnancy were able to do so, there would be a large fall in babies born with HIV. Adding family planning to the prevention-of-parent-to-child transmission (PPTCT) could prevent twice the number of infections to children and four times the number of deaths as PPTCT alone. Access to safe abortion services would prevent 70,000 maternal deaths each year.* | - Our programmes reach people with HIV interventions in the following areas:  
  - Information about their reproductive rights and choices  
  - Information and counselling on reproductive issues, including planning a pregnancy, contraception, safe abortion, post-abortion care and fertility concerns if available  
  - Information on contraceptive qualities of condoms and benefits of triple protection (infection, unintended pregnancy and infertility)  
  - Provision with or referral to family planning, safe abortion services, post-abortion care, prevention of HIV transmission to child or infertility services as available and required  
  - People attending SRH services are provided with information, education and counselling on HIV and reproductive health and provide with or referred to HIV services  
  - Our organisation advocates for supportive policies for integrating HIV and reproductive concerns and for providing information and services for all the reproductive options. | - Mapping and assessment of all the reproductive health education and services described in this standard are carried out and options for access to all the services identified.  
- Plans to strengthen education and services, integrate them and fill in gaps are made with the participation of beneficiaries and stakeholders.  
- Plans include strategies to address challenges related to policy, legal and rights issues.  
- Fertility options as described in the standard are included in training, guides and learning materials. Staff can explain the importance of integrating HIV and reproductive options and how this is being done in their sites.  
- Protocols, activity records and monitoring data include fertility options, e.g. referral for family planning or prevention of HIV transmission to the child.  
- Institutional stigma and discrimination towards people with HIV having children are identified and addressed. |
Note: We use the term PPTCT rather than prevention-of-mother-to-child transmission (PMTCT) to acknowledge that both men and women have responsibility for preventing HIV infection in babies; to encourage the engagement of men in programmes and to reduce stigma, discrimination and violence towards women with HIV who choose to have children.

- Reproductive health options depend on access to quality services, local laws and personal values. Laws that, for example, criminalise women with HIV who have children or end a pregnancy violate rights and result in illness and death.

- Our organisation promotes the integration of reproductive health concerns into HIV interventions as well as the integration of HIV concerns into reproductive health interventions.


**MATERIALS AND RESOURCES**

### STANDARD 6

☑️ Our organisation promotes the delivery of the essential elements of prevention-of-parent-to-child transmission (continued on next page)

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<tr>
<th>STANDARD</th>
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<tr>
<td>6</td>
<td>Implementing the essential elements of PPTCT can keep mothers healthy and reduce the number of babies born of mothers with HIV to less than 1%. This is very cost-effective when compared with treatment.</td>
<td>Organisations collaborate and co-ordinate their programmes in a site with the aim of providing all the components of PPTCT to in the most effective way. This may involve joining up services, referral or reducing barriers such as stigma.</td>
<td>Maps of services in the site are available and beneficiaries, staff and community leaders can explain the map, the plan resulting from it and the initial outcomes.</td>
</tr>
</tbody>
</table>
|          | The prevention of PPTCT keeps mothers, potentially fathers and children healthy and alive and greatly reduces the number of orphans. It has a long-term impact in enabling a generation of children to start life without HIV and with their parents. Preventing transmission to children gives hope and a reason for parents to want to protect themselves from HIV and seek treatment. | This may include:  
- Mobilising communities around the issue of PPTCT and carrying out a participatory assessment  
- Mapping and assessing all interventions and services related to PPTCT with beneficiaries and stakeholders and identifying entry points for integration. | Guidelines and protocols are available for co-ordinated work and referral. Staff can describe how the link ups work. |
<p>|          | Our organisation works to increase the provision and uptake of all the elements of preventing PPTCT from HIV prevention and family planning through to treatment and care for mothers with HIV and their children. | Identifying and addressing all the barriers to uptake of existing services, for example, stigma, criminalisation, cultural and gender issues, cost and distance. | PPTCT is included in training materials and those trained can explain its importance and how they contribute to the programme. |
|          | As part of PPTCT activities, we promote the inclusion of the following elements: | Designing a strategy and plan to link up components and services in ways that increase access and quality of services. | The number of people accessing the different components has increased. |
|          | - HIV prevention programmes for all women and men of reproductive age | Assessing capacity and designing training curriculum for different cadres of community and health service providers. | The number/precentage of pregnant women with HIV accessing antenatal care, HIV testing, ART, safe delivery, advice on infant feeding and postnatal follow up has increased. |
|          | | Designing integrated protocols, monitoring formats and evaluation. | Percentage of beneficiaries who know about the different services and are satisfied with them. |
|          | | Promoting the services and referring people to the specialised services. | |</p>
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</table>
| **STANDARD 6** | ■ Family planning including use of condoms and other contraceptive for individuals and couples  
■ HIV testing before conception and at antenatal care; promotion of couple testing and counselling  
■ Long-term antiretroviral treatment for pregnant women with HIV and their partners  
■ HIV prevention messages for all antenatal and postnatal clients and their partners  
■ Safer delivery of women with HIV in a health facility  
■ Education on safer infant feeding and provision of food if needed  
■ Postnatal care and treatment and care for mothers and infants with HIV.  


<table>
<thead>
<tr>
<th>MATERIALS AND RESOURCES</th>
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</table>
| ■ AVERT, ‘Treatment for children with HIV and AIDS’.  
  www.avert.org/hiv-children.htm |
| ■ Engenderhealth, UNFPA (2004), ‘HIV prevention in maternal health services: training guide’.  
  www.unfpa.org/public/publications/pid/2032 |
| ■ Engenderhealth (2008), ‘COPE® for HIV care and treatment services: a toolkit to accompany the COPE® handbook’.  
| ■ International Treatment Preparedness Coalition (2009), ‘Missing the target series no.7. Failing women, failing children: HIV, vertical transmission and women’s health’.  
  www.aidstreatmentaccess.org/mtt7_final.pdf |
  http://tiny.cc/cm990 |
| ■ WHO (2007-08), ‘IMAI-IMPAC integrated PMTCT training course’.  
  www.uj.ac.za/EN/CorporateServices/ioha/Research/OperationalTools/IMAI/IMC%20training%20materials/Pages/PMTCTclinicalcourses.aspx |
### STANDARD 7

**Our organisation promotes and/or provides STI education, diagnosis and treatment and condoms either directly or through referral (continued on next page)**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>The diagnosis and treatment of some STIs (genital herpes and ulcers) reduces the risk of acquiring HIV infection by 50-300 times. STI services provide opportunities to reach men as well as women with HIV testing and counselling on safe behaviours.</td>
<td>Organisations collaborate and co-ordinate their programmes in a site with the aim of providing universal access to STI education and services. This may involve joining up services, referral and reducing barriers such as stigma.</td>
<td>Maps of services in the site are available and beneficiaries, staff and community leaders can explain the map, the plan resulting from it and the initial outcomes.</td>
</tr>
<tr>
<td></td>
<td>People may be more concerned about visible STI and their impact on fertility than HIV and more motivated to practise safer sex for this reason.</td>
<td>This may include:</td>
<td>Assessments, plans and monitoring and evaluation include STI.</td>
</tr>
<tr>
<td></td>
<td>The integration of antenatal screening services for syphilis and the provision of syndromic* management for other STIs can improve pregnancy outcomes for mothers and newborns and reduce the risk of infertility.</td>
<td></td>
<td>Training and education curricula include STI prevention, signs and symptoms, links with reproductive health, diagnosis, treatment and partner notification.</td>
</tr>
<tr>
<td></td>
<td>Our programmes and policies aim to link or integrate STI education, diagnosis, treatment and condom provision in HIV or SRH services. These include:</td>
<td></td>
<td>Activities are implemented to address the barriers to STI treatment.</td>
</tr>
<tr>
<td></td>
<td>SRH and HIV education including the symptoms, impact, prevention, diagnosis and treatment of STIs</td>
<td></td>
<td>Number of people receiving effective STI treatment.</td>
</tr>
<tr>
<td></td>
<td>Safer sex counselling, education and services covering both prevention of pregnancy, STIs and HIV and the importance of using condoms for protection against unintended pregnancy, STIs and HIV</td>
<td></td>
<td>The number/precentage of pregnant women with HIV accessing antenatal care, HIV testing, ART, safe delivery, advice on infant feeding and postnatal follow up has increased.</td>
</tr>
<tr>
<td></td>
<td>STI diagnosis and treatment, including syndromic* treatment, are integrated with HIV/SRH interventions directly or through referral.</td>
<td></td>
<td>Percentage of beneficiaries who know about the different services and are satisfied with them.</td>
</tr>
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| **STANDARD 7** | ■ Advocacy for universal access to welcoming and quality STI services.  
■ Actions to reduce stigma and make STI services confidential and welcoming to all groups, including those who are stigmatised and criminalised.  
■ As part of PPTCT activities, we promote the inclusion of the following elements:  
■ HIV prevention programmes for all women and men of reproductive age  
■ Family planning including use of condoms and other contraceptive for individuals and couples  
■ HIV testing before conception and at ante-natal care; promotion of couple testing and counselling  
■ Long-term antiretroviral treatment for pregnant women with HIV and their partners  
■ HIV prevention messages for all ante-natal and postpartum clients and their partners  
■ Safer delivery of women with HIV in a health facility  
■ Education on safer infant feeding and provision of food if needed  
■ Postpartum care and treatment and care for mothers and infants with HIV.  
*See Druce, N. and Nolan, A. (2007).  
*Syndromic treatment refers to treatment based on signs and symptoms of STIs rather than laboratory tests. This is more cost effective but misses out STIs that do show signs and symptoms. This is particularly common in women.  
■ Identifying and addressing all the barriers to uptake of existing services, for example, stigma, criminalisation, cultural and gender issues, cost and distance.  
■ Designing a strategy and plan to link up components and services in ways that increase access and quality of services.  
■ Assessing capacity and designing training curriculum for different cadres of community and health service providers.  
■ Designing integrated protocols, monitoring formats and evaluation.  
■ Promoting the services and referring people to the specialised services. | |
| |

**MATERIALS AND RESOURCES**

  www.engenderhealth.org/pubs/hiv-aids-sti/reducing-stigma.php  
- International Union against Sexually Transmitted Infections (2009), ‘STI global update’, Newsletter of the IUSTI.  
  http://tiny.cc/cti9e  
  www.who.int/mediacentre/factsheets/fs110/en  
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<tr>
<td>STANDARD 8</td>
<td>People have a number of needs related to their sexual and reproductive lives and one organisation rarely has the capacity to meet them all.</td>
<td>Work collaboratively with other organisations, networks and government services to ensure that services are joined up and their value enhanced by linkages and referrals to other services and programmes.</td>
<td>Assessment and plans include strengths and weaknesses of relevant local services and actions are being implemented to address the weaknesses.</td>
</tr>
<tr>
<td>Our organisation promotes and refers users to quality, user friendly services and collaborates with existing services and builds their capacity</td>
<td>We promote better access to quality, user-friendly services which meet all sexual and reproductive health and HIV needs in a cost-effective way.</td>
<td>Map and assess all SRH and HIV programmes and services in the site and district with beneficiaries, providers and stakeholders.</td>
<td>Procedures and guidelines available for referral.</td>
</tr>
<tr>
<td></td>
<td>Our organisation facilitates this comprehensive programming through coordination, collaboration and capacity building of government and civil society organisations and the strengthening of community systems, including community outreach workers who refer to wrap-around services.</td>
<td>Design and plan a strategy to maximise linkages in the most cost-effective ways.</td>
<td>The number of beneficiaries is increased as a result of integrating SRH and HIV services.</td>
</tr>
<tr>
<td></td>
<td>Our organisation promotes and refers users to quality, user-friendly services, whenever feasible, rather than setting up parallel services.</td>
<td>Build capacity of staff and community workers to implement plan. Link with government approved training and support government efforts.</td>
<td>Percentage of people referred who are satisfied with the service they received.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promote the SRH and HIV services to the community, specific groups and organisations.</td>
<td>Monitoring indicators demonstrate that the quality of services is improving and highlights on-going development needs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish communication procedures between services to monitor and enhance the effectiveness of referral.</td>
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**MATERIALS AND RESOURCES**

### STANDARD 9

Our organisation works with others to promote and/or implement programmes that address gender and sexuality as an integral component of the SRH and HIV response.

- Issues related to gender and sexuality may reduce people's options to adopt healthy behaviours and to use services as well as having a negative impact on their wellbeing.
- The criminalisation, stigmatisation and marginalisation of groups of people based on their gender and sexuality makes it difficult for them to practice safer sex and access services, for example trans-genders, MSM, sex workers, young people and those living with HIV. Gender inequality and some harmful gender and sexual norms can result in risky sexual practices for all genders. Gender-based violence has been demonstrated to increase the risk of HIV transmission and unintended pregnancy. Some sexual practices can increase a person’s risk of HIV infection and STIs. For example, dry sex or prolonged rough sex can result in tears in the vagina or anus and condom breakage.
- Our organisation promotes a joint approach on SRH and HIV with different government sectors, such as ministries of education and health, and community stakeholders to assess and respond to gender and sexuality issues.
- This joining up is likely to have a greater impact on bringing about change at individual, social, services and policy/legal levels than the organisations working separately. This response should aim to do no harm; be gender sensitive; transform harmful aspects of gender norms and relations; increase gender equality and/or increase the achievement of rights of stigmatised people.
- Establish a description of local gender, sexuality and rights issues synthesised from participatory site assessments and other data sources and validated with stakeholders.
- The description includes the diversity of experience and needs related to gender, sexuality and rights of all people, including those who are marginalised or criminalised.
- Individuals and groups are facilitated to talk openly about these issues in a safe process and environment.
- Action plans include gender sensitive activities, activities to change harmful gender norms, increase gender and sexual equality and empower those who are stigmatised and marginalised.

### MATERIALS AND RESOURCES

- **Bridge** (development and gender website). [www.bridge.ids.ac.uk](http://www.bridge.ids.ac.uk)
- **Institute of Development Studies, Sexuality and development pages**. [www.ids.ac.uk/go/browse-by-subject/sexuality-and-development](http://www.ids.ac.uk/go/browse-by-subject/sexuality-and-development)
- **International Centre for Research on Women**. [www.icrw.org](http://www.icrw.org)
- **IPPF** (2009), ‘The truth about men, boys and sex. Gender transformative policies and programmes’. [http://tiny.cc/qyry0](http://tiny.cc/qyry0)
- **Siyanda** (on-line database of gender and development materials). [www.siyanda.org](http://www.siyanda.org)
- **WHO, Sexual and reproductive health programmes and projects**. [www.who.int/reproductive-health/gender/sexual_health.html#2](http://www.who.int/reproductive-health/gender/sexual_health.html#2)
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<tr>
<td>STANDARD 10</td>
<td>Gender violence and abuse are major risk factors for HIV infection and sexual and reproductive health problems, especially for children, young people, women and stigmatised people such as people with HIV, trans-genders, men who have sex with men and sex workers.</td>
<td>Implement programmes that enable communities to address gender-based and sexual violence and abuse. Assess the causes and effects of vulnerability to sexual violence.</td>
<td>Assessments include the incidence, causes and effects of gender-based violence.</td>
</tr>
<tr>
<td>Our organisation promotes and/or provides interventions to address gender-based and sexual violence and abuse in its HIV and SRH response</td>
<td>Fear of violence and violent behaviours are barriers to communication about managing sex safely, good relationships and the ability to exercise choice about with whom and how a person has sex and what protection is used. It also affects access to diagnosis, treatment and care.</td>
<td>Design activities to reduce violence and support survivors of violence.</td>
<td>Partnership agreements with relevant organisations, including the police, exist and have resulted in an increase in joined up activities to address gender-based violence.</td>
</tr>
<tr>
<td></td>
<td>Our organisation promotes SRH and HIV programmes that recognise and address the issue of gender and sexual violence for different groups, either directly or through collaboration with others.</td>
<td>Provide information and services/referral for PEP, emergency contraception and treatment or prophylaxis for STIs to survivors of sexual violence who arrive within 72 hours of the incident (and preferably within 24 hours).</td>
<td>Training curricula include gender-based violence.</td>
</tr>
<tr>
<td></td>
<td>Actions to reduce violence and support survivors are needed at all levels – individual and relationship; social change; services, policy and laws.</td>
<td>Provide ongoing psychosocial support to survivors of violence.</td>
<td>Treatment within 24 hours after violent episodes has become more accessible.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase knowledge of rights and laws and access to justice.</td>
<td>Staff and community members are able to explain the importance of gender and sexual violence and describe what actions different people are taking to address it.</td>
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</tbody>
</table>

**MATERIALS AND RESOURCES**

Our organisation has a policy and programme to address stigma and discrimination as a major barrier to protective behaviours and the use of services as well as a violation of human rights.

Our organisation implements programmes to address stigma in order that stigmatised people such as transgenders, MSM, sex workers, people with HIV, people who use drugs, children affected by HIV, women who have children outside marriage and others can exercise their rights to programmes, support and services. This creates an enabling environment for SRH and HIV prevention and treatment.

We address stigma at different levels by firstly understanding the attitudes and behaviour of stigmatised people, family, community and service providers, as well as the practices, policies and laws that affect these groups. Actions such as participatory learning sessions, developing confidence and leadership skills in stigmatised people, use of media and systematic monitoring and response to stigma can then be designed.

- Monitor discrimination and responds to findings.
- Conduct participatory learning sessions enable stigmatised people, communities and service providers to understand rights and reduce and respond to stigma and discrimination. This includes, for example, facilitating group work and providing testimony. Participatory learning sessions enable people living with HIV and stigmatised groups to understand their rights and respond to discrimination and its consequences.
- Establish partnerships fostered with human rights institutions, legal services and unions to promote and protect the rights of stigmatised communities.
- Guides and tools for interactive sessions on stigma and discrimination are available.
- Staff have been trained, and have trained others, to facilitate learning sessions with key targets and on relevant areas, for example, user-friendly services with providers; self-esteem and advocacy skills with people living with HIV and key populations.
- Stigma and discrimination monitoring format available and up to date.

**MATERIALS AND RESOURCES**

- The people living with HIV stigma index. www.stigmaindex.org
Appendix 3: Useful websites

AIDSTAR-One
www.aidstar-one.com
A searchable online database of good programmatic practices that shares recent lessons learned in HIV programming and can be used by program planners and implementers.

AVERT
www.avert.org

The Body
www.thebody.com
Information on specific needs of most-affected groups, up-to-date information on all areas of HIV and SRH.

CHANGE Center for Health and Gender Equity
www.genderhealth.org
CHANGE works in three core areas to promote comprehensive, evidence-based SRH policies and programmes; public policy, research, and outreach and constituency building.

The Communication Initiative Network
Information and case studies of the effective use of communication and media in HIV programming.

Eldis
www.eldis.org/go/topics/resource-guides/health/sexual-and-reproductive-health
Eldis reviews current policy issues and explores cutting-edge debates relating to SRH and rights. It provides information on projects in different contexts and languages.

Health and human rights: a resource guide
www.equalpartners.info
This resource guide is designed to support health and human rights advocacy, training, education, programming, and grant-making worldwide.

Family Care International (FCI)
www.familycareintl.org
FCI aims to make pregnancy and childbirth safer around the world. You can download resources on projects, best practice and training from the website.

Family Health International (FHI)
www.fhi.org
An excellent source of SRH capacity-building materials, including HIV and infectious diseases

Global Health e-Learning Center
www.globalhealthlearning.org
Information and e-learning courses on health topics, including SRH and HIV.

The Global Network of People Living with HIV (GNP+)
www.gnpplus.net
Excellent resources on SRH and HIV needs and programmes for people living with HIV.

HIV/AIDS and Sexual and Reproductive Health Integration
www.hivandsrh.org
Resources that reflect field experience and the latest thinking of the health community on integration of HIV and SRH services.

Interagency Gender Working Group (IGWG)
www.igwg.org
Evidence-based good practice, evaluations and training materials.

International Community of Women Living with HIV/AIDS (ICW)
www.icw.org
Excellent resources and toolkits to support women living with HIV in their sexual and reproductive lives.

International HIV/AIDS Alliance
www.aidsalliance.org
More than 300 resources produced by the Alliance and its partners including training manuals, policy briefings, good practice guides and CD-ROMs. All resources can be downloaded and many printed publications can be ordered free of charge.

International Planned Parenthood Federation (IPPF)
www.ippf.org
Resources on comprehensive sexuality education, family planning, HIV and SRH, and rights issues.

The Maternal Health Task Force
www.maternalhealthtaskforce.org
Large database and links to organisations concerned with maternal health.

MenEngage
www.menengage.org
Information and resources on working with men and boys from this global alliance of NGOs and UN agencies that engage men and boys to achieve gender equality.

NAM – Aidsmap
www.aidsmap.com
Up-to-date evidence-based information on all aspects of HIV and SRH.

Naz Foundation International (NFI)
www.nfi.net
Information and resources on working with men who have sex with men.

Network of Sex Work Projects
www.nswp.org
Useful resources on making sex work safe and health services for sex workers.

Partnership for Maternal Newborn and Child Health
www.who.int/pmnch/en/
Information on a partnership of 400 members of the maternal, newborn and child health (MNCH) community working towards reducing maternal and child mortality to achieve MDGs 4 and 5.
Pathfinder  
www.pathfind.org  
Pathfinder resources include training manuals and guides and evidence-based best practice publications.

The Pleasure Project  
www.the-pleasure-project.org  
Supports people to enjoy sexual activity that is both safer and pleasurable, and promote a more positive approach to sexuality.

Promundo  
www.promundo.org.br  
Information and resources on gender, SRH and preventing violence.

Reproductive Health Matters Journal  
www.rhmjournal.org.uk  
In-depth publications on SRH and rights in print and online.

Reproductive Rights  
www.reproductiverights.org  
Tools and experiences of success in influencing legislation through the courts, engaging policy-making, reporting on rights, and sponsoring training for champions of reproductive rights.

SETU A Knowledge Portal in HIV for South Asia  
www.aidsallianceindia.net/?q=node/40  
Excellent source of up-to-date global and regional information on HIV and SRH available for download.

Siyanda  
www.siyanda.org  
A collection of reviews by CSOs of the Beijing Platform for Action, a database of experts and consultants, and a chance to contribute to this international resource.

Stepping Stones  
www.steppingstonesfeedback.org  
Shares information from practitioners around the world who are implementing the Stepping Stones training package, reports and evaluation and new adaptations.

United Nations Children’s Fund  
www.unicef.org

Youth Coalition  
www.youthcoalition.org  
Working internationally for sexual and reproductive rights. Excellent resources on advocacy.

Joint United Nations Programme on HIV/AIDS (UNAIDS)  
www.unaids.org

United Nations Population Fund (UNPFA)  
www.unfpa.org  
Information and resources on issues relating to SRH, women’s empowerment, population and development.

The World Health Organization (WHO)  
www.who.int/en  
Information and resources on global health issues, including STI, HIV, reproductive health and gender-based violence.
Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global alliance of nationally-based organisations working to support community action on AIDS in developing countries. To date we have provided support to organisations from more than 40 developing countries for over 3,000 projects, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to HIV treatment.

The Alliance’s national members help local community groups and other NGOs to take action on HIV, and are supported by technical expertise, policy work, knowledge sharing and fundraising carried out across the Alliance. In addition, the Alliance has extensive regional programmes, representative offices in the USA and Brussels, and works on a range of international activities such as support for South-South cooperation, operations research, training and good practice programme development, as well as policy analysis and advocacy.

www.aidsalliance.org