



PREVENTING HIV AND UNINTENDED PREGNANCIES: STRATEGIC FRAMEWORK 2011–2015

**IN SUPPORT OF THE GLOBAL PLAN TOWARDS THE
ELIMINATION OF NEW HIV INFECTIONS AMONG
CHILDREN BY 2015 AND KEEPING THEIR MOTHERS ALIVE**

THE INTER-AGENCY TASK TEAM FOR PREVENTION AND TREATMENT OF
HIV INFECTION IN PREGNANT WOMEN, MOTHERS, AND THEIR CHILDREN

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ABOUT THIS FRAMEWORK

This framework supports the 'Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive'. It is a product of The Inter-agency Task Team (IATT) for Prevention and Treatment of HIV Infection in Pregnant Women, Mothers, and their Children and was developed by the IATT Working Group on Primary Prevention of HIV and the Prevention of Unintended Pregnancies in Women Living with HIV (now included with the Integration Working Group under the re-configured IATT).

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ii. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. International Community of Women Living with HIV and Global Network of People Living with HIV, 8 April 2011. www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf

iii. E-consultation on PMTCT Components One and Two. ICW and GNP+, 29 November–20 December 2010 in Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. International Community of Women Living with HIV and Global Network of People Living with HIV, 8 April 2011. Appendix B(1). www.gnpplus.net/images/stories/Empowerment/consultations/Appendix_B1_PMTCT_E-consultation_Report_April_2011.pdf

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NOTE ON TERMINOLOGY

Elimination of mother-to-child transmission of HIV (eMTCT)

There has been a shift from *preventing* mother-to-child transmission of HIV to *eliminating* such transmission as reflected in the global targets 2011–2015 (see *Introduction*). People living with HIV have indicated that the term 'elimination' of mother-to-child transmission is difficult as it fails to recognize that HIV is not just a virus but is part of people's lives, affecting how the community relates to them on every levelⁱⁱⁱ. Particularly when used alone ('elimination') it is also perceived to be derogatory, since, if taken out of context, without qualifying terms, it can seem to connote an end to the lives of people living with HIV. The term 'elimination' can:

- evoke fear and be disempowering for people living with HIV;
- prevent people from accessing necessary services and, subsequently, from being able to prevent transmitting HIV to their child, if these services are associated with the term; and
- be understood to mean eliminating women living with HIV or infants living with HIV in order to eliminate mother-to-child transmission.ⁱⁱⁱ

The term 'elimination' should not be used alone, as a short-hand or as a slogan. Stakeholders must carefully consider choice of terminology in programming to ensure definitions are clear, not normative, clouded in ambiguity or value laden. This document uses the terms elimination of mother-to-child transmission or eMTCT, never 'elimination' on its own.^{iv}



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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome	M&E	Monitoring and evaluation
ANC	Antenatal care	MCH/MNCH	Maternal and child health/maternal, newborn and child health
ART	Antiretroviral therapy	MDG	Millennium Development Goal
ARV	Antiretroviral	MEC	Medical eligibility criteria for contraceptive use
BCC	Behaviour change communication	MOH	Ministry of Health
CBO	Community-based organization	MSM	Men who have sex with men
CSO	Civil society organization	MTCT	Mother-to-child transmission (of HIV)
CTX	Co-trimoxazole	NGO	Non-governmental organization
ECOSOC	Economic and Social Council of the United Nations	OI	Opportunistic infection
EID	Early infant diagnosis	OVC	Orphans and vulnerable children
eMTCT	Elimination of mother-to-child transmission (of HIV)	PEP	Post-exposure prophylaxis
FBO	Faith-based organization	PHC	Primary health care
FP	Family planning	PICT	Provider-initiated HIV counselling and testing
GBV	Gender-based violence	PLHIV	People living with HIV
GIPA	Greater involvement of people living with HIV	PP	Postpartum
GHI	Global Health Initiative	PreP	Pre-exposure prophylaxis
GNP+	Global Network of People Living with HIV	PMTCT	Prevention of mother-to-child transmission (of HIV)
H4+/H5	UNFPA, UNICEF, WHO, World Bank and UNAIDS	PSM	Product and supply chain management
HBC	Home-based care	RTI	Reproductive tract infection
HCT	HIV counselling and testing	SPR	Selected practice recommendations for contraceptive use
HIV	Human immunodeficiency virus	SRH	Sexual and reproductive health
HPV	Human papillomavirus	SRHR	Sexual and reproductive health rights
HSV	Herpes simplex virus	STI	Sexually transmitted infection
ICW	International Community of Women Living with HIV/AIDS	SW	Sex worker
IMAI	Integrated management of adolescent and adult illness	TB	Tuberculosis
IPPF	International Planned Parenthood Federation	UN	United Nations
IATT	Inter-agency Task Team (for Prevention and Treatment of HIV Infection in Pregnant Women, Mothers, and their Children)	UNAIDS	Joint United Nations Programme on HIV/AIDS
IDU	Injecting drug user	UNFPA	United Nations Population Fund
IEC	Information, education and communication	UNGASS	United Nations General Assembly Special Session on HIV/AIDS
IPPF	International Planned Parenthood Federation	UNICEF	United Nations Children's Fund
LAM	Lactational amenorrhea method	VCT	Voluntary counselling and testing
		WHO	World Health Organization
		YPLHIV	Young people living with HIV

EXECUTIVE SUMMARY

We are at a turning point for delivering on the promise to end child and maternal mortality and improve health – marked by bold new commitments. This strategic framework supports one such commitment, the 'Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive'. It offers guidance for preventing HIV infections and unintended pregnancies – both essential strategies for improving maternal and child health, and eliminating new paediatric HIV infections.

This framework should be used in conjunction with other related guidance that together address all four prongs of eliminating mother-to-child transmission of HIV. This document focuses on strengthening rights-based policies and programming within health services and the community for:

- **Prong 1:** Primary prevention of HIV in women of childbearing age (with special emphasis on pregnant and breastfeeding women)
- **Prong 2:** Prevention of unintended pregnancies in women living with HIV (as part of rights-based sexual and reproductive health (SRH) of people living with HIV (PLHIV)).

Prongs 1 and 2, together with safer infant feeding (prong 3), and treatment (prongs 3 and 4), are essential for improving the lives of women and children and eliminating mother-to-child transmission of HIV (eMTCT). The rationale for prongs 1 and 2 includes:

- Remaining HIV-negative, particularly throughout pregnancy and breastfeeding (period of higher risk) protects infants and children from becoming HIV-positive by eliminating the possibility of HIV transmission from the mother.
- Primary prevention of HIV improves survival and well-being; HIV is the leading cause of death among women of childbearing age, contributing significantly to maternal mortality.
- The benefits of family planning are far-reaching, ranging from fewer maternal and newborn deaths and healthier mothers and children to increased family savings and productivity, better prospects for education and employment, and ultimately improvement in the status of women.
- Unintended pregnancies contribute to maternal morbidity and mortality; 27% of maternal deaths can be prevented by meeting unmet need for family planning.
- HIV-related morbidity and mortality in a mother living with HIV impact critically upon her child's survival.

- Fewer unintended pregnancies mean fewer infants born to mothers living with HIV, thus resulting in a smaller number of potentially HIV-positive infants.

The principles upon which this framework is based are:

1. Addressing structural determinants of HIV and sexual and reproductive ill-health
2. Focusing on human rights and gender
3. Promoting a coordinated and coherent response (i.e. the Three Ones Principle)
4. Meaningfully involving people living with HIV (i.e. GIPA Principle)
5. Fostering community participation by young people, key populations at higher risk, and the general community
6. Reducing stigma and discrimination
7. Recognizing the centrality of sexuality as an essential element in human life and in individual, family and community well-being.

It offers guidance to:

1. Implement a package of services for preventing HIV and unintended pregnancies within stigma-free integrated SRH and HIV services
2. Utilise key entry points to integrating services for HIV and SRH
3. Strengthen national programme implementation, including to deliver prong 1 and 2 interventions
4. Carry out five key strategies:
 - Strategy 1:** Link SRH and HIV at the policy, systems and service delivery levels
 - Strategy 2:** Strengthen community engagement
 - Strategy 3:** Promote greater involvement of men
 - Strategy 4:** Engage organizations of people living with HIV
 - Strategy 5:** Ensure non-discriminatory service provision in stigma-free settings.



1

INTRODUCTION



A new era has dawned for helping women and children lead healthier lives. Joining the global response, a bold commitment has emerged through a 'Global Plan Towards the Elimination¹ of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive'.²

Governments and civil society are determined to turn this vision into reality by 2015, the horizon for achieving the Millennium Development Goals (MDGs). The Global Plan charts the course to achieve this urgent goal, directly linked to other ongoing maternal and child health initiatives (see *Annex 1*). This united response recognizes that HIV contributes significantly to maternal and child mortality. This strategic framework has been developed in support of the Global Plan by offering guidance for preventing HIV infections and unintended pregnancies – both essential strategies for improving maternal and child health (MCH) and eliminating new paediatric HIV infections.

The new goal represents a strategic shift from preventing to eliminating mother-to-child transmission of HIV (PMTCT to eMTCT) (see *Note on Terminology*, page i), and has spawned robust new targets and indicators to guide national planning. The goal also recognizes the critical importance of improving maternal health to benefit both women and children. Achieving this goal requires that national governments are supported to deliver the full range of MTCT interventions integrated with sexual and reproductive health, particularly maternal, newborn, and child health (MNCH), family planning, and HIV treatment services (see *Figures 1 and 2*). Eliminating mother-to-child transmission of HIV is an integral part of countries' efforts to achieve MDGs 3–6 (see *Box 1*).

The framework for action

Eliminating new HIV infections among children and keeping their mothers alive is based on a four-pronged strategy.⁴ This strategy provides the foundation upon which national plans are developed and implemented, and encompasses a range of HIV prevention and treatment measures for mothers and their children together with essential maternal, newborn and child health, family planning and other SRH services.

Prong 1: Prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care, postpartum and postnatal care and other health and HIV service delivery points, including working with community structures.

Prong 2: Providing appropriate counselling and support, and contraceptives, to women living with HIV to meet their unmet needs for family planning and spacing of births, and to optimize health outcomes for these women and their children.

Prong 3: For pregnant women, ensuring access to HIV counselling and testing and, for pregnant women living with HIV, ensuring access to the antiretroviral drugs needed to prevent HIV infection from being passed on to their babies during pregnancy, delivery and breastfeeding.

Prong 4: HIV care, treatment and support for women, children living with HIV and their families.

BOX 1: HOW eMTCT CONTRIBUTES TO ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS³

The elimination of new HIV infections among children and keeping their mothers alive contributes directly towards achieving four of the MDGs, where HIV currently holds back progress. Similarly, progress on achieving other MDGs contributes to HIV prevention and treatment for women and children.

MDG 3: Promote gender equality and empower women – by supporting women's empowerment through access to HIV prevention information, HIV prevention and treatment services, and sexual and reproductive health services; by involving mothers living with HIV as key partners in delivering the plan and engaging their male partners. By empowering women, they are better able to negotiate safer sex and by eliminating gender-based violence women's vulnerability to HIV is reduced.

MDG 4: Reduce child mortality – by reducing the number of infants infected with HIV; by providing treatment, care and support for uninfected children born to mothers living with HIV and ensuring effective linkages to life-saving treatment for children living with HIV; and, indirectly, by improving maternal health and ensuring safer infant

feeding practices. By improving neonatal conditions and family care practices survival rates of children born to women living with HIV are increased.

MDG 5: Improve maternal health – through preventing HIV among women and providing family planning for HIV-positive women of childbearing age; and by ensuring effective care, treatment and support for mothers living with HIV. Strong health systems can help ensure that every birth is safe and pregnant women are able to detect HIV early and enrol in treatment.

MDG 6: Combat HIV/AIDS, malaria and other diseases – by preventing the spread of HIV through preventing infection in women of childbearing age; preventing HIV transmission to children, and treating mothers, and ensuring strong and effective linkages to ongoing care, treatment and support for children and mothers living with HIV. By providing tuberculosis (TB) treatment, deaths among pregnant women living with HIV are reduced. By preventing TB and malaria, child and maternal mortality among women and children living with HIV is reduced.

Focus of this framework

This framework focuses on what can be done to strengthen programming for prongs 1 and 2 – preventing HIV and unintended pregnancies (see *Section 2 Scope*). It supports delivering a package of services (see *Sections 5 and 6, Tables 2 and 4*) within stigma-free integrated SRH and HIV

services, and the community. The framework also outlines key strategies for linking SRH and HIV, eliminating stigma and discrimination, and engaging the community, male partners, and people living with HIV (see *Section 9 Key Strategies and Actions*). The strategies and packages of services primarily aim to reach pregnant women, women living with HIV and their partners (see *Figure 2 and Section 2 Scope*).

FIGURE 1: FOUR PRONGS TO ELIMINATE MOTHER-TO-CHILD TRANSMISSION OF HIV AND IMPROVE MATERNAL HEALTH

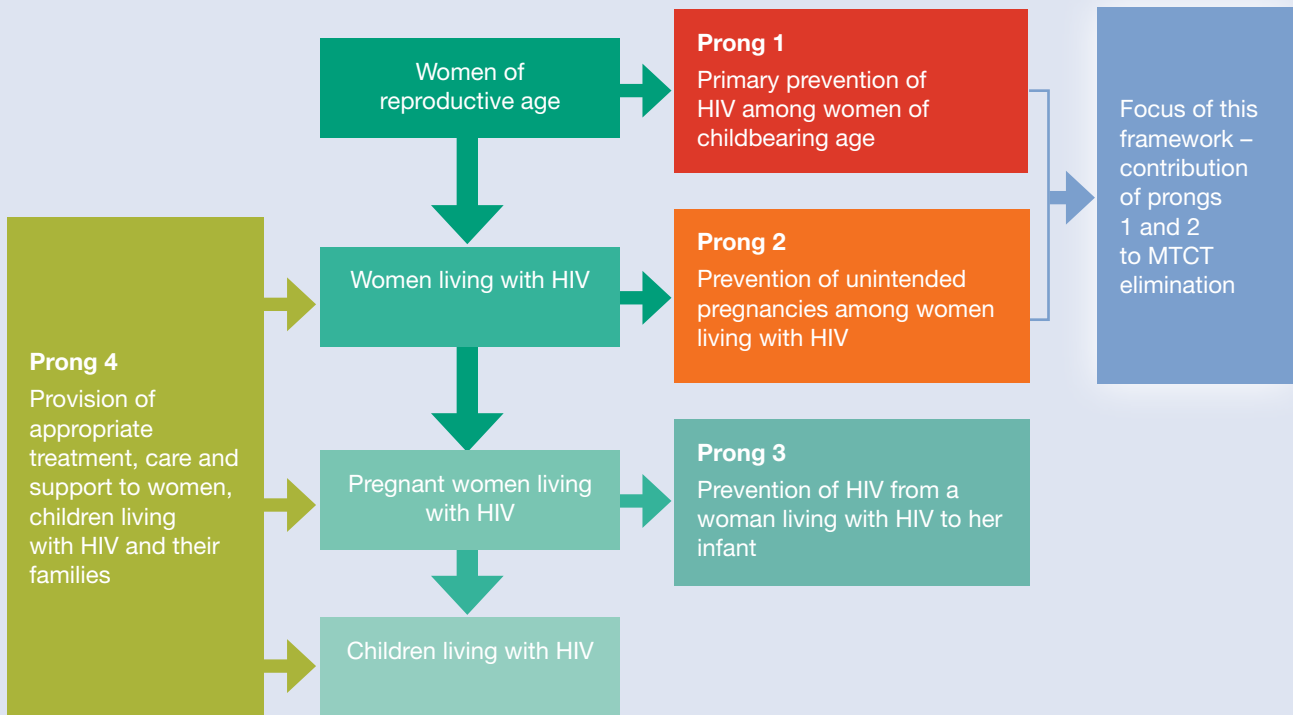
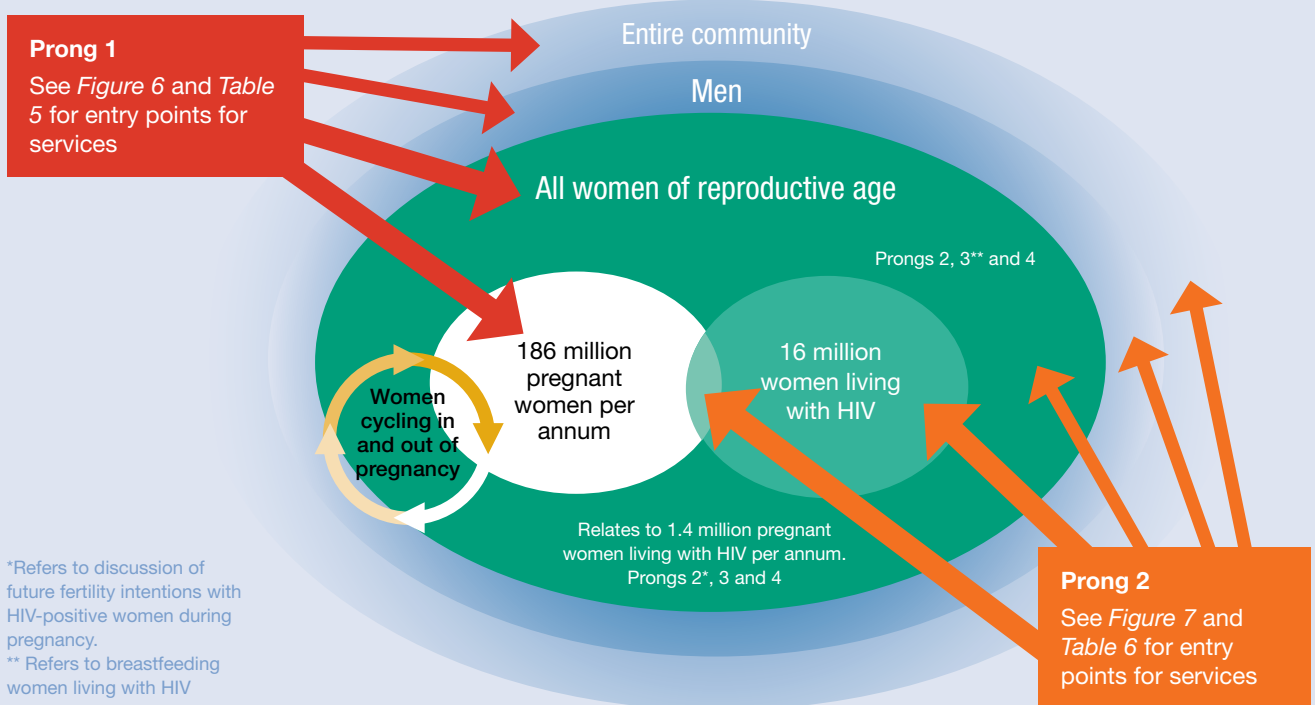


FIGURE 2: FOCUS POPULATIONS OF THIS FRAMEWORK (FIGURE IS NOT TO SCALE)



Contribution of prongs 1 and 2 to eliminating MTCT and improving maternal health

Two global targets for eliminating MTCT and reducing maternal death by 2015 have been set:⁵

- Reduce the number of new HIV infections among children by 90%
- Reduce the number of AIDS-related maternal deaths by 50%.

Additional targets have been developed for each of the four PMTCT prongs (see *Figure 4*) with associated indicators (see *Section 10 Targets and Indicators*). The specific targets for this framework are:

- **Prong 1:** 50% reduction in HIV incidence in women of reproductive age (15–49 years and 15–24)
- **Prong 2:** reduce unmet family planning need to zero (among all women).

Figure 4 (page 8) outlines how prongs 1 and 2 contribute to the targets, and identifies key issues.

Modelling shows that achieving the targets for prongs 1 and 2 would contribute a 13% reduction in new infant infections towards the 90% reduction target (see *Figure 3*).

Preventing HIV and unintended pregnancies would also result in reductions in maternal morbidity and mortality, as well as additional benefits for women (see *Sections 5 and 6*). Implementing the 2010 WHO PMTCT recommendations⁶ to provide HIV-positive pregnant women with more effective ARV prophylaxis or treatment would contribute an additional 60% reduction, with a further 6% decrease resulting from limiting breastfeeding to 12 months.

Clearly, expanding coverage of effective interventions related to all four prongs is required to achieve the goals of eliminating MTCT and improving maternal and child health and survival. This framework's guidance for preventing HIV and unintended pregnancies will significantly contribute to achieving these goals.

FIGURE 3: NEW CHILD INFECTIONS IN 25 COUNTRIES 2009–2015 BY PMTCT PROPHYLAXIS⁷

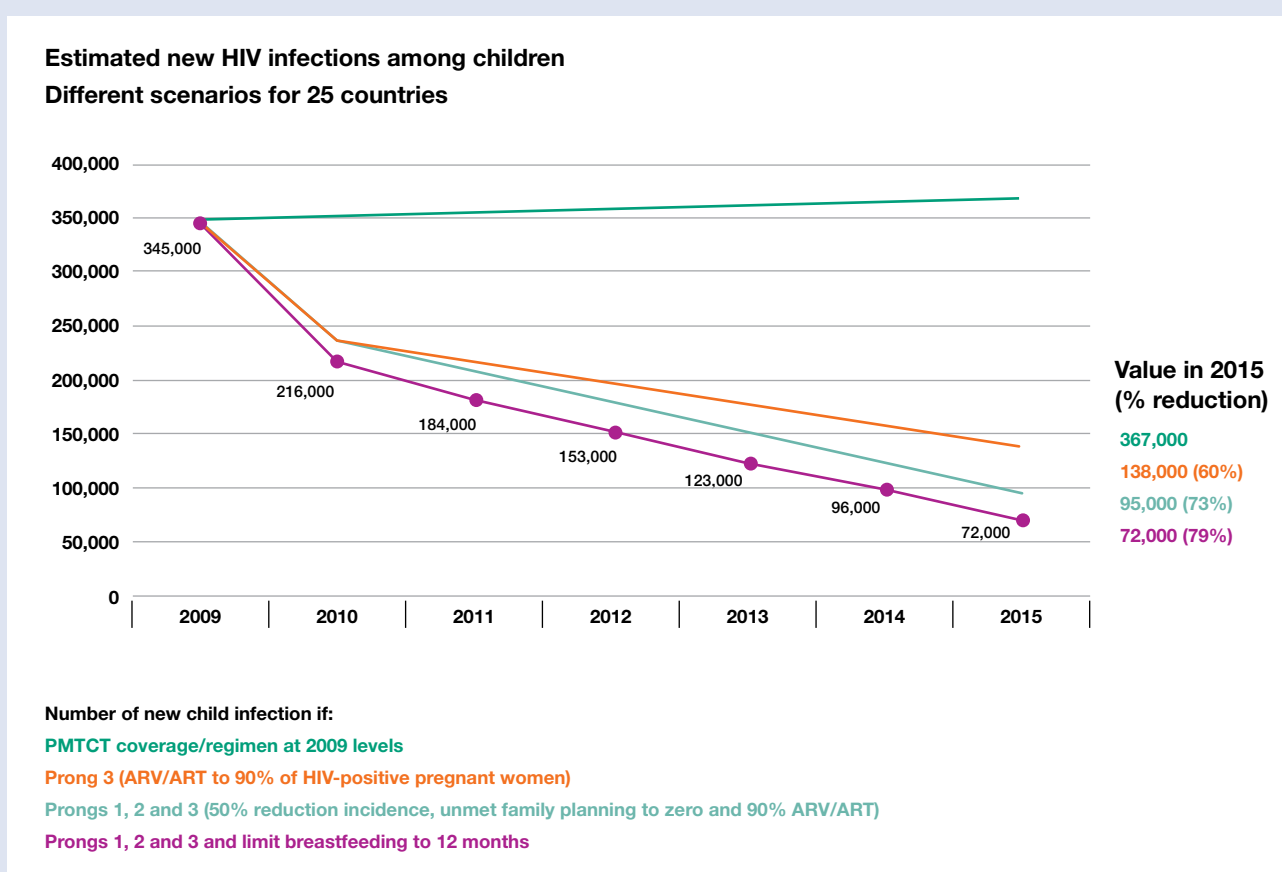


FIGURE 4: PREVENTING HIV AND UNINTENDED PREGNANCIES: TARGETS, CONTRIBUTION AND KEY ISSUES

Towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive

Global Target #1: Reduce the number of new HIV infections among children by 90%

Global Target #2: Reduce the number of AIDS-related maternal deaths by 50%

(see Section 10: Elimination of MTCT monitoring framework for 2015: Targets and indicators)

Prong 1: Primary prevention of HIV among women of reproductive age

Target: 50% reduction in HIV incidence in women of reproductive age (15–49 years and 15–24)

How prong 1 contributes:

By supporting HIV-negative women to remain HIV-negative especially during pregnancy and breastfeeding (MDGs 5 & 6), this will in turn:

- reduce the number of reproductive age/maternal deaths (MDGs 5 & 6)
- reduce the number of HIV-positive infants (MDGs 4 & 6).

Key issues prong 1

- Potentially increased risk of infection (seroconversion) for women during pregnancy, postpartum and breastfeeding period
- Inadequate engagement of male partners for practicing safer sex, ending violence, and supporting partners
- Lack of awareness of the possibility of HIV transmission to children and how to avoid it
- Insufficient levels of HIV counselling and testing coupled with the need to increase access to treatment for prevention.

Prong 2: Preventing unintended pregnancies among women living with HIV

Target: reduce unmet family planning need to zero among all women

How prong 2 contributes:

By reducing the number of unintended pregnancies in HIV-positive women of childbearing age (MDG 5), this will in turn:

- reduce the number of maternal deaths and improve maternal health (family planning is one of the three pillars for reducing maternal mortality, and improves maternal health) (MDGs 5 & 6)
- reduce the number of HIV-positive infants (MDGs 4 & 6)
- improve child survival (MDGs 4 & 5) by keeping their mothers alive.

Key issues prong 2

- High level of unintended pregnancies and unmet need for family planning
- Lack of awareness of reproductive rights
- Stigma in health care settings and community which is a barrier to women living with HIV discussing fertility intentions and accessing family planning services
- Inadequate availability of and access to family planning services.

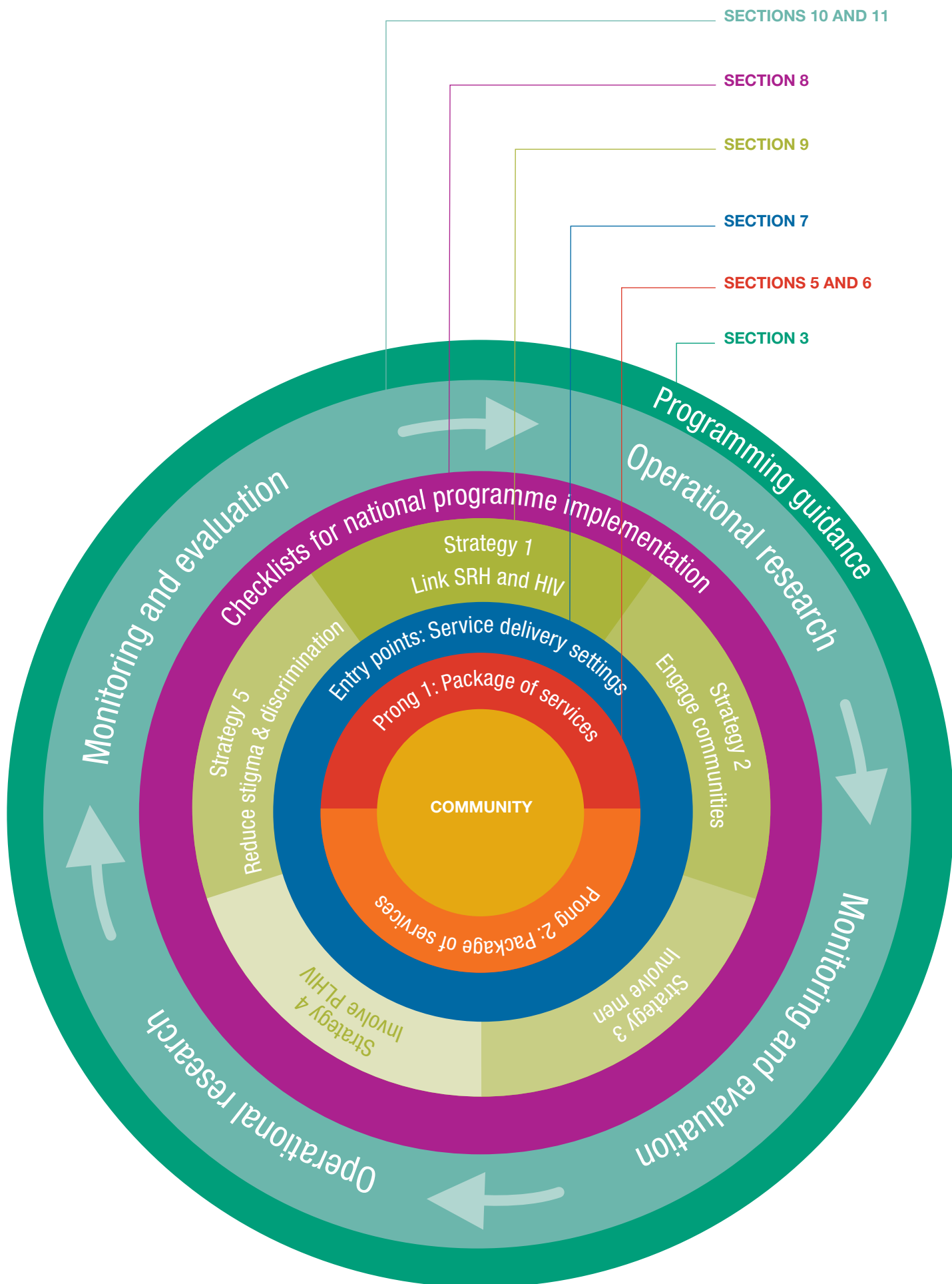
Prong 3: Preventing HIV transmission from a woman living with HIV to her infant

Target: 90% reduction in HIV-related maternal deaths up to 12 months postpartum

Target: 90% reduction in HIV-attributable deaths among infants and children <5 years

Prong 4: Providing appropriate treatment, care and support to women, children living with HIV and their families

FRAMEWORK AT A GLANCE



2

PURPOSE, SCOPE AND INTENDED AUDIENCE



Purpose

The purpose of this framework is to contribute to eliminating new HIV infections among children and improving maternal and child health by strengthening policies and programming for (see *Introduction, Figure 1*):

- **Prong 1:** Primary prevention of HIV in women of childbearing age (with special emphasis on pregnant and breastfeeding women)
- **Prong 2:** Prevention of unintended pregnancies in women living with HIV (as part of rights-based sexual and reproductive health of people living with HIV).

Scope

This framework focuses predominantly on action to be taken within the health sector, with strong links to action within the community. It primarily articulates strategies and interventions that are to be delivered through the continuum of care for pregnant and breastfeeding women, and other integrated sexual and reproductive health and HIV services (e.g. family planning, sexually transmitted infections (STIs), gender-based violence (GBV) prevention and management, and antiretroviral therapy (ART), linked to related strategies for engaging the community (see *Section 9 Key Strategies and Actions*). As women and their partners cycle between their communities and health services, they will accrue mutually reinforcing benefits from action taken within both spheres (see *Introduction, Figure 2*).

As articulated in the Global Plan, prong 1 pertains to “*Prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care, postpartum and postnatal care and other health and HIV service delivery points, including working with community structures*”. Therefore, this framework, in relation to prong 1, focuses particularly but not exclusively on pregnant and breastfeeding women, recognizing their unique vulnerabilities and the opportunities for impact as they transit through health systems (see *Section 5 Prong 1* and *Section 7 Entry Points*). Additional guidance for primary prevention among all women of childbearing age, young people (15–24 years of age), and key populations (e.g. sex workers, women, people who use drugs, etc.) including within other sectors such as education, social services, and labour, is covered in other publications (see *Section 3 Related Programming Guidance*).

Similarly, the framework primarily focuses on preventing unintended pregnancies in women living with HIV (see *Section 6 Prong 2* and *Section 7 Entry Points*), although integrating SRH and HIV services will also strengthen family planning programmes and uphold reproductive rights for all women, regardless of HIV status (see *Section 3 Related Programming Guidance*).

The health sector alone, however, cannot be expected to deliver all the actions required for preventing HIV and unintended pregnancies. While recognizing that education, socio-cultural and economic circumstances affect health and human rights, it is beyond the scope of this framework to fully address all these socio-economic determinants.

Intended audience

The framework is aimed at global, regional and national partners working in SRH and HIV, who are responsible for eliminating new HIV infections among children and improving maternal and child health including:

- national policy-makers and programme managers
- implementing partners (including public and private sectors as well as civil society organizations (CSOs))
- community partners (including non-governmental organizations (NGOs), organizations and networks of people living with HIV, and HIV advocates, including women’s and key populations’ organizations).

It may also be a useful resource for donors as well as health care providers for whom a related job aid will be produced.

3

RELATED PROGRAMMING GUIDANCE



This framework should be used in conjunction with related programming guidance (see *Table 1*) for:

- implementing comprehensive eMTCT services (all four prongs), maternal health, family planning and HIV prevention
- linking SRH and HIV
- fostering gender equality and empowerment of women and girls.

TABLE 1: KEY GUIDANCE DOCUMENTS FOR SCALING UP THE FOUR PRONGS OF COMPREHENSIVE PMTCT/eMTCT BY 2015⁸ (SEE ALSO ANNEX 2 ANNOTATED BIBLIOGRAPHY)

Elimination of new HIV infections among children and improving maternal and child health (MDGs 4, 5 and 6)

- Countdown to zero. Global plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive. Global Task Team, 2011.
- A Global Action Framework for Elimination of Mother-to-Child Transmission of HIV. IATT, 2011.
- Global Strategy for Women's and Children's Health. UN Secretary-General, 2010.
- Priority interventions: HIV/AIDS prevention, treatment and care in the health sector. WHO, 2010.
- Reducing Inequities: Ensuring Universal Access to Family Planning as a key component of Sexual and Reproductive Health. UNFPA, 2009.
- Rapid assessment tool for sexual and reproductive health and HIV linkages: Generic guide. IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, Young Positives, 2009.
- Guidance on global scale-up of the prevention of mother-to-child transmission of HIV: Towards universal access for women, infants and young children and eliminating HIV and AIDS among children. IATT, 2007.
- Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. UNAIDS, 2007.

PRONG 1 Primary Prevention of HIV among women of childbearing age	PRONG 2 Prevention of unintended pregnancies among women living with HIV	PRONG 3 Prevention of HIV transmission from a woman living with HIV to her infant	PRONG 4 Provision of appropriate treatment, care and support to women, children living with HIV and their families
<ul style="list-style-type: none"> ■ Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015. In Support of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive. Inter-agency Task Team for Prevention and Treatment of HIV Infection in Pregnant Women, Mothers, and their Children (IATT), 2011. ■ Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people. Recommendations for a public health approach 2011. WHO, 2011. ■ Delivering HIV test results and messages for re-testing and counselling in adults. WHO, 2010. ■ UNAIDS Guidance Note on HIV and Sex Work. UNAIDS, 2009. 	<ul style="list-style-type: none"> ■ Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015. In Support of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive. IATT, 2011. ■ Positive Health, Dignity and Prevention Policy Framework. UNAIDS, GNP+, 2011. ■ Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people. Recommendations for a public health approach 2011. WHO, 2011. ■ IMAI one-day orientation on adolescents living with HIV. Participants manual and facilitator guide. WHO, 2010. 	<ul style="list-style-type: none"> ■ Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access. Recommendations for a public health approach (2010 version). WHO, 2010. ■ Guidelines on HIV and infant feeding. Principles and recommendations for infant feeding in the context of HIV and a summary of evidence. WHO, 2010. ■ Essential Prevention and Care Interventions for Adults and Adolescents Living with HIV in Resource-Limited Settings. WHO, 2008. 	<ul style="list-style-type: none"> ■ Antiretroviral Therapy for HIV Infection in Adults and Adolescents – recommendations for a Public Health Approach – 2010 revision. WHO, 2010. ■ Antiretroviral therapy for HIV infection in infants and children: Towards universal access. Recommendations for a public health approach: 2010 revision. WHO, 2010. ■ Plus all documents under Prong 2.

TABLE 1: (CONTINUED)

PRONG 1	PRONG 2	PRONG 3	PRONG 4
<ul style="list-style-type: none"> ■ Guidance on testing and counselling for HIV in settings attended by people who inject drugs: improving access to treatment, care and prevention. UNODC Regional Centre for Asia and the Pacific, WHO WPRO and SEARO, 2009. ■ Operational guidance for scaling up male circumcision services for HIV prevention. WHO, UNAIDS, 2009. ■ Position Statement on Condoms and HIV Prevention. UNFPA, UNAIDS, WHO, 2004. Updated 2009. ■ Global Guidance on HIV and Young People. IATT on Young People, 2008. Seven Guidance Briefs. ■ Guidance on provider-initiated HIV counselling and testing in health facilities. UNAIDS, WHO, 2007. ■ Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. UNAIDS, 2007. ■ Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries. IATT on Young People, 2006. ■ HIV/AIDS and injecting drug users: WHO Evidence for Action series. Technical guidance. ■ HIV/AIDS prevention and care for female injecting drug users. UNODC, 2006. ■ Intensifying HIV Prevention: UNAIDS Policy Position Paper. UNAIDS, 2005. ■ Condom Programming for HIV Prevention: A Manual for Service Providers. UNFPA, 2004. ■ Condom Programming for HIV Prevention: An Operations Manual for Programme Managers. UNFPA, 2004. ■ Rapid Condom Needs Assessment Tool for Condom Programming. UNFPA, Population Council, 2003. ■ WHO is currently developing health-sector guidance for prevention, treatment and care of sex workers, as well as guidance on couples HIV counselling and testing, and ART for Prevention. 	<ul style="list-style-type: none"> ■ Antiretroviral therapy for HIV infection in adults and adolescents. Recommendations for a public health approach – 2010 revision. WHO, 2010. ■ Advancing the Sexual and Reproductive Health and Human Rights of Injecting Drug Users living with HIV. GNP+, INPUD, 2010. ■ Advancing the Sexual and Reproductive Health and Human Rights of Sex Workers living with HIV. GNP+, NSW, 2010. ■ Advancing the Sexual and Reproductive Health and Human Rights of Migrants living with HIV. GNP+, 2010. ■ Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A Guidance Package. GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, 2009. ■ Reproductive choices for women with HIV. Wilcher R, Cates W. Bulletin of the World Health Organization, 2009. ■ Guidance on testing and counselling for HIV in settings attended by people who inject drugs: improving access to treatment, care and prevention. UNODC Regional Centre for Asia and the Pacific, WHO WPRO and SEARO, 2009. ■ Position Statement on Condoms and HIV Prevention. UNFPA, UNAIDS, WHO, 2004. Updated 2009. ■ Essential Prevention and Care Interventions for Adults and Adolescents Living with HIV in Resource-Limited Settings. WHO, 2008. ■ Global Guidance on HIV and Young People. IATT on Young People, 2008. Seven Guidance Briefs. ■ Reproductive choices and family planning for people living with HIV: counselling tool. WHO, 2007. ■ Sexual and reproductive health of women living with HIV/AIDS: guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings. WHO, 2006. ■ Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries. IATT on Young People, 2006. ■ Intensifying HIV Prevention: UNAIDS Policy Position Paper. UNAIDS, 2005. ■ Condom Programming for HIV Prevention: A Manual for Service Providers. UNFPA, 2004. ■ Condom Programming for HIV Prevention: An Operations Manual for Programme Managers. UNFPA, 2004. ■ Rapid Condom Needs Assessment Tool for Condom Programming. UNFPA, Population Council, 2003. ■ WHO is currently developing health-sector guidance for prevention, treatment and care of sex workers, as well as guidance on couples HIV counselling and testing, and ART for Prevention. 		

TABLE 1: (CONTINUED)

THESE INTERVENTIONS ARE ESSENTIAL FOR THE IMPLEMENTATION OF EACH OF THE FOUR PMTCT PRONGS**MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN****Ending gender-based violence**

- Preventing intimate partner and sexual violence against women. Taking action and generating evidence. WHO, LSHTM, 2010.
- Addressing Gender-based Violence: UNFPA Strategy and Framework for Action. UNFPA, 2009.
- Partnering with Men to End Gender-Based Violence. Practices that Work from Eastern Europe and Central Asia. UNFPA, 2009.
- Programming to Address Violence against Women: Ten Case Studies. UNFPA, 2007; 8 Case Studies Volume 2. UNFPA, 2009.
- Ending Violence against Women, Programming for Prevention, Protection and Care. UNFPA, 2007.

Supporting women's reproductive rights and empowering them

- Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV. Operational plan for the UNAIDS action framework: addressing women, girls, gender equality and HIV. UNAIDS, 2010.
- UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV. UNAIDS, 2009.

Increasing access to information and sexual and reproductive health services

- Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health. WHO, UNFPA, UNICEF, World Bank, 2010.
- Strategic considerations for strengthening the linkages between family planning and HIV/AIDS policies, programmes, and services. WHO, USAID, Family Health International, 2009.
- Sexual and reproductive health and HIV linkages: evidence review and recommendations. IPPF, UCSF, UNAIDS, UNFPA, WHO, 2009.
- Medical eligibility criteria for contraceptive use. WHO, 2009.
- Global elimination of congenital syphilis: rationale and strategy for action. WHO, 2007.
- Comprehensive Cervical Cancer Control: A Guide to Essential Practice, WHO, 2006.
- WHO is currently updating guidelines on sexually transmitted and reproductive tract infections.

Engaging male partners

- Engaging Men and Boys in Gender Equality and Health Toolkit. UNFPA, 2010.
- Policy approaches to engaging men and boys in achieving gender equality and health equity. WHO, 2010.
- Men's Reproductive Health Curriculum. EngenderHealth, 2008.
- Involving Men in Promoting Gender Equality and Women's Reproductive Health. UNFPA, 2007.
- Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. WHO, 2007.

4

GUIDING PRINCIPLES



Principles relevant for this framework include those that relate directly to eMTCT and maternal health⁹ as well as the guiding principles in *Box 2* for linking SRH and HIV of which PMTCT/eMTCT is a key pillar (see *Section 9 Key Strategies and Actions, Strategy 1*).

For more background information on the Guiding Principles see *Annex 3*.

BOX 2: GUIDING PRINCIPLES FOR LINKING SRH AND HIV

From the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: Generic Guide*. IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, Young Positives, 2009.¹⁰

- 1. Address structural determinants:** Root causes of HIV and sexual and reproductive ill-health need to be addressed. This includes action to reduce poverty, ensure equity of access to key health services and improve access to information and education opportunities.
- 2. Focus on human rights and gender:** Sexual and reproductive and human rights of all people including women and men living with HIV, need to be emphasized, as well as the rights of key populations at higher risk such as people who use drugs, men who have sex with men (MSM) and sex workers. Gender sensitive policies to establish gender equality and eliminate gender-based violence are additional requirements.
- 3. Promote a coordinated and coherent response:** Promote attention to SRH priorities within a coordinated and coherent response to HIV that builds upon the principles of one national HIV framework, one broad-based multi-sectoral HIV coordinating body, and one agreed country level monitoring and evaluation system (Three Ones Principle).
- 4. Meaningfully involve people living with HIV (i.e. GIPA principle):** Women and men living with HIV need to be fully involved in designing, implementing and evaluating policies and programmes and research that affect their lives.
- 5. Foster community participation:** Young people, key populations at higher risk, and the community at large are essential partners for an adequate response to the described challenges and for meeting the needs of affected people and communities.
- 6. Reduce stigma and discrimination:** More vigorous legal and policy measures are urgently required to protect people living with HIV and vulnerable populations from discrimination.
- 7. Recognize the centrality of sexuality:** Sexuality is an essential element in human life and in individual, family and community well-being.

5

PRONG 1: PRIMARY PREVENTION OF HIV: RATIONALE AND PACKAGE OF ESSENTIAL SERVICES



Rationale

Primary prevention of HIV (prong 1) and treatment are both essential for improving the lives of women and children and eliminating mother-to-child transmission of HIV:

- Remaining HIV-negative, particularly throughout pregnancy and breastfeeding, protects infants and children from becoming HIV-positive by eliminating the possibility of HIV transmission from the mother.
- Modelling has demonstrated that elimination of mother-to-child transmission of HIV will not be possible without addressing primary prevention among women of reproductive age (see *Introduction, Contribution of Prong 1 to eMTCT*).
- Primary prevention of HIV improves survival and well-being. HIV is the leading cause of death among women of childbearing age, contributing significantly to maternal mortality.¹³
- HIV-related morbidity and mortality in a mother living with HIV impact critically upon her child's survival.¹⁴
- Acute maternal HIV infection during pregnancy and breastfeeding¹⁵ is associated with very high rates of MTCT.¹⁶

In addition to supporting broader efforts to prevent HIV, in the context of eMTCT and maternal health, pregnant and breastfeeding women and their partners warrant special attention, and are a key focus of this framework (see *Section 2 Scope and Figure 5*):

- For most women, pregnancy is a key entry point to the health system, and provides a unique opportunity to address their health needs, including primary prevention of HIV (see *Section 7 Entry Points*).
- HIV-negative women are at increased risk of infection during pregnancy and breastfeeding¹⁷ due to physiological¹⁸ and behavioural risks.^{19, v}
- Seroconversion during pregnancy has been documented, underscoring the need for enhanced primary prevention efforts during this period and the need for repeat HIV testing.²⁰
- Both parents may be particularly motivated to protect the well-being of their infant as well as their own health, increasing their likelihood of adopting safer practices and new prevention technologies such as treatment for prevention (see *Box 4*) or post-exposure prophylaxis (PEP) or potentially pre-exposure prophylaxis (PrEP).

v. Family planning may contribute to HIV prevention not only through condom use but also by reducing the amount of time a woman spends pregnant which may reduce the risk of HIV acquisition and transmission. However, certain hormonal contraceptive methods may increase acquisition and transmission of HIV (see *Box 7, page 30*).

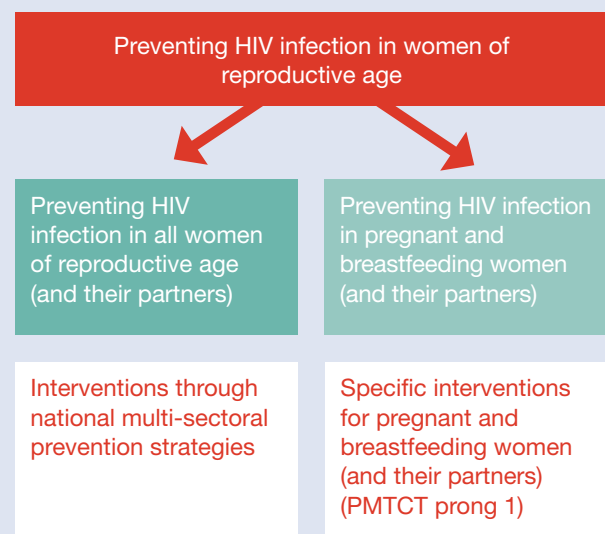
“ Globally, the leading cause of death among women of reproductive age is HIV/AIDS... The most important risk factors for death and disability in this age group in low- and middle-income countries are lack of contraception and unsafe sex. These result in unwanted pregnancies, unsafe abortions, complications of pregnancy and childbirth, and sexually transmitted infections including HIV.”

Women and health: today's evidence tomorrow's agenda. WHO, 2009.¹¹

“ Healthy mothers raise healthy children. Healthy children grow up stronger and better educated and help build more prosperous societies. And a health system that delivers for mothers and children will deliver for the whole community.”

Ban Ki-moon, United Nations Secretary-General.¹²

FIGURE 5: SCOPE OF PMTCT PRONG 1 INTERVENTIONS (SEE ALSO INTRODUCTION, FIGURE 2 AND SECTION 2 SCOPE)



HIV counselling and testing: pathway to prevention and treatment

Preventing HIV in the context of maternal health requires offering a range of related services for women and their partners, including the four recommended antenatal care (ANC) visits (see *Table 2 Package of Essential Services*). Several of these services in particular need to be strengthened to maximise their potential impact – HIV counselling and testing for couples; repeat testing; and post-test counselling (*Box 3 and Section 9 Key Strategies and Actions, Strategy 3*). HIV counselling and testing is a pathway to prevention and treatment services for women and their partners.

BOX 3: HIV COUNSELLING AND TESTING: PATHWAY TO SERVICES

Pregnancy provides a major opportunity to offer women HIV-related services, including HIV counselling and testing – the pathway for HIV prevention, treatment, care and support services.

Couples counselling and testing

- Research shows serodiscordance rates of over 50% among women and their partners attending antenatal clinics.²¹
- Couples HIV counselling and testing is an important and feasible intervention that can be effectively integrated into existing maternal, newborn and child health (MNCH) and other SRH services. Working with couples, rather than just the individual partner, has been shown to be an effective intervention for reducing the risk of HIV transmission among serodiscordant couples.²² The benefits of sensitively implemented, user-friendly couples counselling and testing include mutual disclosure, increased uptake of and adherence to ARV interventions for PMTCT²³, improved uptake and continuation of family planning methods, an opportunity to provide family-centred care and treatment, and increased preventive benefits of testing²⁴ (see *Section 9 Key Strategies and Actions, Strategy 3*).

HIV re-testing

- Many countries need to reorient programmes to accommodate repeat HIV testing during antenatal care. With significant reported HIV incidence during pregnancy in generalized epidemics, pregnant women who test HIV-negative in their first or second trimesters should be re-tested in their third trimester.²⁵ If a woman does not return for testing during her third trimester, she should be recommended to test at labour or, if that is not possible, immediately post-delivery.²⁶

Intensified post-test counselling:

- Post-test counselling is important for women who test HIV-negative so that they understand their risk factors, in particular their heightened risk of HIV acquisition during pregnancy, postpartum, and breastfeeding (see *Rationale* above).
- Counselling must provide accurate and non-judgmental information.
- People living with HIV have emphasized the importance of peer-to-peer counselling by people living with HIV.²⁷ Peer counsellors should be engaged within health facilities wherever feasible and, at a bare minimum, providers must be able to link women with peer support groups in the community (see *Section 9 Key Strategies and Actions, Strategy 2*).
- Health care workers and people living with HIV delivering peer-to-peer counselling (see *Section 9 Key Strategies and Actions, Strategies 2 and 4*) need to be trained according to the areas on which they are to provide information, counselling and services to pregnant women.²⁸

Supporting rights

- The experience of testing and being diagnosed HIV-positive while pregnant may: have traumatic consequences for a woman; affect her ability to seek services and support for herself and her child; and have adverse consequences, including HIV-related discrimination and violence.²⁹ Women should be offered an HIV test but also be supported to determine whether and when to test, as well as to assert their rights to informed consent, confidentiality and freedom from coercion and be provided with appropriate support services.

Antiretroviral treatment contributes to prevention

Evidence has emerged that lowering viral load with antiretroviral drugs contributes not only directly to preventing onward HIV transmission to infants (prong 3), but also to primary prevention of HIV (prong 1) within serodiscordant heterosexual relationships (Box 4).

BOX 4: TREATMENT FOR PREVENTION³⁰

Results announced by the United States National Institutes of Health show that if a HIV-positive person adheres to an effective antiretroviral therapy regimen, the risk of transmitting the virus to their uninfected sexual partner can be reduced by 96%³¹, as well as having health benefits for the HIV-positive person.³²

“The HPTN 052 study provides compelling evidence for a new HIV prevention approach that links prevention and care efforts,” said Quarraisha Abdool Karim, HPTN co-principal investigator and associate scientific director of CAPRISA. *“Strategies for scaling up knowledge of HIV status and increasing treatment coverage are critical next steps to realizing the public health benefits of this finding. This is also very good news for women who bear a disproportionate burden of HIV infection acquired from infected male partners but have few options to reduce their risk especially if their partner refuses to use condoms.”*

“This breakthrough is a serious game changer and will drive the prevention revolution forward. It makes HIV treatment a new priority prevention option,” said Michel Sidibé, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS). *“Now we need to make sure that couples have the option to choose Treatment for Prevention and have access to it.”*

The availability of Treatment for Prevention will not only empower people to get tested for HIV, but also to disclose their HIV status, discuss HIV prevention options with their partners and access essential HIV services. It will also significantly contribute to reducing the stigma and discrimination surrounding HIV.

UNAIDS and WHO recommend that couples make evidence-informed decisions on which combination of HIV prevention options is best for them. UNAIDS urges that Treatment for Prevention be one of the options made available to couples. WHO will release guidelines to help countries make this a reality for people who choose to use this new HIV prevention option. The guidelines will include specific recommendations on increasing access to HIV counselling and testing and the use of ART among discordant couples.

Note on terminology: Treatment as Prevention refers to the additional prevention dividend resulting from access to HIV treatment by medically eligible people living with HIV. Treatment for Prevention involves people living with HIV choosing to take antiretroviral therapy to reduce sexual transmission of HIV to their sexual partner, even though they do not require treatment for their own health. Both have prevention benefits for HIV-negative partners. For the purposes of this document, treatment for prevention is used to encompass both.

Prong 1 package of essential services

The Package of Essential Services (Table 2) for primary prevention of HIV is intended for use by programme managers and health providers. This package builds on the existing key elements of primary prevention of HIV in the context of maternal and child health (see Annex 4). It goes further, however, by providing the rationale for each service and related guidance to carry out each of the key actions, and reflects the most recent issues and research (e.g. treatment for prevention). All of these services can be carried out within maternal health and other SRH, and HIV services, and some can be carried out within the community (e.g. media, schools, workplace, community groups), (see Section 7 Entry Points). Note that the package of services should be modified according to the key features of the HIV epidemic and sexual and reproductive health needs in each country. For example, in settings where injecting drug use is a common mode of HIV transmission, increased emphasis should be given to harm reduction (see Section 3 Related Programming Guidance).

BOX 5: LINKING SRH AND HIV: GATEWAYS TO INTEGRATION – A CASE STUDY FROM SWAZILAND: TOWARDS ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV³³

The case study outlines how challenges to implementing the prongs 1 and 2 packages of essential services were addressed in four sites³⁴. It demonstrates that it is feasible to implement the package of essential services (Table 2) and the key strategies (Section 9) outlined in this framework.

Checklists for national programme implementation

Much can be done by programme managers and health providers within maternal and other SRH services, linked to the community, to help women and their partners remain HIV-negative. At the systems level, to support this package of services, governments and district programme managers will need to undertake a set of related activities within the health services, including joint HIV and SRH planning, service integration, health provider training, commodities security, and engagement with the community (see *Section 8 Checklists for National Programme Implementation*). Checklists are provided to lay the groundwork for implementation of the packages of services (*Section 8*).

Key strategies

In order to effectively implement the delivery of the packages of essential services for prongs 1 and 2, five key strategies will contribute to overcoming barriers to women accessing comprehensive eMTCT services (see *Section 9 Key Strategies and Actions*), namely:

- **Strategy 1:** Link SRH and HIV at the policy, systems and service delivery levels
- **Strategy 2:** Strengthen community engagement
- **Strategy 3:** Promote greater involvement of men
- **Strategy 4:** Engage organizations of people living with HIV
- **Strategy 5:** Ensure non-discriminatory service provision in stigma-free settings.

TABLE 2: PRONG 1 PACKAGE OF ESSENTIAL SERVICES

DESCRIPTION OF SERVICE	HOW IT CONTRIBUTES TO PRIMARY PREVENTION	KEY ACTIONS*
<p>Information and counselling to reduce the risk of sexual HIV transmission</p>	<ul style="list-style-type: none"> ■ Improves motivation and ability to practice safer sex and to access services through increased awareness of: <ul style="list-style-type: none"> > potentially higher risk of acquiring HIV during pregnancy and breastfeeding > possibility of transmitting HIV to infants during pregnancy, childbirth, and breastfeeding > how to practice safer sex > benefits of knowing one's HIV status, including access to treatment to reduce viral load > SRH and HIV health services. 	<ul style="list-style-type: none"> ■ Provide information and counselling on: <ul style="list-style-type: none"> > risk of HIV seroconversion during pregnancy and breastfeeding 31, 35, 36 > HIV transmission to infants, and how to reduce it 31, 35, 36 > safer sex and condom use, including condom negotiation skills with partners 12, 13, 31, 35, 36, 45, 51, 72 (see also <i>Condoms</i> below) > benefits and availability of SRH and HIV services, including eMTCT, and HIV counselling and testing 31, 68, 69, 71, 73 > optimal infant feeding in the context of HIV 32 > male partner responsibility for practicing safer sex 20, 21 > benefits of knowing one's HIV status and accessing ARVs, since ART can reduce viral load thus contributing to primary prevention of HIV 53 > human rights issues, especially pertaining to reproductive rights, gender-based violence, the right to informed consent, confidentiality, disclosure, and freedom from coercion or force (e.g. for HIV testing, fertility decisions, etc.) 4, 5, 7, 17, 19, 24, 29, 31, 60, 61

* All numbers in blue refer to *References to Packages of Essential Services and Key Strategies and Actions*.

TABLE 2: PRONG 1 PACKAGE OF ESSENTIAL SERVICES

DESCRIPTION OF SERVICE	HOW IT CONTRIBUTES TO PRIMARY PREVENTION	KEY ACTIONS*
<p>HIV counselling and testing (particularly for pregnant, postpartum, and breastfeeding women and their male partners) and referral for or on site treatment</p>	<ul style="list-style-type: none"> ■ Individual and couples HIV counselling and testing with strengthened post-test counselling for HIV-negative women and repeat testing will support clients to practice safer sex. ■ Learning HIV status is an important entry point to link people living with HIV with appropriate HIV treatment and care, which itself contributes to HIV prevention (see <i>Treatment for prevention</i> below and <i>Box 4: Treatment for Prevention</i>). ■ Antenatal care is an opportune time to raise awareness of the potential increased risk of HIV transmission/acquisition during pregnancy and breastfeeding, and resultant seroconversion. ■ Family planning services may contribute to HIV prevention not only through condom use but also by reducing the amount of time a woman spends pregnant which may reduce the risk of HIV acquisition and transmission. However, certain hormonal contraceptive methods may increase acquisition and transmission of HIV (see <i>Box 7</i>, page 30). 	<ul style="list-style-type: none"> ■ Offer provider-initiated HIV counselling and testing as part of routine MNCH, including repeat testing for HIV-negative pregnant, postpartum, and breastfeeding women coupled with risk reduction counselling and provision of prevention commodities. 17, 28, 29 ■ Promote couples counselling, as appropriate, with voluntary mutual disclosure and testing. 84 ■ Strengthen post-test counselling for HIV-negative women. Counselling should include information on: <ul style="list-style-type: none"> > Pregnancy-related concerns including danger signs of labour, sexual activity during pregnancy, safer sex and condom use 47 > HIV and STI prevention, including information on modes of transmission, and potential risk for seroconversion during pregnancy 30, 51, 55, 57, 59 72, 76 > Partner HIV and syphilis testing (preferably on-site), and referral for treatment if positive for HIV and/or syphilis 20, 21, 25, 31, 53, 84 > Safe and voluntary disclosure of HIV status 17, 28, 29 > Optimal infant feeding, including exclusive breastfeeding 32 > Gender-based violence prevention and management 19, 31, 48, 58, 60, 61 > Harm reduction, family planning (see footnote in <i>Rationale</i> above) contraceptive use and the lactational amenorrhea method (LAM) during the breastfeeding period 33, 34, 36, 44, 47 > Shared responsibility on HIV prevention among partners, including negotiation skills to support safer sex 20, 21, 31, 53, 84 > The importance of postpartum follow-up, including family planning (see footnote in <i>Rationale</i> above), assessment for postpartum depression, infant feeding information, and continued HIV prevention 17, 31, 35, 47 > Benefits of ART for reducing viral load to contribute to primary prevention of HIV. 53

TABLE 2: PRONG 1 PACKAGE OF ESSENTIAL SERVICES

DESCRIPTION OF SERVICE	HOW IT CONTRIBUTES TO PRIMARY PREVENTION	KEY ACTIONS*
<p>Treatment for prevention (see <i>Box 4: Treatment for prevention</i>)</p>	<ul style="list-style-type: none"> ■ Offering ART to HIV-positive partners contributes to primary prevention (e.g. HIV-positive partners of HIV-negative pregnant women): <ul style="list-style-type: none"> > ART lowers the concentration of HIV (also known as viral load) in the bloodstream and in genital secretions. Since viral load is the single greatest risk factor for all modes of HIV transmission, ART use decreases the risk that HIV will be transmitted from one person to another > Observational studies suggest that ART reduces the sexual transmission of HIV in generalized epidemics, especially among serodiscordant couples. 	<ul style="list-style-type: none"> ■ Forthcoming WHO Guidelines. ■ See also <i>Box 3: HIV Counselling and Testing</i> and <i>Section 9 Key Strategies and Actions, Strategy 3</i>.
<p>STI screening and management</p>	<ul style="list-style-type: none"> ■ Treating certain STIs, especially ulcerative and inflammatory ones, decreases the risk of HIV transmission and acquisition.³⁵ 	<ul style="list-style-type: none"> ■ Intensify antenatal screening and treatment of STIs: 25, 30, 31, 72, 76 <ul style="list-style-type: none"> > Conduct syphilis screening at first ANC visit and other SRH visits, and provide immediate treatment if positive to client and sexual partner(s) 25, 31, 47, 76 > Intensify use of syndromic case management of STIs where other methods are not available (e.g. genital ulcer, vaginal discharge). 72, 76 ■ Provide counselling on STI prevention (including information on recognition of symptoms, when and where to access services and relevant transmission information). 25, 31, 47, 72, 76 ■ See <i>Condoms</i> below. ■ Enhance counselling on the link between STIs (human papillomavirus) and cervical cancer. 15, 72 ■ Provide screening for cervical cancer and treatment or referral. 15, 72 ■ Offer treatment for partners of women diagnosed with an STI. 25, 30, 72, 76 ■ Offer herpes simplex virus (HSV) management. 30, 47
<p>Condoms (female and male): promotion, provision and building skills for negotiation and use</p>	<ul style="list-style-type: none"> ■ Female and male condoms are currently the only barrier devices to protect against the sexual transmission or acquisition of HIV.³⁶ 	<ul style="list-style-type: none"> ■ Promote the use of female and male condoms for women and their partners, including during pregnancy, postpartum, and infant feeding. 12, 31, 45, 51 ■ Provide condoms and lubricants. 12, 13, 64 ■ Teach skills for negotiating condom use with partners. 12, 13, 64 ■ Encourage partner attendance at clinics. 21 ■ Provide rights-based family planning, counselling and contraceptives, including but not limited to condoms (see footnote v, page 19). 12, 13, 44, 47, 64, 66, 73

TABLE 2: PRONG 1 PACKAGE OF ESSENTIAL SERVICES

DESCRIPTION OF SERVICE	HOW IT CONTRIBUTES TO PRIMARY PREVENTION	KEY ACTIONS*
<p>Blood safety and anaemia prevention to reduce blood-related transmission</p>	<ul style="list-style-type: none"> ■ Practicing universal precautions and preventing the need for blood transfusion will decrease the risk of HIV transmission. 	<ul style="list-style-type: none"> ■ Adhere to universal precautions. 31, 36 ■ Ensure appropriate management of labour to reduce the need for delivery-related blood transfusions. 31, 36 ■ Enforce national guidelines for blood safety. 31 ■ Enforce strict blood transfusion criteria. 31 ■ Provide iron and folate supplementation, and as appropriate, malaria preventive therapy, insecticide treated nets, and de-worming, to reduce the need for delivery-related blood transfusions. 31 ■ Treat anaemia and malaria. 31
<p>Gender-based violence prevention and impact mitigation</p>	<ul style="list-style-type: none"> ■ Gender-based violence is a human rights violation that must be eliminated. It can also contribute to HIV transmission in several significant ways, directly or by affecting access to services, and ability to practice safer sex.³⁷ 	<ul style="list-style-type: none"> ■ Take history and assess risk of violence, including by intimate partners, and ways to avoid it. 19, 58, 60, 61 ■ Provide counselling and psychosocial support, as well as emergency contraception and HIV and STI post-exposure prophylaxis for women, men and adolescents who have experienced sexual violence. 19, 58, 60, 61 ■ Refer people who have experienced or are experiencing violence to appropriate services, including legal and psychological support services. 19, 60, 61 ■ Provide information on services and organizations specializing in gender-based violence. 19, 60, 61

6

PRONG 2: PREVENTION
OF UNINTENDED
PREGNANCIES IN
WOMEN LIVING WITH HIV:
RATIONALE AND PACKAGE
OF ESSENTIAL SERVICES



Rationale

Preventing unintended pregnancies among women living with HIV (prong 2) is essential for improving the lives of women and children, and eliminating mother-to-child transmission of HIV:

- The benefits of family planning are far-reaching, ranging from fewer maternal and newborn deaths and healthier mothers and children to increased family savings and productivity, better prospects for education and employment, and ultimately improvement in the status of women.⁴⁰
- There is a high unmet need for family planning, particularly in regions with a high HIV prevalence.⁴¹
- The global unintended pregnancy rate is 38%, and reaches an estimated 51–90% among women living with HIV in some settings.⁴²
- Unintended pregnancies contribute to maternal morbidity and mortality; 27% of maternal deaths can be prevented by meeting unmet need for family planning.⁴³
- HIV-related morbidity and mortality in a mother living with HIV impact critically upon her child's survival.⁴⁴
- Fewer unintended pregnancies mean fewer infants born to mothers living with HIV, thus resulting in a smaller number of potentially HIV-positive infants.
- Modelling has demonstrated that elimination of mother-to-child transmission of HIV will not be possible without addressing unintended pregnancies (see *Introduction, Contribution of Prong 2 to eMTCT*), and may be cost effective (see *Section 11 Operational Research*).

Reproductive choice is a basic human right, yet women living with HIV are reporting human rights violations such as coerced abortion and sterilization, or denial of the right to be sexually active and have children.⁴⁵ Supporting rights-based efforts to prevent unintended pregnancies among women living with HIV is part of wider efforts to respond to the full range of sexual and reproductive health needs of women living with HIV.⁴⁶ Family planning can help women living with HIV and their partners attain their fertility desires, whether these are treating infertility, assisting those who wish not to have children, or delaying a pregnancy. As such, women living with HIV and their partners should have access to the entire range of SRH services. Furthermore, new evidence suggests that pregnancy in women living with HIV within the context of serodiscordant couples increases the risk of female-to-male HIV transmission, which may reflect biological changes of pregnancy that could increase the likelihood of HIV transmission.⁴⁷

People living with HIV have been at the forefront of advocating for and responding to these needs, partnering to develop guidance on addressing the sexual and reproductive health needs of people living with HIV⁴⁸, SRH and HIV service integration (see *Section 9 Key Strategies and Actions, Strategy 1*) and developing the concept of and framework for Positive Health, Dignity and Prevention⁴⁹, which takes a holistic approach to HIV prevention for people living with HIV recognizing the health and dignity of the person.

Couples and individuals have the right “to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health ... free of discrimination, coercion and violence.”

Programme of Action of the International Conference on Population and Development, paragraph 7.3.³⁸

“ From a public health perspective, decision-makers and service providers must recognize that people living with HIV do enter into relationships, have sex, and bear children. Ensuring that we can enjoy these normal aspects of a productive and fulfilling life is key to maintaining our own health, and that of our partners and families.”

Kevin Moody, International Coordinator and CEO, Global Network of People Living with HIV.³⁹

Family planning package of key interventions

WHO in collaboration with UNFPA, UNICEF, the World Bank and the Partnership for Maternal, Newborn and Child Health developed a package of key effective interventions for family planning for community and/or facility levels in developing countries⁵⁰ (see *Table 3*). These interventions have been incorporated into the essential package of services for preventing unintended pregnancies among women living with HIV (see *Table 4*).

TABLE 3: PACKAGE OF KEY EFFECTIVE INTERVENTIONS FOR FAMILY PLANNING⁵¹

INTERVENTION AT HOME/COMMUNITY LEVEL	KEY SUPPLIES AND COMMODITIES NEEDS
<p>Health education for women, men, families and communities:</p> <ul style="list-style-type: none"> ■ To increase awareness of benefits of safe sex, family planning and birth spacing starting from the pre-pregnancy period, during pregnancy and after childbirth ■ Enable adolescents, women and men to access various sexual and reproductive health services through integrated and linked services ■ Counselling and distribution of contraceptive methods including emergency contraception ■ Awareness of signs of domestic and sexual violence and referral. 	<ul style="list-style-type: none"> ■ Counselling, health education and promotion materials ■ Job aids ■ Contraceptive methods <ul style="list-style-type: none"> > Condoms for STI/HIV and pregnancy prevention > Oral contraception including emergency contraception > Injectables.
INTERVENTION AT FIRST LEVEL HEALTH FACILITIES	KEY SUPPLIES AND COMMODITIES NEEDS
<p>All the above plus:</p> <ul style="list-style-type: none"> ■ Counselling and provision of the full range of family planning methods ■ HIV counselling and testing in generalized epidemics ■ Dual protection (female and male condoms) ■ Screening for and recognition and possible management of STIs ■ HIV counselling and testing ■ Screening for and management of signs/symptoms of domestic violence and sexual assault ■ Screening for cancer of the cervix and the breast ■ Identification of initial needs of an infertile couple and referral ■ Management or referral of problems. 	<p>All of the above plus:</p> <ul style="list-style-type: none"> ■ Decision-making aids for clients ■ Full range of contraceptive methods (including vasectomy) ■ Oral and parenteral antibiotics ■ Laboratory test kits for STI/HIV ■ Surgical equipment to insert/remove implants ■ Sphygmomanometer.
INTERVENTIONS AT REFERRAL FACILITIES	KEY SUPPLIES AND COMMODITIES NEEDS
<p>All of the above plus:</p> <ul style="list-style-type: none"> ■ Treatment of medical conditions, side effects and/or complications ■ Management of methods of choice if not provided at first level of care (tubal ligation/vasectomy/insertion and removal of implants, difficult removal of devices etc.) ■ Appropriate management of infertile couples including HIV discordant couples. 	<p>All of the above plus:</p> <ul style="list-style-type: none"> ■ Appropriate operating theatre for surgical methods ■ Surgical equipment.

In addition to the family planning information and services that all women need, women living with HIV may need strengthened or additional information and services, which are specific to HIV and to rights (see *Box 6*).

BOX 6: SPECIFIC FAMILY PLANNING NEEDS OF WOMEN LIVING WITH HIV

Strengthened or additional information, counselling, and services are needed on:

- **rights including reproductive rights:** respecting fertility, sexuality, and contraceptive method choices, which do not force or coerce women into abortion or sterilization⁵²
- **drug interactions:** between certain ARVs and hormonal contraceptives⁵³
- **contraceptives:** see *Box 7* and latest WHO medical eligibility criteria for contraceptive use for women living with HIV⁵⁴
- **treatment for infertility:** women living with HIV may be more likely to have difficulty getting pregnant as a consequence of either her own reduced fertility or that of her partner⁵⁵
- **STIs:** people living with HIV may be at greater risk, specifically for:
 - > human papillomavirus (HPV), which is a risk factor for cervical and anal cancers⁵⁶
 - > syphilis, which may manifest differently and require more aggressive treatment⁵⁷
 - > genital herpes (HSV-2 or HSV-1), which may be more severe, as well as prolonged or atypical in presentation, particularly in those with low CD4 counts. Asymptomatic and symptomatic HSV-2 reactivation is also more frequent.⁵⁸
- **serodiscordance:** lowering the risk of HIV infection to serodiscordant partner, if intending to get pregnant (see *Section 5, Box 4: Treatment for Prevention*)
- **potential risk to the woman's health if she becomes pregnant,** especially if her CD4 count is low⁵⁹: more susceptible during pregnancy to malaria and anaemia⁶⁰, HIV increases the risk of preterm birth and low birth weight⁶¹, and more likely to be affected by reproductive health complications such as miscarriage, postpartum haemorrhage, puerperal sepsis and complications of caesarean section and unsafe abortion.⁶²

Prong 2 package of essential services

The package of essential services (*Table 4*) for preventing unintended pregnancies among women living with HIV is intended for use by programme managers and health providers. This package builds on the existing family planning interventions for all women (*Table 3*) and the package of essential services for high-quality maternal care (see *Annex 4*). It goes further, however, by focusing on family planning services for women living with HIV in the context of eMTCT (*Box 6*). The package provides the rationale for each service and related guidance to carry out each of the key actions, and reflects the most recent issues and research. All of these services can be carried out within maternal health and other SRH and HIV services, and some can be carried out within the community (e.g. media, schools, workplace, community groups), (see *Section 7 Entry Points*). Note that the package of services should be modified according to the key features of the HIV epidemic and sexual and reproductive health needs in each country (see *Section 3 Related Programming Guidance*).

Checklist for national programme implementation

Much can be done by programme managers and health providers within maternal and other SRH services, linked to the community to help women and their partners remain HIV-negative. At the systems level, to support this package of services, governments and district programme managers will need to undertake a set of related activities within the health services, including joint HIV and SRH planning, service integration, health provider training, commodities security, and engagement with the community (see *Section 8 Checklists For National Programme Implementation*). Checklists are provided to lay the groundwork for implementation of the packages of services (*Section 8*).

Key strategies

In order to effectively implement the delivery of the prongs 1 and 2 packages of essential services, five key strategies will contribute to overcoming barriers to women accessing comprehensive eMTCT services (see *Section 9 Key Strategies and Actions*), namely:

- **Strategy 1:** Link SRH and HIV at the policy, systems and service delivery levels
- **Strategy 2:** Strengthen community engagement
- **Strategy 3:** Promote greater involvement of men
- **Strategy 4:** Engage organizations of people living with HIV
- **Strategy 5:** Ensure non-discriminatory service provision in stigma-free settings.

BOX 7: HORMONAL CONTRACEPTIVES AND HIV

Excerpts from *Statement on the Heffron et al study on the safety of using hormonal contraceptives for women at risk of HIV infection*. October 2011, WHO

“ ... Findings from a prospective cohort study among 3,790 heterosexual HIV sero-discordant couples from Heffron and colleagues published on 4 October 2011 in *The Lancet Infectious Diseases* suggest that use of hormonal contraception may increase the risk of acquiring HIV infection two-fold. (Heffron R, Donnell D, Rees H, et al. 2011. Use of hormonal contraceptives and risk of HIV-1 transmission: a prospective cohort study. *The Lancet Infectious Diseases*. Published online Oct 4, 2011. DOI:10.1016/S1473-3099(11)70247-X).

Additionally, the study reports that HIV-infected women who used hormonal contraception were two-fold more likely to transmit their infection to their un-infected partner compared with HIV-positive women who did not use hormonal contraception. Hormonal methods used by women in this analysis were primarily progestin-only injectables, with a smaller number using combined oral contraceptive pills.

Results of this study provide additional information to the published body of evidence on hormonal contraception and HIV, and offer data regarding HIV acquisition and transmission risk among HIV sero-discordant couples. However, like previously published studies, these findings were derived from observational data, which may be biased by self-selection. ... Furthermore, few new HIV infections were recorded among contraceptive users (10 among injectable users and 3 among oral contraceptive users). These methodological issues and limitations underscore the need to thoroughly evaluate the body of evidence on the topic in its entirety so as to weigh the risks and benefits of hormonal contraceptive use for women at risk of HIV and those who are HIV infected.

Currently, systematic reviews conclude that the weight of evidence does not indicate that use of hormonal contraception increases the risk of HIV acquisition, transmission or disease progression among the general population, but may have an impact on women at high risk of HIV infection, such as sex workers. Given the crucial role of contraception in helping women with, or at risk of, HIV infection to prevent unintended pregnancies and

prevent perinatal transmission of HIV to their infants, as well as the adverse social and health consequences of unwanted pregnancy, WHO and partners have urged for more research to resolve key gaps in our understanding of the topic.

In light of the study by Heffron and colleagues, as well as the public health concerns it raises, WHO is convening a Technical Consultation on 31 January to 1 February 2012 to re-examine the totality of evidence on potential effects of hormonal contraception on HIV acquisition, disease progression, and infectivity/transmission to sexual partners. ...

The technical consultation will bring together a multi-disciplinary group of experts to evaluate the available scientific evidence in this area. Through a consensus-based process, current WHO recommendations on contraceptive use for women at risk of HIV, women with HIV infection or AIDS, will be assessed to determine whether they remain consistent with the updated body of evidence or whether modifications need to be made. ... WHO will issue a statement on recommendations for contraceptive use in high HIV incidence and prevalence settings after a consensus has been reached at the conclusion of the consultation. ”

Note that:

- In the study, the HIV-1-seropositive partners were not taking ART (See methodological section of Heffron study, and also from this framework, *Section 5 Box 4 Treatment for Prevention*)
- Pregnancy increases the risk of HIV acquisition and transmission (See from this framework *Section 5 Rationale, footnote v and endnote 17*).

For the most up-to-date information please refer to the statement on recommendations from the WHO Technical Consultation 31 January to 1 February 2012 and the subsequent most recent edition of the evidence-based guidance on contraceptive use, *Medical Eligibility Criteria for Contraceptive Use*, WHO.

BOX 8: LINKING SRH AND HIV: GATEWAYS TO INTEGRATION – A CASE STUDY FROM SWAZILAND: TOWARDS ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV ⁶³

The case study outlines how challenges to implementing the prongs 1 and 2 packages of essential services were addressed in four sites.⁶⁴ It demonstrates that it is feasible to implement the package of essential services (*Table 3*) and *Section 9 Key Strategies and Actions* outlined in this framework.

TABLE 4: PRONG 2 PACKAGE OF ESSENTIAL SERVICES

DESCRIPTION OF SERVICE	HOW IT CONTRIBUTES TO PREVENTION OF UNINTENDED PREGNANCIES	KEY ACTIONS*
<p>Information and counselling to support reproductive rights, including preventing unintended pregnancies</p>	<ul style="list-style-type: none"> ■ Improves motivation and ability to exercise reproductive rights, including family planning, and to access services through increased awareness of: <ul style="list-style-type: none"> > reproductive health as a right > fertility options > benefits of family planning > how to prevent unintended pregnancies > SRH and HIV health services, including family planning. 	<ul style="list-style-type: none"> ■ Provide health education to women, men, families and community: <ul style="list-style-type: none"> > to increase awareness of benefits of safer sex, family planning and birth spacing starting from the pre-pregnancy period during pregnancy and after childbirth 12, 13, 31, 51, 52, 66, 71 > to enable adolescents, women and men to access various reproductive health services through integrated and linked services 6, 22, 31, 47, 52, 66, 67, 68, 69, 71, 73 > counselling and distribution of contraceptive methods including emergency contraception 44, 71 > awareness of signs of domestic and sexual violence and referral 3, 19, 58, 60, 61 ■ Provide information and counselling to women living with HIV on: <ul style="list-style-type: none"> > human rights-related issues, especially pertaining to reproductive health, gender-based violence, informed consent, confidentiality, disclosure, and freedom from coercion or force in the context of HIV care, fertility decision-making processes, etc. 4, 5, 6, 7, 17, 29, 31, 39, 58, 60, 61, 66, 71 > the risk of HIV transmission during pregnancy, delivery and infant feeding 31, 32, 35, 36 52, 53, 66 > safer pregnancy (e.g. consider mother's health status and ART options during pregnancy), maternal health during pregnancy (possible reproductive health complications) and infant feeding 11, 31, 32, 35 > the safety of and eligibility to use a wide selection of contraceptives and family planning methods in the context of HIV 44, 52, 71 > the link between STIs (HPV) and cervical cancer 15, 71 ■ Increase SRH counselling for adolescents living with HIV 4, 5, 6, 7, 39, 52, 54, 71. 88 ■ Promote STI screening and treatment (in particular genital herpes and syphilis). 25, 30, 31, 72, 76
<p>Clinical management of HIV</p>	<ul style="list-style-type: none"> ■ Optimizing HIV health status can lead to improved maternal and therefore child health outcomes ■ Poor health status can negatively impact on fertility ■ Some ARV drugs can be teratogenic while others can interact with certain hormonal contraceptives, affecting their efficacy ■ HIV treatment services can be good entry points for counselling on reproductive rights and offering family planning services ■ Treatment for prevention can reduce the risk of HIV transmission within HIV discordant couples. 	<ul style="list-style-type: none"> ■ Implement existing guidelines on ART, opportunistic infections and comorbidities. 9, 22, 44

* All numbers in blue refer to *References to Packages of Essential Services and Key Strategies and Actions*.

TABLE 4: PRONG 2 PACKAGE OF ESSENTIAL SERVICES

DESCRIPTION OF SERVICE	HOW IT CONTRIBUTES TO PREVENTION OF UNINTENDED PREGNANCIES	KEY ACTIONS*
<p>Rights-based family planning counselling and services</p>	<ul style="list-style-type: none"> ■ Providing family planning counselling and services within a human rights framework supports the decision-making of women living with HIV regarding: <ul style="list-style-type: none"> > fertility and infertility > contraceptive method(s) choices > timing and spacing of children as desired. 	<ul style="list-style-type: none"> ■ Provide counselling on reproductive rights, including discussion of the right to be free from coercion, and rights to confidentiality, privacy, and informed consent 20, 22, 28, 31, 39, 52, 67, 71 ■ Assess fertility 47, 66, 71 ■ Counselling and provision of a full range of family planning methods: 12, 22, 44, 47, 52, 53, 66, 71 <ul style="list-style-type: none"> > Provide counselling on birth spacing in relation to maternal and perinatal health 47, 66 > Provide counselling to HIV discordant couples about HIV prevention, including how to minimize the risk of HIV transmission/acquisition and other STIs, especially when trying to conceive, and on ART as prevention and ART for prevention 9, 17, 47, 52, 53, 66, 71, 72, 76 ■ Refer to or provide a complete range of SRH services according to needs 5, 22, 28, 31, 47, 52, 66, 71 (see also <i>STI screening and management</i>). Depending on: <ul style="list-style-type: none"> > Intention to get pregnant: <ul style="list-style-type: none"> • Counselling on reducing vertical transmission, conception among HIV concordant and serodiscordant couples 28, 52, 66, 71 • Safe pregnancy and routine ANC recommendations 71 • Use of ARVs during pregnancy and breastfeeding to reduce vertical transmission 11 > Intention to delay or prevent pregnancy: <ul style="list-style-type: none"> • Ascertain if currently using a method of contraception 44 • If yes: what method? • Taking ARVs? Possible interactions between ARVs and hormonal contraceptives 44 • Counselling about method options, use, and side effects, including shifting and discontinuation 44 • Provide contraceptive supplies 12, 44, 64, 67, 71 • Dual protection (female and male condoms) and lubricant 12, 13, 31, 51, 52, 64, 66, 71 • Need for concomitant STI prevention and management 30, 31, 44, 71, 72, 76 > Failure to conceive: <ul style="list-style-type: none"> • Identification of initial needs of the infertile couple, and referral 47, 52, 53, 66, 71 • Appropriate management of the infertile couple, including serodiscordant couples. 47, 52, 53, 66, 71

TABLE 4: PRONG 2 PACKAGE OF ESSENTIAL SERVICES

DESCRIPTION OF SERVICE	HOW IT CONTRIBUTES TO PREVENTION OF UNINTENDED PREGNANCIES	KEY ACTIONS*
<p>STI screening and management</p>	<ul style="list-style-type: none"> ■ Preventing and managing STIs, especially ulcerative and inflammatory, ones are important to protect health, including fertility ■ For people living with HIV some STIs, such as herpes, can be more severe with low CD4 counts ■ Syphilis infection in persons living with HIV can increase HIV viral load and decrease CD4 cell counts⁶⁵ ■ Maternal syphilis infection has also been associated with increased risk of mother-to-child transmission.⁶⁶ In addition, syphilis during pregnancy causes 750,000 neonatal and foetal deaths each year in developing countries. Prevention and control of syphilis in pregnancy is therefore an important component of efforts to attain improved MCH outcomes. 	<ul style="list-style-type: none"> ■ Screening for and recognition and possible management of STIs: 25, 30, 31, 47, 71, 72, 76 <ul style="list-style-type: none"> > Conduct syphilis screening at first ANC and other SRH visit(s), and provide immediate treatment if positive to client and sexual partner(s) 25, 31, 71, 72, 76 > Intensify use of syndromic case management of STIs where other methods are not available (e.g., genital ulcer, vaginal discharge) 72, 76 > Provide counselling on STI prevention (including information on recognition of symptoms, when and where to access services and relevant transmission information) 22, 25, 31, 47, 52, 66, 72, 76 > Screening for cancer of the cervix and of the breast 15, 71, 72 > Offer treatment for partners of women diagnosed with a STI. 25, 30, 72, 76
<p>Gender-based violence prevention and impact mitigation</p>	<ul style="list-style-type: none"> ■ Gender-based violence is a pre-eminent human rights violation ■ Women living with HIV may experience additional violence based on HIV-status ■ Violence or even fear of violence may interfere with access to health, social, and legal services, and exercising reproductive rights. 	<ul style="list-style-type: none"> ■ Screening for and management of signs/symptoms of domestic violence and sexual assault: 19, 58, 60, 61 <ul style="list-style-type: none"> > Take history and assess risk of violence, including by intimate partners, and ways to avoid it 19, 58, 60, 61 > Provide counselling and psychosocial support, as well as emergency contraception and HIV and STI post-exposure prophylaxis for women, men and adolescents who have experienced sexual violence 19, 58, 60, 61 > Refer people who have experienced or are experiencing violence to appropriate services, including legal and psychological support services 19, 60, 61 > Provide information on services and organizations specializing in gender-based violence. 19, 60, 61
<p>Stigma and discrimination eradication</p>	<p>See <i>Section 9 Key Strategies and Actions, Strategy 5</i></p>	<p>See <i>Section 9 Key Strategies and Actions, Strategy 5</i></p>

Text in orange refers to interventions outlined in the package of key effective interventions for family planning for community and/or facility levels in developing countries (see *Table 3*).⁶⁷

7

ENTRY POINTS: SERVICE DELIVERY SETTINGS



Priority health service entry points for delivering PMTCT interventions include those services for maternal and newborn health, family planning, STIs, HIV counselling and testing, and HIV treatment.⁶⁸ There are also additional community and health service entry points for delivering interventions for prongs 1 and 2.⁶⁹

Entry points for prong 1

The entry points for primary prevention include (see *Figure 6* and *Table 5*):

- **Maternal, newborn and child health services:** as women cycle in and out of pregnancy, MNCH services are the backbone of primary prevention for women of reproductive age. This is the time when women are both at an increased risk of HIV acquisition and are most likely to enter services. This is an opportunity to provide the full package of services.
- **Family planning services:** women may seek family planning services after or unrelated to a pregnancy. Family planning provides opportunities to integrate HIV counselling and testing and to promote and provide condoms for dual protection. Preventing unintended pregnancies also lowers the heightened risk of HIV acquisition and transmission during pregnancy and breastfeeding.⁷⁰

- **HIV counselling and testing:** increased HIV counselling and testing, including couples HIV counselling and testing, is the gateway to knowing one's status, being counselled on safer sex and provided with condoms as well as being able to access services such as ART, including treatment for prevention.
- **Antiretroviral therapy services:** accessing ART contributes to HIV prevention in serodiscordant partners (see *Section 5 Prong 1, Box 4: Treatment for Prevention*).
- **Sexually transmitted infection services:** STI services provide an entry point for providing STI screening and treatment, safer sex information and counselling, HIV counselling and testing, and condoms.

FIGURE 6: OPPORTUNITIES FOR DELIVERING PMTCT PRONG 1 INTERVENTIONS

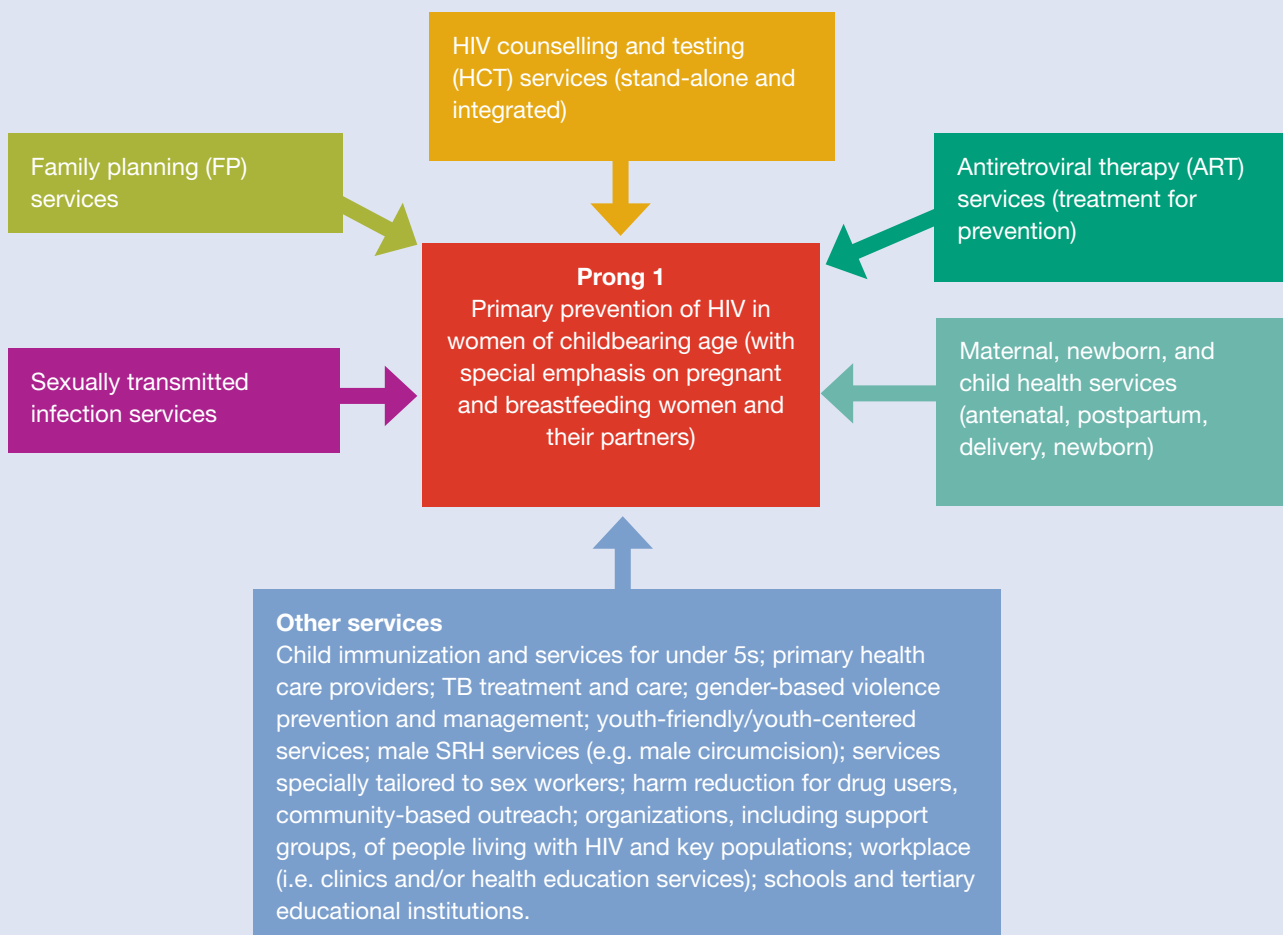


TABLE 5: PRONG 1 PACKAGE OF ESSENTIAL SERVICES: ENTRY POINTS AND CHALLENGES

SERVICE (SEE TABLE 2: PRONG 1 PACKAGE OF ESSENTIAL SERVICES)	ENTRY POINTS						CHALLENGES TO PROVISION AND UPTAKE OF SERVICES
	MNCH	FP	STI	HCT	ART	Community	
Information and counselling to reduce the risk of sexual HIV transmission	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓	✓✓✓	<ul style="list-style-type: none"> ■ Sensitivity to discussing sexual matters ■ Low perception of risk of HIV infection by women and their partners ■ Inadequate community awareness of vulnerability to HIV during pregnancy/postpartum and of vertical transmission resulting in insufficient demand
HIV counselling and testing (particularly for pregnant, postpartum, and breastfeeding women and their male partners) and referral or on site treatment	✓✓✓	✓✓	✓✓	✓✓✓	✓	✓	<ul style="list-style-type: none"> ■ Reluctance of client or partner to be tested ■ Fear of discrimination, disclosure and consequences, including criminalization ■ Insufficient counselling of postpartum HIV-negative women ■ Fear of consequences of disclosure
Treatment for prevention (see Section 5, Box 4: Treatment for Prevention)	✓	✓	✓	✓	✓✓✓	✓	<ul style="list-style-type: none"> ■ Stigma and discrimination in health care settings and elsewhere ■ Male partner reluctance to learn HIV status ■ Loss to follow-up
STI screening and management	✓✓✓	✓✓	✓✓✓	✓	✓	✓	<ul style="list-style-type: none"> ■ Asymptomatic nature of STIs ■ Lack of awareness of implications of STIs on future fertility, HIV acquisition and transmission, and infants' health ■ Inadequate STI management and dual protection in ANC and postpartum services
Condoms (female and male): promotion, provision, and building skills for negotiation and use	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	<ul style="list-style-type: none"> ■ Inadequate emphasis on dual protection in ANC and postpartum services ■ Lack of understanding that HIV can be transmitted or acquired during pregnancy and postpartum
Blood safety and anaemia prevention to reduce blood-related transmission	✓✓✓	✓✓	✓	✓	✓	✓	<ul style="list-style-type: none"> ■ Insufficient practice of universal precautions ■ Inadequate attention to anaemia prevention and treatment in ANC ■ Inadequate attention to blood safety in delivery services ■ Overcoming the reluctance of women to access hospitals and clinics for ANC and delivery
Gender-based violence prevention and impact mitigation	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	<ul style="list-style-type: none"> ■ Lack of understanding that gender-based violence is a human rights violation ■ Lack of empowerment to demand cessation of gender-based violence

This generic table indicates what services could logically be provided by each service entry point. Number of 'ticks' correlates to how important and commonly used an entry point may be. However, service delivery modalities and entry points, and their priority for delivering the packages of services will vary by country context.

Entry points for prong 2

There are four principal entry points for women living with HIV to be offered family planning services (see *Figure 7* and *Table 6*), namely:

- **Maternal, newborn and child health services:** many women learn their HIV status in antenatal clinics, during delivery, postpartum or in newborn services where family planning should be a routine part of service provision to varying extents.
- **Family planning services:** women living with HIV may learn their status through HIV counselling and testing in family planning clinics, or already know their status when accessing these family planning services.
- **HIV treatment and care services:** women living with HIV who access HIV clinical care should receive integrated SRH services, including family planning, or at least be referred to such services. People living with HIV have indicated preferences for HIV and family planning services to be provided in both HIV clinics and in community-based facilities, if they are integrated.⁷¹
- **Sexually transmitted infection services:** STI services provide an entry point for providing STI screening and treatment, information, counselling and condoms for dual protection, and/or contraceptives or referral to family planning services.

FIGURE 7: OPPORTUNITIES FOR DELIVERING PMTCT PRONG 2 INTERVENTIONS

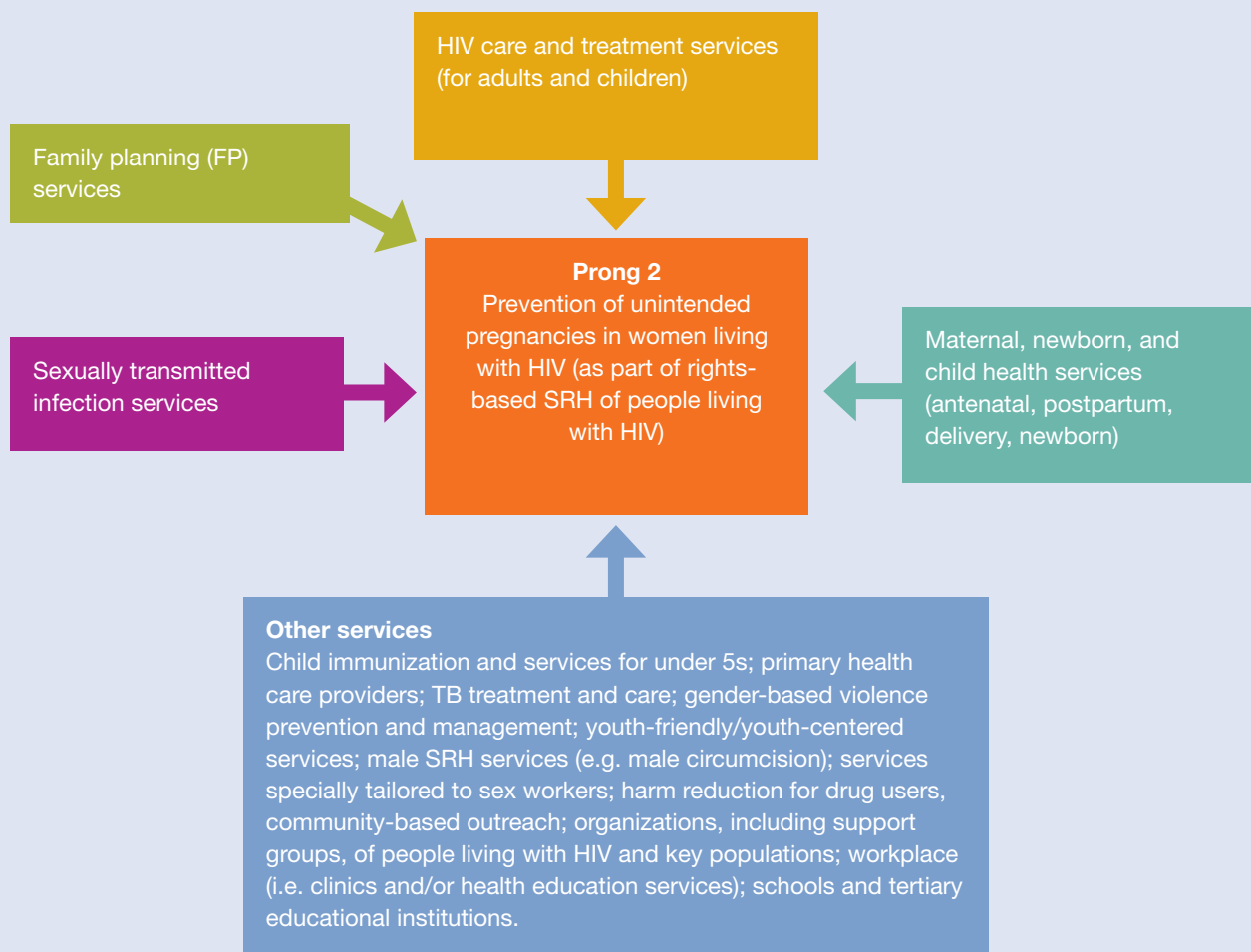


TABLE 6: PRONG 2 PACKAGE OF ESSENTIAL SERVICES: ENTRY POINTS AND CHALLENGES

SERVICE (SEE TABLE 4: PRONG 2 PACKAGE OF ESSENTIAL SERVICES)	ENTRY POINTS						CHALLENGES TO PROVISION AND UPTAKE OF SERVICES
	MNCH	FP	STI	HCT	ART	Community	
Information and counselling to support reproductive rights, including preventing unintended pregnancies	✓✓✓	✓✓✓	✓✓	✓✓	✓✓✓	✓✓✓	<ul style="list-style-type: none"> ■ Sensitivity to discussing sexual matters ■ Stigma and discrimination in health services and the community ■ Lack of awareness of benefits of family planning and availability of services ■ Fear of violence if partner learns of HIV-positive status
Clinical management of HIV, including treatment for prevention	✓✓✓	✓✓	✓	✓	✓✓✓	✓	<ul style="list-style-type: none"> ■ Stigma and discrimination in health services and the community ■ Fear of violence if partner learns of HIV-positive status ■ Lack of ability to access services due to social, cultural, geographical or economic (user fees, long waiting times and cost of transportation) barriers ■ Loss to follow-up
Rights-based family planning, counselling and services	✓✓✓	✓✓✓	✓	✓✓	✓✓✓	✓✓	<ul style="list-style-type: none"> ■ Package of family planning services for women living with HIV not widely available ■ Insufficient integration of family planning in ANC/postpartum, VCT, treatment programmes ■ Sensitivity to discussing sexual matters ■ Stigma and discrimination in health services and the community ■ Weakness in follow-up post HIV-positive test result in family planning services
STI screening and management	✓✓✓	✓✓✓	✓✓✓	✓	✓✓✓	✓	<ul style="list-style-type: none"> ■ Asymptomatic nature of STIs ■ Lack of awareness of implications of STIs for future fertility and infants' health ■ Inadequate STI management and dual protection in ANC and postpartum services
Gender-based violence prevention and impact mitigation	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	<ul style="list-style-type: none"> ■ Lack of understanding that gender-based violence is a human rights violation ■ Lack of empowerment to demand cessation of gender-based violence

This generic table indicates what services could logically be provided by each service entry point. Number of 'ticks' correlates to how important and commonly used an entry point should be. However, service delivery modalities and entry points, and their priority for delivering the packages of services will vary by country context.

8

CHECKLISTS FOR NATIONAL PROGRAMME IMPLEMENTATION



This section provides actions for governments, including district programme managers, to strengthen programming based on the Global Plan 10-point plan, the IATT priority implementation areas, and illustrative checklists for delivery of services for prongs 1 and 2. These actions are cross-referenced to relevant sections of this framework.

Country implementation actions⁷⁴: 10-point plan⁷⁵

The *Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive* outlines a 10-point action plan for implementation by the 22 priority countries^{vi} which can be adapted by countries with low and concentrated epidemics. Many of the actions contained in this framework for preventing HIV and unintended pregnancies will help countries implement the 10-point plan:

1. Conduct a strategic assessment of key barriers to elimination of new HIV infections among children and keeping their mothers alive (*Section 7, Tables 5 and 6, and Section 9 Key Strategies and Actions, Strategy 1*).
2. Develop or revise nationally-owned plans towards elimination of new HIV infections among children and keeping their mothers alive and cost them (see *Table 7*).
3. Assess the available resources for elimination of new child HIV infections and keeping their mothers alive and develop a strategy to address unmet needs.
4. Implement and create demand for a comprehensive, integrated package of HIV prevention and treatment interventions and services (see *Sections 5 and 6, Tables 2 and 4 Package of Essential Services and Section 9 Key Strategies and Actions, Strategies 1–5*).
5. Strengthen synergies and integration fit to context between HIV prevention and treatment and related health services to improve MCH outcomes (see *Section 9 Key Strategies and Actions, Strategy 1*).
6. Enhance the supply and utilization of human resources for health (*Section 9 Key Strategies and Actions, Strategies 1 and 2, and see Table 7*).
7. Evaluate and improve access to essential medicines and diagnostics and strengthen supply chain operations (see *Table 7*).
8. Strengthen community involvement and communication (see *Section 9 Key Strategies and Actions, Strategies 2–5*).
9. Better coordinated technical support to enhance service delivery (see *Section 9 Key Strategies and Actions, Strategy 1*).
10. Improve outcomes assessment, data quality, and impact assessment (see *Table 7 and Section 9 Key Strategies and Actions, Strategies 4 and 5*).

vi. Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

“ Elimination of MTCT requires a new level of commitment, and a different way of coordinating efforts. It means taking stock of PMTCT programmes in each country, and identifying bottlenecks and fault lines of inequity in service coverage.⁷² Programme management and planning at national, sub-national and facility levels are critical to the process. Of particular importance is the need to identify populations that are still not reached and the reasons why they have no access to or are not using available services, including whether programme strategies being employed are adequate.”

A Global Action Framework for the Elimination of Mother-to-Child Transmission of HIV.⁷³

Key IATT tools and guidelines developed in support of the Global Plan

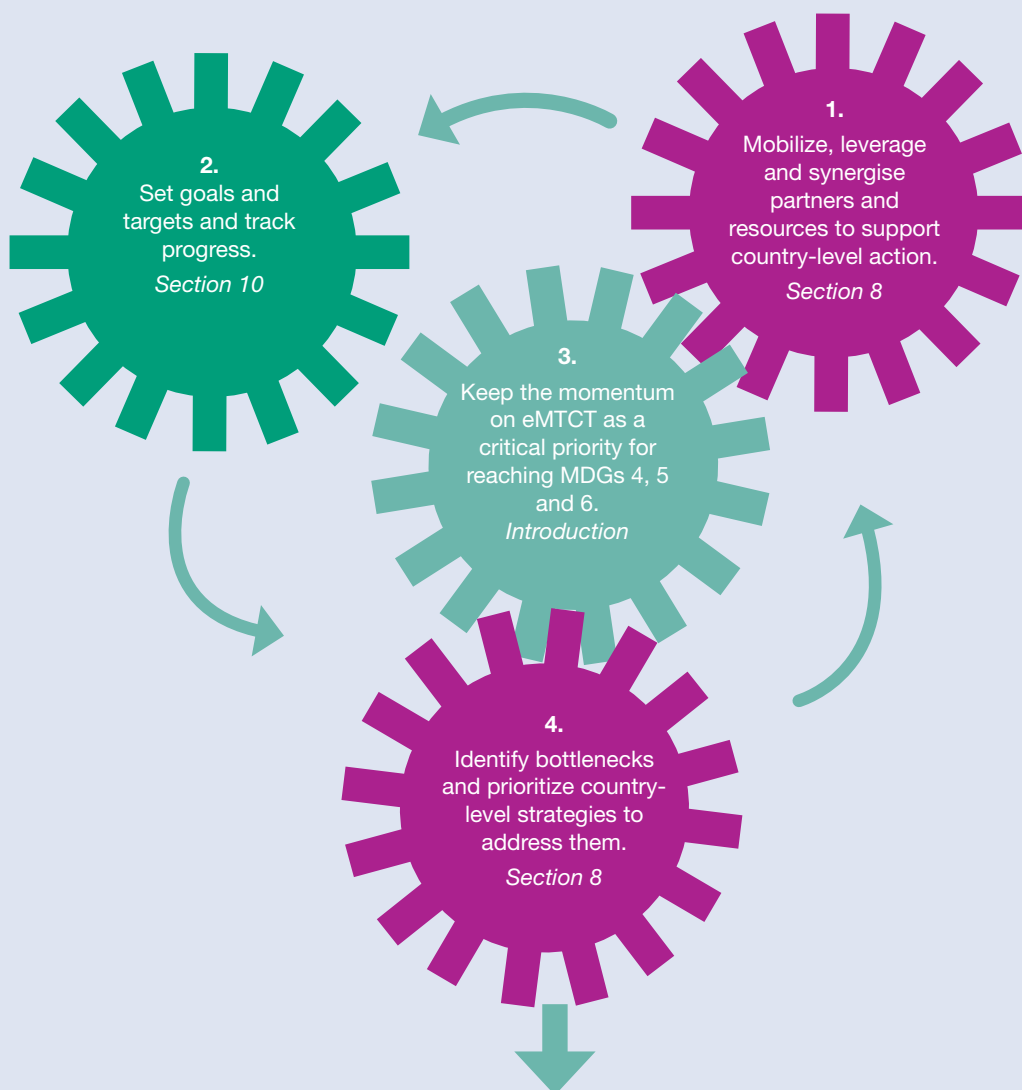
1. Checklist for rapid review of existing national PMTCT plans (see *Section 9 Key Strategies and Actions, Strategy 1, Box 9: Rapid Assessment Tool for Linking SRH and HIV*).
2. Dashboard for collection of baseline data/information and monitoring progress at national and sub-national level (see *Section 9 Key Strategies and Actions, Strategies 1 and 2, and Section 10 Targets and Indicators*).
3. Guidance and excel tool for an equity-focused bottleneck analysis at sub-national level (*Section 9 Key Strategies and Actions, Strategies 1–5*).
4. Guide for setting national goals and targets (*Section 10 Targets and Indicators*).
5. Step-by-step guide for developing national eMTCT plans (see this framework: *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015*. IATT, 2011).
6. National core PMTCT M&E indicators and definitions (*Section 10 Targets and Indicators*).
7. Global M&E framework for eMTCT (*Section 10 Targets and Indicators*).
8. Impact assessment guide (*Section 9 Key Strategies and Actions, Strategies 1–5 and Section 10 Targets and Indicators*).
9. Guidance on costing of eMTCT plans (*Sections 5 and 6, Tables 2 and 4 Package of Essential Services and Section 11 Operational Research*).
10. Planning guide for developing national technical support plan for eMTCT (see this framework: *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015*. IATT, 2011).

National programme implementation

Building on this 10-point plan, the Global Action Framework for the Elimination of Mother-to-Child Transmission of HIV of the IATT⁷⁶ recommends a set of actions in four strategic priority areas to guide and accelerate global, regional and country level efforts towards eMTCT (see *Figure 8*). It also provides a set of actions for countries that conform to the following five priority implementation areas (see *Figure 8*).

Table 7 includes all actions from the Global Action Framework, relevant to all four prongs as well as additional actions specific to prongs 1 and 2 (in italics).⁷⁷ Actions are cross-referenced to relevant sections of this framework.

FIGURE 8: GLOBAL ACTION FRAMEWORK STRATEGIC PRIORITY AREA AND PRIORITY IMPLEMENTATION AREAS AT THE COUNTRY LEVEL



1. Strategic re-visioning of national plans and resources allocation in light of programme performance
2. Adapt PMTCT approaches to the performance of the MNCH platform
3. Enabling rapid scale-up by addressing human resource constraints
4. Timely assessment of supply requirements and system functionality linked to programme performance
5. Improving communication and community-based approaches to promote increased demand, utilization and follow-up

TABLE 7: IMPLEMENTATION AREAS FOR FOCUSED COUNTRY-LEVEL ACTION TO OVERCOME BOTTLENECKS

IMPLEMENTATION AREAS	ACTIONS
<p>Undertake strategic re-visioning of national plans and resources allocation in light of programme performance including identified bottlenecks</p>	<ul style="list-style-type: none"> ■ Revise national plans to align them with eMTCT goals and targets. This goes beyond rhetorically stating elimination as a goal to determining strategic priorities and programming shifts required to achieve eMTCT based on analysis of current performance and bottlenecks (see <i>Introduction, Table 1 (Targets) and Sections 5 and 6, Prongs 1 and 2</i>). ■ Identify financial gaps and align budgets to address the revision of national plans in line with eMTCT, taking into account underachieving districts for targeted resource allocation. ■ <i>Prepare joint proposals building on the comparative strengths of both SRH/MNCH and HIV/ PMTCT programmes and the specific needs of the country (e.g. Global Fund proposals should fully include SRH/MNCH partners in strategic planning, budgeting, fund raising, and Country Coordinating Mechanisms) (see Section 9 Key Strategies and Actions, Strategy 1).</i> ■ <i>Systematically address PMTCT in H4+/H5 joint planning and identify opportunities for maximizing efficient use of technical and financial resources through collaborative work (see Section 9 Key Strategies and Actions, Strategy 1).</i>
<p>Adapt PMTCT programmatic approaches to the performance of the MNCH platform</p>	<ul style="list-style-type: none"> ■ Undertake PMTCT programme assessment focusing on bottleneck analysis⁷⁸ that looks at (see <i>Section 9 Key Strategies and Actions, Strategy 1</i>): <ul style="list-style-type: none"> > the HIV/AIDS contribution to overall maternal, neonatal and child mortality > the MNCH landscape and its interactions with PMTCT-related interventions across all points of the service delivery cascade > the partnership framework around MNCH, PMTCT, adult and paediatric care and treatment, including areas of support and specific activities > target populations and their access and utilization of antenatal, childbirth, postnatal and paediatric services. ■ An analytical description of key areas of synergies, missed opportunities for delivering key services and responses to policy and systemic challenges, with areas and opportunities for improvement is a primary outcome. ■ Identify women and children who are not reached through equity analysis and assess reasons why they are not accessing or utilizing available services. This should include facility- as well as community-based assessments to fully comprehend the spectrum of social, cultural, economic and systemic barriers (see <i>Section 9 Key Strategies and Actions, Strategies 1 and 2, and Section 11 Operational Research</i>). ■ In a bi-directional integration and linkages goal, build capacity across the SRH/MNCH platform and at all points of delivery of PMTCT interventions to (see <i>Section 9 Key Strategies and Actions, Strategy 1</i>): <ul style="list-style-type: none"> > Prong 1 – Operationalize primary prevention in the context of PMTCT: use antenatal, childbirth, postnatal care, family planning, STIs, immunization and under 5 services as entry points for the provision of primary HIV prevention services. The elimination of MTCT will not be achieved without lowering the rate of new infections among women of childbearing age including pregnant women (see <i>Section 5, Prong 1 and Section 7 Entry Points</i>). <ul style="list-style-type: none"> • Countries should develop and implement policies and programme strategies that promote and support the provision of primary HIV prevention services at all possible entry points for women, particularly at all points of service delivery across the MNCH platform. • Particular attention should be paid to: the specific needs of adolescent girls, people who use drugs, sex workers, populations of humanitarian concern; male partner involvement; couples counselling and testing and discordant couples; gender-based violence; and stigma and discrimination. > Prong 2 – Improve the synergies and operational linkages between PMTCT and family planning and other SRH services to significantly reduce unmet need for family planning. Access to rights-based family planning and other SRH services is critical to the success of PMTCT programmes, achieving eMTCT and overall improved maternal health, in addition to providing other intrinsic benefits for women (see <i>Section 6, Prong 2 and Section 7 Entry Points</i>). <ul style="list-style-type: none"> • Countries should develop and implement policies and programme strategies that ensure: <ul style="list-style-type: none"> • the provision of family planning services as an integral component of the eMTCT package of services in MNCH/PMTCT and ART centres • the provision of HIV counselling and testing services in family planning settings • involvement of male partners • all the while, respecting the reproductive rights of HIV-positive women.

TABLE 7: IMPLEMENTATION AREAS FOR FOCUSED COUNTRY-LEVEL ACTION TO OVERCOME BOTTLENECKS

IMPLEMENTATION AREAS	ACTIONS
	<ul style="list-style-type: none"> <li data-bbox="421 248 1449 539">> Rapidly expand access to more efficacious ARV regimens for PMTCT and quality infant feeding counselling and support, including extended prophylaxis during the breastfeeding period (prongs 3 and 4). Elimination of MTCT requires a functional continuum of care within MNCH settings for timely access to CD4 cell counts to determine ART eligibility of pregnant women living with HIV; more efficacious ARVs for pregnant women including ART for those in need of treatment for their own health and prophylaxis consistent with the most recent WHO recommendations and quality infant feeding counselling and support including extended prophylaxis during the breastfeeding period. Where necessary, appropriate policy decisions should be made to promote and support context-adapted task shifting and sharing (see <i>Section 6 Prong 2, Table 4</i>). <li data-bbox="421 551 1449 723">> Strengthen linkages and referral mechanisms between SRH services with ART, paediatrics and other SRH clinics and communities. Countries should develop and implement strategies for linking SRH and HIV, addressing policy, system and service delivery issues. In addition to ART and other reproductive health services, attention should be paid to entry points for children including immunization and nutrition (see <i>Section 9 Key Strategies and Actions, Strategy 1</i>). <li data-bbox="389 734 1449 846">■ <i>Establish and/or strengthen coordinating mechanisms and structures for SRH/MNCH and HIV/PMTCT with clear delineation of common goals, objectives, roles and responsibilities at all levels (e.g. national, district and local) to achieve mutual goals (see Section 9 Key Strategies and Actions, Strategy 1).</i> <li data-bbox="389 857 1449 1093">■ <i>In countries where national maternal and newborn health Task Forces exist (intended to monitor and support the implementation of the national maternal and newborn health Road Map⁷⁹), these Task Forces should be reinforced to include, if it is not yet the case, HIV programme experts, in order to support SRH/MNCH-HIV integration, and joint reporting and accountability mechanisms. Any related coordinating body should also include representation from other sectors as well as the community, including people living with HIV and key populations, to ensure that a broad range of perspectives are actively engaged in planning, monitoring, and implementation of PMTCT (see Section 9 Key Strategies and Actions, Strategies 1 and 4).</i> <li data-bbox="389 1104 1449 1216">■ <i>Undertake joint SRH/MNCH and HIV strategic programme planning and budgeting for PMTCT to expand primary prevention, family planning, and access to HIV testing, clinical/immunological staging and ARV interventions for pregnant women, mothers, their children and their male partners (see Section 9 Key Strategies and Actions, Strategies 1 and 3).</i> <li data-bbox="389 1227 1449 1317">■ <i>The objectives, roles and responsibilities of each programme in implementing specific PMTCT activities at national and district levels must be clearly defined (see Section 7 Entry Points and Section 9 Key Strategies and Actions, Strategies 1 and 2).</i> <li data-bbox="389 1328 1449 1496">■ <i>Integrate or strengthen integration of core programme elements related to PMTCT (including HIV counselling and testing/re-testing, couples counselling for pregnant women, assessments and ART for women living with HIV and their partners, early infant diagnosis (EID) and paediatric ART) within relevant SRH/MNCH programme departments with transfer of responsibilities and resources as needed based on a joint road map for integration (see Section 7 Entry Points and Section 9 Key Strategies and Actions, Strategy 1).</i> <li data-bbox="389 1507 1449 1597">■ <i>Countries implementing collaborative activities should jointly set country-specific SRH and PMTCT targets pertinent to both, define baselines, key indicators and plan collaborative activities (see Section 10 Targets and Indicators).</i> <li data-bbox="389 1608 1449 1720">■ <i>In all settings, integrate pre-service and in-service training and continuing education for service delivery providers on essential interventions during pregnancy, delivery, postpartum and child health, and PMTCT (see human resources below, Sections 5 and 6, Tables 2 and 4, and Section 9 Key Strategies and Actions, Strategies 1 and 5).</i> <li data-bbox="389 1731 1449 1843">■ <i>Adapt, develop, and/or promote jointly updated national guidelines and tools using existing guidance where available (e.g. IMPAC, Integrated Management of Adult and Adolescent Illness/ Integrated Management of Childhood Illness (IMAI/IMCI), Needs Assessment and Planning and Programming) (see Section 3 Related Programming Guidance).</i> <li data-bbox="389 1854 1449 1933">■ <i>Develop integrated monitoring systems, nationally harmonized indicators, joint programme reviews, joint supervision, and joint resource mobilization to strengthen monitoring and evaluation (M&E) systems (see Section 10 Targets and Indicators).</i>

TABLE 7: IMPLEMENTATION AREAS FOR FOCUSED COUNTRY-LEVEL ACTION TO OVERCOME BOTTLENECKS

IMPLEMENTATION AREAS	ACTIONS
<p>Improve the quality of service delivery by addressing human resources for health, especially task shifting and sharing</p>	<ul style="list-style-type: none"> ■ In line with a bi-directional integration of MNCH and PMTCT platforms, undertake assessment of the national health workforce status. This should include human resources policies, funding, national and sub-national management and regulatory frameworks that guide decision-making, training curricula and remuneration policies (see <i>Section 9 Key Strategies and Actions, Strategy 1</i>). ■ Develop strategies to strengthen and maintain the workforce based on country assessment findings with attention to training, mentoring, routine supportive supervision, schemes to increase and retain human resources in response to increased demands and opportunities for appropriate tasking shifting/sharing⁸⁰ (see <i>Section 9 Key Strategies and Actions, Strategies 1 and 5</i>). ■ Identify new possible cadres to expand as necessary and existing under-utilized cadres that can be strengthened. This should include: <ul style="list-style-type: none"> > supporting professionalization of nursing and midwifery cadres > advocacy among doctors for greater recognition of the role of nursing and midwifery cadres > expanding opportunities for increased engagement and utilization of working with persons living with HIV within the health system (see <i>Section 9 Key Strategies and Actions, Strategy 4</i>) > defining and strengthening a national mentoring programme and supportive supervision. ■ Provide support to: <ul style="list-style-type: none"> > coordinate training and re-training of health care workers, in line with national plans (see also <i>Section 9 Key Strategies and Actions, Strategy 5</i>) > implement pre-service training curricula that are current and reflective of programme needs (see also <i>Section 9 Key Strategies and Actions, Strategy 5</i>) > recruit, train and retain community health workers that will promote increased demand for and facilitate access to and utilization of services (see also <i>Section 9 Key Strategies and Actions, Strategy 2</i>) > train people living with HIV and members of key populations as peer educators (see also <i>Section 9 Key Strategies and Actions, Strategy 4</i>). ■ <i>Revise curricula and strengthen supervision and in-service training to enhance capacity of health providers, in maternal health services, family planning and other SRH and HIV services, and of community health workers (as appropriate) to routinely carry out activities to support (see Section 9 Key Strategies and Actions, Strategies 1 and 2):</i> <ul style="list-style-type: none"> > Prong 1 – <i>primary prevention including through provider-initiated couples HIV counselling and testing as appropriate; intensified HIV post-test counselling; HIV re-testing; counselling on susceptibility to HIV during pregnancy, postpartum, and breastfeeding including implications for infants; condom provision, guidance on use, and skills-building to negotiate use; treatment for prevention; STI and gender-based violence prevention and management; counselling for serodiscordant couples; prevention and treatment of anaemia; blood safety; and provision of confidential stigma-free services (see Section 5 Prong 1, Table 2).</i> > Prong 2 – <i>reproductive rights and prevention of unintended pregnancies in women living with HIV including through HIV clinical management, establishing fertility intentions; counselling on reproductive rights; infertility services; STI and gender-based violence prevention and management; provision of a full range of contraceptives (including but not limited to condoms for dual protection); understanding potential drug interactions between certain ARVs and hormonal contraceptives; sensitization training to reduce stigma and discrimination in service provision (see Section 6, Prong 2, Table 4 and Section 9 Key Strategies and Actions, Strategy 5).</i> > Enhance capacity building and supervision of peer counsellors, especially women living with HIV, to enhance their skills to provide support to women and their partners attending maternal and other SRH and HIV services (see <i>Section 9 Key Strategies and Actions, Strategies 2 and 3</i>). > Examine protocols for potential revision to include: provider-initiated HIV counselling and testing; couples counselling as appropriate; HIV re-testing during pregnancy, delivery and breastfeeding; engagement of men; and intensified counselling on primary prevention (see <i>Section 9 Key Strategies and Actions, Strategy 1</i>).

TABLE 7: IMPLEMENTATION AREAS FOR FOCUSED COUNTRY-LEVEL ACTION TO OVERCOME BOTTLENECKS

IMPLEMENTATION AREAS	ACTIONS
<p>Timely assessment of supply requirements and system functionality linked to programme performance</p>	<ul style="list-style-type: none"> ■ Define at the global level common guidance and procedures for systems assessment and forecasting, and set up technical assistance mechanisms for avoidance of and timely response and investigation of stock outs. ■ Establish mechanisms for better coordination and information sharing among co-existing programme-related product and supply chain management (PSM) systems. ■ Develop indicators and mechanisms to assess global availability of essential supplies and overall PSM system performance assessment including stock outs. ■ Build capacity at national and sub-national levels focusing on PSM-related data analysis for effective supply planning, forecasting and operational follow-up. ■ Promote and support large scale implementation of innovations. ■ <i>Strengthen logistics systems to ensure commodities are available for HIV prevention and prevention of unintended pregnancies including: full range of contraceptives including condoms (female and male) and lubricants; condom demonstration model(s); STI drugs; HIV test kits; cervical cancer screening equipment and supplies; HIV prevention information materials; iron and folate; de-worming medicine; fertility drugs; pre-exposure prophylaxis (PEP) (for HIV and pregnancy); rape kits; ARVs; sterile injecting equipment, gloves; and safe blood supply (see Section 9 Key Strategies and Actions, Strategy 1).</i> ■ <i>Integrate PMTCT and SRH commodities and drugs into one national system for drug and laboratory procurement and supply (see Section 9 Key Strategies and Actions, Strategy 1).</i>
<p>Improve communication and community-based approaches, including community involvement, to promote increased demand, utilization and follow-up support for services</p>	<ul style="list-style-type: none"> ■ Develop and implement policies and innovative programme solutions that address barriers to access and utilization such as user fees, non-conditional and conditional cash transfers, vouchers and social insurance (see also Section 9 Key Strategies and Actions, Strategy 2). ■ Develop and implement community-based communication strategies to improve household behaviours, promote awareness, and increase demand for and utilization of services (see Section 9 Key Strategies and Actions, Strategies 2–4). ■ Develop and implement policies and programme approaches that foster community involvement, building on existing community structures such as NGOs, CBOs, community health workers, skilled birth attendants, networks of people living with HIV and key populations (see Section 9 Key Strategies and Actions, Strategies 2 and 4). ■ Support development and implementation of regulatory frameworks and motivation systems (including for the community and people living with HIV) (see Section 9 Key Strategies and Actions, Strategies 2–4). ■ Promote and support operational research for innovative approaches to service delivery in areas with weak health systems, including areas affected by humanitarian crises (see Section 11 Operational Research). ■ <i>Increase demand for and utilization of SRH and HIV services, and awareness of PMTCT including through the media, other community outreach, and by providing in-school PMTCT education as part of HIV and comprehensive sexuality education (see Sections 5 and 6, Tables 2 and 4 Package of Essential Services: Information and Counselling, and Section 9 Key Strategies and Actions, Strategy 2).</i>

TABLE 7: IMPLEMENTATION AREAS FOR FOCUSED COUNTRY-LEVEL ACTION TO OVERCOME BOTTLENECKS

IMPLEMENTATION AREAS	ACTIONS
<p>Mobilize and leverage partners and resources to support country level implementation</p>	<ul style="list-style-type: none"> ■ Conduct mapping of available resources and define the gap that needs to be filled to help address the bottlenecks that impede implementation and progress. This mapping needs to be done across the sector, guided by all stakeholders (see <i>Section 9 Key Strategies and Actions, Strategy 1</i>). ■ Promote and support strategic orientation to planning taking into consideration – the need for PMTCT programmes to be linked and integrated into broader MNCH and other SRH responses. This will enable PMTCT investments to support broader health system strengthening and also ensure that PMTCT is included in domestic budgets and that resource needs, gaps and expenditure at the lowest levels are clearly identified. This strategic planning engagement will help ensure that eMTCT is embedded in larger resource commitments such as national proposals to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and Partnership Frameworks (see <i>Section 9 Key Strategies and Actions, Strategy 1</i>). ■ Develop and implement resource leveraging strategies to help address the bottlenecks and gaps that are impeding implementation. ■ Promote and facilitate investors’ participation in all key steps of the programme – international partner representation and participation should be encouraged at national level. This provides an opportunity to both create awareness amongst donors and investors of the potential that PMTCT programmes have for both HIV and MNCH outcomes. It also provides a platform for donors and investors to share their concerns and priorities with the government and implementers. This opportunity will help create goodwill and appeal for PMTCT programmes among the donors. ■ Develop a framework and strategies for effective communication and coordination among all key stakeholders such as the government, implementing partners, civil society, NGOs, donors and the UN agencies. This will enhance a shared understanding of the current and developing status of investments in eMTCT and will enable partners themselves to support further resource mobilization. Donors’ requests for sector-related information and documents need to be addressed and clear reporting on results will ensure continued investments for PMTCT outcomes. ■ <i>Countries, as needed, should receive support for joint planning and budgeting regarding health systems strengthening, in particular distribution of financial and human resources, updating of national guidelines and tools, procurement, and service delivery. At local/district level, joint planning and management should include capacity building, supervision, drugs/commodities, M&E and accountability. This includes involvement/representation of key staffing impacted by such planning (see Section 9 Key Strategies and Actions, Strategy 1).</i> ■ <i>Advocate with national governments, health providers, and donors to increase their understanding of and commitment to:</i> <ul style="list-style-type: none"> > <i>implement the full package of essential services under prongs 1 and 2 (see Sections 5 and 6, Tables 2 and 4 Package of Essential Services), including through integration of services, and supportive policies and systems for linking SRH and HIV (see Section 9 Key Strategies and Actions, Strategies 1 and 2)</i> > <i>human rights principles, upon which implementation of PMTCT is based, including that prong 2 is grounded in respect for the rights of people living with HIV to decide freely and responsibly the number, spacing and timing of their children and to have the information to do so⁸¹ (see Section 9 Key Strategies and Actions, Strategy 5, and Sections 5 and 6, Tables 2 and 4).</i> ■ <i>Advocate for SRH, including maternal health, to take increased responsibility for PMTCT and other related HIV interventions. Develop joint SRH/MNCH and HIV advocacy strategies to ensure coherence between their messages directed to key stakeholders, decision-makers and the community. Make use of the UN Secretary-General’s Global Strategy on Women’s and Children’s Health, which specifically refers to the importance of PMTCT, and other MNCH initiatives, in advocacy and communication messages (see Introduction and Sections 5 and 6, Prongs 1 and 2).</i> ■ <i>Jointly mobilize additional resources to strengthen integrated SRH/MNCH and HIV/PMTCT programmes (see Section 9 Key Strategies and Actions, Strategy 1).</i>

Checklist for services that support prongs 1 and 2 of comprehensive PMTCT

The questions in the following two checklists for prongs 1 and 2 (Table 8 and 9) were derived from a case study in Swaziland on the implementation of prongs 1 and 2 (see Box 5: *Linking SRH and HIV: Gateways to Integration – a Case Study from Swaziland: Towards Elimination of Mother-to-Child Transmission of HIV* and Box 8). They will help an organization assess whether it is effectively providing services for prongs 1 and 2.

Y = Yes, we undertake this work/activity

N = No, we do not undertake this work/activity

I = Insufficient, in preparation, or being considered

There is no formalized scoring process for this assessment. Instead, it is suggested that the questions answered with 'no' or 'insufficient' be used as a starting point for reflection.

TABLE 8: CHECKLIST FOR SERVICES THAT SUPPORT PRONG 1

#	QUESTION	Y	N	I	
1	Are community- and facility-based health education activities, aimed at both young and adult women, and their partners conducted to increase awareness about the advantages of and the availability of services to:	support informed decision-making about sexual debut, the risks of HIV transmission and the use of contraception, including condoms?			
		support consistent use of male or female condoms to prevent HIV transmission, other STIs, and unintended pregnancy?			
		encourage uptake of voluntary counselling and testing in order to determine their HIV status?			
		encourage the early treatment of sexually transmitted infections?			
2	Are these activities and services provided in an adolescent- or youth-friendly manner and do they attempt to address – even in a partial way – the structural factors that increase women’s vulnerability to HIV, such as:	gender inequality?			
		multiple concurrent partnerships?			
		violence against women?			
		HIV-related stigma and discrimination?			
3	Are women who have experienced gender-based violence routinely provided with:	counselling support and related SRH services?			
		psychosocial and legal support?			
		emergency contraception in the event of a sexual assault?			
		post-exposure prophylaxis in the event of a sexual assault?			

TABLE 8: CHECKLIST FOR SERVICES THAT SUPPORT PRONG 1

#	QUESTION	Y	N	I	
4	For those women who are pregnant, have tested HIV-negative and are attending antenatal, or postpartum care services, are they routinely:	provided with information and counselling on safer sex, risk reduction and condom use during the course of their pregnancy and the postpartum period?			
		provided with information and counselling on STI prevention (including information on the recognition of symptoms) and, where necessary, the treatment of STIs?			
		encouraged and supported to involve their male partner in their antenatal and postnatal care consultations?			
		provided with an opportunity to discuss the issue of postpartum sexual activity and contraception early after delivery or even late in the last trimester to provide women with the appropriate knowledge to allow them to make informed decisions regarding their reproductive futures?			
		provided with the contraceptives of choice in preparation for postpartum sexual activity and, importantly, provided with condoms during their antenatal care consultations?			
		encouraged to re-test for HIV on a regular basis throughout and after their pregnancy – ideally with their partner in the context of a couple counselling session?			
5	Are contraceptive commodities and, importantly, male and female condoms, readily available to women at every consultation they have with a health service provider?				
6	Are creative strategies used by health care providers to encourage greater male involvement in antenatal, maternity and postpartum care (see Section 9 Key Strategies and Actions, Strategy 3) such as:	educational talks?			
		an invitation to attend a medical consultation without waiting in line?			
		couple counselling?			
7	Are health care providers, with a women's consent, able to skilfully address male partners in such a way as to raise awareness of their responsibility for practicing safer sex and facilitate the associated behaviour change (see Section 9 Key Strategies and Actions, Strategy 3)?				
8	To ensure the components of PMTCT prong 1 are integrated into routine practice within the facility and organization:	are all members of the health team sufficiently trained to provide the above interventions with their clients?			
		has the team agreed at which points in the PMTCT process (i.e. provider-initiated HIV counselling and testing, antenatal care, intrapartum care, postnatal care, and follow-up of exposed infants) the above information and counselling will be provided to clients?			
		has the health team identified which members of the health team will provide clients with the above information and services?			
		are the above elements incorporated into standard operating procedures or guidelines of the facility or organization so that all (and specifically new) members of the health team are aware of this practice?			

TABLE 9: CHECKLIST FOR SERVICES THAT SUPPORT PRONG 2

#	QUESTION	Y	N	I	
1	Do women living with HIV also receive, as part of their routine HIV services, SRH counselling that:	affirms the right of women living with HIV, and couples, to make an informed decision about whether and when they want children?			
		provides women with information on the healthy timing and spacing of pregnancies?			
		focuses, on a regular basis, on fertility intentions – and if a pregnancy is desired, is a client provided with the necessary pre-conception counselling and care so as to plan for conception in a way that optimizes her health, that of her partner (particularly in the case of a sero-discordant couple) and prevents MTCT?			
		provides information, in a non-judgmental manner, on the full range of contraceptive options available to women, their use and side effects and how a client can access the commodity of their choice at the service delivery site – including the availability of and access to emergency contraception?			
		provides follow-up and support to assess the continuation or switch of the chosen contraceptive method?			
		discusses the value of dual protection and provides the client with skills-building support to reduce unprotected sex (and, for example, introduce the use of condoms into her existing and future sexual relationships)?			
		discusses the involvement and joint responsibility of the client's male partner(s) in practicing safer sex, contraception and planning for conception – and considers ways the client can encourage his involvement in these issues in the future?			
		provides information and counselling on STI prevention (including information on the recognition of symptoms) and, where necessary, the treatment of STIs?			
	provides support for HIV disclosure, particularly in sero-discordant couples?				
2	If a support group for people living with HIV is convened, are the above sexual and reproductive health and rights issues similarly raised and discussed as part of the content of this group (see <i>Section 9 Key Strategies and Actions, Strategy 4</i>)?				
3	Are members of the health team equipped to provide counselling and support for perinatally infected adolescents who, increasingly, will require similar information and services related to family planning and dual protection, pre-conception care and PMTCT (see <i>Section 9 Key Strategies and Actions, Strategy 5</i>)				
4	Are contraceptive commodities and, importantly, male and female condoms, readily available to women living with HIV at every consultation they have with a health service provider?				
5	Are women living with HIV who have experienced gender-based violence routinely provided with:	counselling, psychosocial and legal support?			
		emergency contraception and other related services in the event of a sexual assault?			
6	To ensure the components of PMTCT prong 2 are integrated into routine practice within the facility and organization:	are all members of the health team sufficiently trained to provide the above interventions with their clients?			
		has the team agreed at which points in the PMTCT process (i.e. provider-initiated HIV counselling and testing, antenatal care, intrapartum care, postnatal care, and follow-up of HIV-exposed infants) the above information and counselling will be provided to clients?			
		has the health team identified which members of the health team will provide clients with the above information and services?			
		are the above elements incorporated into standard operating procedures or guidelines of the facility or organization so that all (and specifically new) members of the health team are aware of this practice?			

9

KEY STRATEGIES AND ACTIONS

Strategy 1: Link SRH and HIV at the policy, systems and service delivery levels

Strategy 2: Strengthen community engagement

Strategy 3: Promote greater involvement of men

Strategy 4: Engage organizations of people living with HIV

Strategy 5: Ensure non-discriminatory service provision in stigma-free settings





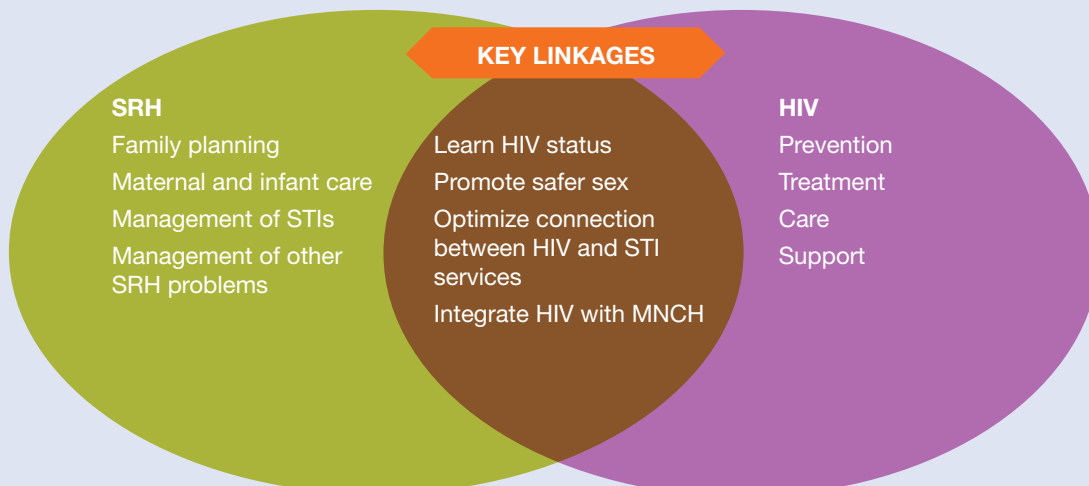
STRATEGY 1: LINK SRH AND HIV AT THE POLICY, SYSTEMS AND SERVICE DELIVERY LEVELS

Achieving the targets for improving maternal health and eliminating mother-to-child transmission of HIV requires linking HIV and SRH responses. Programming for prongs 1 and 2 requires effectively integrating MNCH, family planning, STI, and HIV services (see *Figure 9*), while jointly addressing health systems' bottlenecks, and ensuring a supportive policy environment respecting human rights. Action needs to be taken at the policy, systems and service delivery levels. (see *Section 7 Entry Points, Section 8 Operational Issues and Section 9 Key Strategies and Actions*). In this climate of increased harmonization, collaboration, and accountability, and spurred by pressure to make significant headway towards reaching MDGs 3, 4, 5 and 6, the political and programmatic imperative of a joint SRH and HIV response is undeniable.

Key points

- The rationale for linking SRH and HIV responses is indisputable – most HIV infections are sexually transmitted or are associated with pregnancy, childbirth and breastfeeding⁸³; and the risk of HIV transmission and acquisition can be further increased in the presence of certain STIs. Moreover, sexual and reproductive ill-health and HIV share root causes, including economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and social marginalization of the most vulnerable populations (see *Annex 3 Gender Equality and Empowerment* section).
- The potential public health benefits of linking SRH and HIV are: improved access to and uptake of key HIV and SRH services; better access of people living with HIV to SRH services tailored to their needs; reduction in HIV-related stigma and discrimination; improved coverage of underserved and key populations; greater support for dual protection; improved quality of care; decreased duplication of efforts and competition for scarce resources; better understanding and protection of individuals' rights; mutually reinforcing complementarities in legal and policy frameworks; enhanced programme effectiveness and efficiency; and better utilization of scarce resources for health.⁸⁴

FIGURE 9: PRIORITY PROGRAMMATIC LINKAGES BETWEEN SRH AND HIV⁸²



- Linkages refer to bi-directional synergies in policy, systems and services between SRH and HIV. Integration⁸⁵, a subset of linkages, refers to the service delivery level aspects and can be understood as joining operational programmes to ensure effective outcomes through many modalities (multi-tasked providers, referral, one-stop shop services under one roof, etc.).
- SRH and HIV linkages pertain not only to service delivery but also to the policy domain, addressing legislation and policies that violate human rights and hamper access to services. This would include policies relating to age-of-consent, gender-based violence, comprehensive sexuality education, child marriage, criminalization of HIV transmission and behaviours of key populations, and stigma and discrimination.
- It is vitally important to address the SRH concerns of people living with HIV. Linking SRH and HIV means supporting the rights of people living with HIV to be sexually active and to make childbearing decisions freely and responsibly; eliminating stigma and discrimination; ensuring privacy and confidentiality, including of HIV status; providing clinical services that are tailored to people living with HIV.
- The evidence base for SRH and HIV linkages indicates that integrating SRH and HIV services is beneficial and feasible as it can: increase access to and uptake of services; improve health and behavioural outcomes, including condom use; increase knowledge of HIV and other STIs; and improve quality of services. One of the potential benefits of integrating services is cost savings incurred through linked service modalities – e.g. multi-tasking, sharing equipment, and robust referrals – which, through increased service coverage, can have greater outcome impact, offsetting any higher initial start-up costs⁸⁶ (see *Section 11 Operational Research*).
- The UNGASS June 2011 Political Declaration on HIV and AIDS recognized the significance of linking SRH and HIV in achieving the intertwined goals of MDGs 3, 4, 5, and 6, noting that “access to sexual and reproductive health has been and continues to be essential to HIV and AIDS responses ... ; underscoring the importance of strengthening health systems, in particular primary health care and the need to integrate the HIV and AIDS response into it; and calling to strengthen the advocacy, policy and programmatic links between HIV and TB responses, primary health care services, sexual and reproductive health, maternal and child health, etc.”.⁸⁷
- Integrating SRH and HIV can increase HIV counselling and testing, and ART coverage which are important for fulfilling the human right to health, and supporting HIV prevention⁸⁸ (see *Section 5 Prong 1, Box 4: Treatment for Prevention*).
- The linkages agenda was founded on the principles of human rights, including through participation of people living with HIV and key populations. Despite social and political sensitivities, linking SRH and HIV requires a focus on key populations such as men who have sex with men (MSM), people who use drugs and sex workers. It also addresses the rights and SRH of people living with HIV for which a significant body of guidance has been developed (see *Annex 2, Annotated Bibliography, Section PMTCT Prong 2: Preventing unintended pregnancies among women living with HIV*).⁸⁹

BOX 9: RAPID ASSESSMENT TOOL FOR LINKING SRH AND HIV⁹⁰

The *Rapid Assessment Tool for Linking SRH and HIV* is designed to assess HIV and SRH bi-directional linkages at the policy, systems, and service delivery levels; identify current critical gaps in policies and programmes; and contribute to the development of country-specific action plans to forge and strengthen these linkages. While it focuses primarily on the health sector, it can be linked to assessments of other relevant sectors (e.g. education), and community aspects are also a significant part of the assessment process.

Clearly there are gaps and challenges in strengthening linkages between SRH and HIV on all three levels – policy, systems (partnerships, coordination mechanisms, capacity building, monitoring and evaluation, logistics, etc.), and service delivery (‘integration’). The tool’s strength is its ability to generate findings that can initiate dialogue on the steps needed to develop country-specific plans to forge and strengthen linkages.

Summaries of some completed rapid assessments can be found on www.srhivlinkages.org (see *Box 10: SRH and HIV Linkages Web Portal*).

The way forward for linkages includes actions to:

- measure linkages progress (additional work on indicators is underway)
- close research gaps (stigma, cost, etc.) (see *Section 11*)
- strengthen joint planning and implementation e.g. MNCH/PMTCT and sexuality education
- establish sustainable coordination mechanisms linked to health systems strengthening
- support the full scope of linkages (human rights, stigma and discrimination, gender-based violence, etc.)
- link with other health and non-health sectors
- meaningfully engage PLHIV and key populations.

- The scope of SRH and HIV linkages ultimately needs to be broadened to encompass other health issues such as tuberculosis, viral hepatitis, malaria, and ultimately primary health care tied to national and global efforts for national development in relevant sectors such as education, labour, food and water security, and social protection.

Box 9 highlights the importance of country implementation of the *Rapid Assessment Tool for Linking SRH and HIV* to identify key gaps in policies, systems, and service delivery to deliver on the joint SRH and HIV goals.

Table 10 illustrates the bi-directional nature of integration, highlighting examples of specific programmes that can be integrated to strengthen implementation of prongs 1 and 2.

TABLE 10: BI-DIRECTIONAL SRH AND HIV SERVICE INTEGRATION

INTEGRATING SRH INTO HIV	INTEGRATING HIV INTO SRH
<p>Family planning into HIV counselling and testing</p> <p>Family planning services offered simultaneously with HIV counselling and testing increase access to family planning for those testing HIV-positive (prong 2); support dual protection from condoms which increases protection from HIV, STIs, and unintended pregnancies (prongs 1 and 2); and decrease unintended pregnancies (prongs 1 and 2).</p>	<p>HIV counselling and testing into family planning</p> <p>As family planning services are reaching sexually active individuals (especially women), they are an ideal vehicle for offering HIV counselling and testing (prong 1). Client care continues through direct service provision or referral for those who test HIV-positive (prongs 2 and 4).⁹¹ Primary prevention counselling and services can be provided for those testing HIV-negative (prong 1).</p> <p>Options for integration:</p> <ul style="list-style-type: none"> ■ Full integration: Providers trained to conduct pre- and post-test counselling and rapid HIV testing on site ■ Partial integration: Providers trained to offer HIV counselling and testing, and refer for pre-test or post-test counselling and HIV testing.⁹²
<p>Sexually transmitted infections management into antenatal care</p> <p>STIs increase the risk of HIV transmission and acquisition. STI management, especially of syphilis, benefits women and their infants (congenital syphilis). Provision of information and condoms for HIV/STI prevention benefits HIV-positive and HIV-negative clients (prongs 1 and 2).</p>	<p>HIV counselling and testing into antenatal care</p> <p>As HIV counselling and testing is the pathway to prevention, treatment, care and support, it enables:</p> <ul style="list-style-type: none"> ■ HIV-negative women to know about HIV and transmission, providing an opportunity for the provision of information and condoms for HIV/STI protection, and messages on re-testing/couples testing (prong 1) ■ HIV-positive women to prevent vertical transmission (prong 3), protect their own health (prong 4) and that of their serodiscordant partners (treatment for prevention) (prong 1), and to address future fertility intentions (prong 2).
<p>Family planning into HIV prevention, treatment, care and support</p> <p>HIV-positive individuals who are already accessing HIV treatment, care and support services can benefit from rights-based family planning services (prong 2).</p>	<p>HIV prevention, treatment, care, and support into community-based reproductive health interventions</p> <p>Community health workers can provide information and counselling on PMTCT, family planning, particularly dual protection (prongs 1 and 2), ART treatment literacy and adherence.</p>
<p>STI management including cervical cancer into HIV treatment, care and support</p> <p>Women living with HIV and their partners need their STIs treated, condoms provided for HIV/STI prevention (prongs 1 and 2), and screening and management of cervical cancer.</p>	<p>Antiretroviral therapy into SRH service delivery programmes⁹³</p> <p>As SRH services are already reaching sexually active individuals, including women living with HIV (prong 2), they are an ideal vehicle for providing ART for the mother's health (prong 4) and the health of her serodiscordant partner (treatment for prevention prong 1), and preventing vertical transmission (prong 3).</p>

BOX 10: SRH AND HIV LINKAGES WEB PORTAL

The Inter-agency Working Group on SRH and HIV Linkages (led by UNFPA, WHO and IPPF), has developed a web portal – www.srhhivlinkages.org – which contains key linkages tools and guidance documents, country summaries of SRH and HIV linkages rapid assessments, advice on obtaining funding (e.g. Global Fund to fight AIDS, Tuberculosis and Malaria), standardized PowerPoint presentations and key documents on a variety of linkages topics (e.g. SRH of people living with HIV, PMTCT) etc. It is updated every six months to provide state of the art guidance.

Key actions to implement the strategy

Key actions can be taken to implement this strategy at the policy, systems, and service delivery levels by policy-makers, programme managers, health providers and other community members. Links to documents for carrying out these actions are provided (see corresponding set of reference numbers) in *References to Key Strategies and Actions, and Packages of Essential Services*.

Recommended key actions

Policy

- Conduct assessment of SRH/HIV linkages (policy, systems and services), identify gaps, and devise an action plan for implementing comprehensive eMTCT. 1, 63, see *Box 9*
- Advocate among SRH and HIV policy-makers and programme managers for strengthened commitment to implement prongs 1 and 2.⁹⁴ 1, 16, 27, 35, 42, 47, 52, 63, 69, 85, 86
- Establish or strengthen a coordinating body at the national and district levels that enables SRH and HIV programme managers to coordinate and integrate joint programmes. 1, 27, 40, 63, 68, 69, 73, 80
- Review national eMTCT priorities, goals and targets, and set appropriate numerical population-based targets accompanied by indicators for prongs 1 and 2. 1, 16, 31, 47, 63, 69, 80
- Review and revise training curricula and protocols for SRH and HIV primary care health service providers to implement prongs 1 and 2. 12, 28, 36, 38, 70, 75, 76

Systems

- Develop national and district level plans to support the delivery of a comprehensive package of eMTCT interventions in both rural and urban settings, addressing:
 - > **partnerships** – for situation analysis, planning, budgeting, resource mobilization, advocacy, implementation, monitoring and evaluation by development partners, including civil society (networks of people living with HIV, key populations at higher risk, women’s organizations, young people, etc.) 3, 4, 5, 6, 7, 14, 31, 35, 42, 46, 52, 63, 73, 85
 - > **coordination mechanisms** – for SRH and HIV joint planning, management and administration of linked advocacy and policies, and integration of services 14, 18, 31, 43, 52, 59, 68, 69, 73, 80
 - > **human resources and capacity building** – joint SRH and HIV capacity building, including pre- and in-service training, of health providers to implement prongs 1 and 2. 3, 4, 5, 6, 7, 12, 31, 36, 38, 52, 59, 63, 68, 70, 71, 75, 76
 - > **logistics and supplies systems** – to ensure SRH and HIV commodities security, preferably using combined systems, including but not limited to condoms for dual protection; water-based lubricants; the full range of contraceptives; PEP kits; delivery kits; ‘dignity’ kits for humanitarian settings; post-rape kits; STI and HIV test kits (including rapid HIV tests); ARVs; drugs to treat STIs, opportunistic infections and malaria; iron/folate; safe injecting equipment; opioid substitution therapy, etc. 13, 18, 31, 59, 64, 69, 73

- > **laboratories** – for the combined needs of SRH and HIV including haemoglobin concentration, blood grouping and typing, STI diagnosis, (including RPR VDRL⁹⁵ for syphilis), HIV diagnosis, CD4 count, HIV viral load, liver function tests, urinalysis, random blood sugar, pregnancy testing, diagnosis of cervical and other cancers, etc. 18, 35, 59

- Develop appropriate guidelines, tools and competencies to support the provision of family planning and other SRH care as a critical component of the continuum of care and support for women living with HIV in the context of eMTCT and HIV care for children.⁹⁶ 12, 36, 41, 47, 52, 70, 75, 76

Service delivery

- Support the integration of evidence-informed and human rights-based SRH and HIV services that contribute to the implementation of prongs 1 and 2, particularly (see *Section 7 Entry Points*, and *Table 10*):
 - > Family planning services in MNCH and ART services. 2, 3, 4, 5, 6, 7, 47, 52, 59, 66, 67, 68, 69, 71, 73
 - > STI diagnosis and treatment in ART, MNCH, gender-based violence and family planning services. 3, 4, 5, 6, 7, 18, 25, 26, 30, 47, 52, 59, 68, 69, 70, 71, 76, 87
 - > HIV counselling and testing in MNCH, STI, gender-based violence and family planning services. 3, 4, 5, 6, 7, 17, 28, 29, 30, 33, 47, 68, 69, 70, 71, 73
 - > Gender-based violence prevention and impact mitigation in HIV counselling and testing, ART, MNCH, STI, and family planning services. 3, 4, 5, 6, 7, 23, 47, 58, 59, 60, 61, 62, 71, 79
- Modify as required and implement the packages of essential services for prongs 1 and 2 along with related protocols and guidance. 1, 31, 59 and *Sections 5 and 6, Tables 2 and 4 Package of Essential Services* and all documents in *Annex 2 Annotated Bibliography*.



STRATEGY 2: STRENGTHEN COMMUNITY ENGAGEMENT

Community engagement, working with health services, is essential for successful implementation of prongs 1 and 2. It includes generating demand for services, changing social norms and practices, directly providing services through community health workers, including peer support educators, advocating for health and rights, and providing home-based care.

Key points

- Raising awareness within the community of eMTCT, ARV treatment literacy, and reproductive rights can create demand for SRH and HIV services that deliver interventions for prongs 1 and 2, including by male partners.
- Community engagement can foster social norms and practices that will support prongs 1 and 2 such as condom use, knowing one's HIV status, accessing ART and contraceptives, and awareness of exercising human rights, including freedom from violence and coercion.
- Health care workers are members of the community and favourable changes in community attitudes will improve their own ability to deliver services free from stigma and discrimination.⁹⁷
- Community health workers are a valuable extension of health services and can provide services directly as well as inform health programming managers about how to better meet the needs of clients.
- Community-based services are more accessible and may provide more privacy and confidentiality. Voluntary counselling and testing services that are offered in community settings facilitate uptake.⁹⁸
- Peer support is known to be essential for women who learn that they are HIV-positive. It is particularly traumatic for women to learn their status during pregnancy as they struggle with the diagnosis, disclosure to their partners, and other concerns. Women may prefer to engage with women who have been in the same position and who can provide emotional support and facilitate access to services⁹⁹ (see *Section 9 Key Strategies and Actions, Strategies 4 and 5*).
- As an extension of facility-based health services, social protection services such as economic empowerment and legal support can be provided directly in community settings alongside health care interventions.¹⁰⁰

BOX 11: FAMILY LIFE ASSOCIATION OF SWAZILAND: WORKING WITH MENTOR MOTHERS

The presence of a Mentor Mother from Mothers2Mothers is welcome in the Manzini clinic of the Family Life Association of Swaziland (FLAS). A Mentor Mother can spend an hour counselling a mother – time which a doctor does not have. Not only do they mentor and support other HIV-positive women through the PMTCT process, but they also form part of a local team of community volunteers associated with FLAS. *“The activities that the FLAS community volunteers undertake involve going door-to-door and educating people in the community about HIV in general, talking about some of the key SRH-related issues, the PMTCT programme and discussing the availability of ART”*, says the Director. The objectives of this outreach work include:

- reducing the level of HIV-related stigma among local community members
- encouraging those people who require treatment – such as ART – or SRH counselling, to attend the FLAS clinic.

Mothers2Mothers now operates in nine countries¹⁰¹ with 704 programme sites and has 1,747 HIV-positive women working as Mentor Mothers to help other women living with HIV. The Mentor Mothers are treated as staff, receive pay and additional weeks of training. They have a formal role in supporting health systems and in training clients.¹⁰²

Community systems strengthening

The Global Fund to fight AIDS, Tuberculosis and Malaria in collaboration with the UN and other stakeholders has developed a Community Systems Strengthening Framework¹⁰³, which aims to achieve improved health outcomes by developing the role of communities and of community-based organizations in the design, delivery, monitoring and evaluation of services and activities related to prevention, treatment, care and support for people living with HIV.

FIGURE 10: COMMUNITY AND HEALTH ACTORS AND SYSTEMS – COMPLEMENTARY AND CONNECTED¹⁰⁴



Key actions to implement the strategy

Key actions can be taken to implement this strategy at the policy, systems, and service delivery levels by policy-makers, programme managers, health providers and other community members. Links to documents for carrying out these actions are provided (see corresponding set of reference numbers) in *References to Key Strategies and Actions, and Packages of Essential Services*.

Recommended key actions

Policy

- Advocate among policy-makers, health managers and providers for greater attention to the HIV prevention and SRH needs of pregnant, postpartum and breastfeeding women, and women living with HIV. 2, 3, 4, 5, 6, 7, 12, 13, 23, 27, 35, 68, 71, 86
- Incorporate messages for prongs 1 and 2 in all eMTCT, HIV and SRH messaging. 17, 20, 25, 26, 28, 29, 33, 35, 36, 45, 52, 53, 59, 66, 71, 84
- Ensure protocols enable community health care workers to provide appropriate services for prongs 1 and 2. 3, 4, 5, 6, 7, 14, 22, 25, 26, 35, 47, 52, 59, 14, 28, 31, 38, 59, 63, 71, 73
- Develop and support policies and programmatic approaches to eliminate HIV-related violence, stigma and discrimination in the context of eMTCT. 3, 19, 23, 58, 60, 61
- Address, through social protection mechanisms, socioeconomic factors that keep service utilization low. 78

Systems

- Build capacity and provide technical and financial support as necessary to community-based organizations. 14, 31, 36, 52, 59, 63, 74, 82, 85, 91
- Establish effective linkages between SRH and HIV services and community-based providers. 13, 14, 23, 28, 31, 35, 41, 42, 52, 59, 62, 63, 68, 69, 73
- Establish and strengthen community mechanisms to empower community members to mobilize around community-led solutions. 3, 4, 5, 6, 7, 14, 42, 52, 59, 62, 74, 91
- Promote and facilitate the participation of people living with HIV, especially women and mothers living with HIV and key populations, in planning and service delivery, advocacy and community engagement. 3, 4, 5, 7, 14, 39, 42, 46, 52, 56, 59, 62, 63, 74, 82, 91 (see also *Strategy 4*)
- Train community health providers in implementing prongs 1 and 2. 12, 30, 39, 47, 66, 70, 72, 75, 76
- Improve data quality and impact assessment, as well as promote the use of SRH indicators that adequately capture community-based activities.¹⁰⁵ 13, 14, 35, 47, 52, 59, 62, 73

Service delivery

- Define a standard package of interventions for prongs 1 and 2 that can be implemented by community-based providers. 14, 22, 31, 52, 59, 78
- Provide services for prongs 1 and 2 at the community level, as appropriate. 17, 28, 29, 31, 33, 35, 47, 52, 59 see *Section 7 Entry Points*
- Promote and finance peer support models for delivering PMTCT, MNCH, SRH and HIV services. 14, 62
- Provide community support programmes with updated and integrated guidelines on SRH and HIV. 17, 29, 39, 41, 47, 69, 76, 87 and all documents in *Section 3 Related Programming Guidance*
- Ensure the availability of appropriate SRH and HIV commodities at the community level. 13, 59, 64, 69, 73



STRATEGY 3: PROMOTE GREATER INVOLVEMENT OF MEN

Male partner involvement is critical for effective implementation of prongs 1 and 2. Further efforts are needed to ensure that men access services to improve their own health as well as the health of their partners, and children. Engaging with the community and the labour and education sectors is also necessary to support behaviours and social norms that promote SRH and gender equality (see also *Section 9 Key Strategies and Actions, Strategy 2*).

Key points

- Men often influence women's access to and utilization of SRH and HIV services.¹⁰⁶
- Male involvement can result in: reduced gender-based violence; increased contraceptive use; increased use of SRH services by men; increased communication with spouse or partner about child health, contraception and reproductive decision-making; and decreased rates of STIs.¹⁰⁷
- Couples HIV counselling and testing can: increase awareness of HIV status; foster mutual disclosure, enhance the uptake of services, including ART for an HIV-positive serodiscordant partner; and support each other to access and adhere to ART and eMTCT interventions¹⁰⁸ (see *Section 5 Prong 1, Box 3: HIV Counselling and Testing*).
- Treatment for prevention requires that men know their status and access ART, which will benefit themselves and serodiscordant partners (see *Section 5 Prong 1, Box 3: HIV Counselling and Testing*).
- Services including male circumcision that specifically benefit men by addressing their SRH and HIV needs will provide additional opportunities to increase their willingness to engage in eMTCT interventions.¹⁰⁹
- There are positive changes in men's and boys' behaviour and attitudes when they participate in programmes that address HIV, SRH and gender-based violence.¹¹⁰

BOX 12: MALE INVOLVEMENT SWAZILAND¹¹¹

Great emphasis is placed on encouraging male involvement in the maternal and child health facility at King Sobhuza II clinic in Manzini, Swaziland. The clinic sees about 60,000 women and children each year and has integrated HIV-related services (HIV counselling and testing, treatment and PMTCT) into its maternal and child health services.

Service providers routinely discuss with each woman the health of her partner, specifically her knowledge of his HIV status. As a way of encouraging greater male involvement, the clinic has developed a standard 'notification' ('love letter') for their client's partner. The letter 'kindly invites' the partner to visit the clinic and to discuss one or more of the following health issues: their 'health as a father', the 'health of the person you are in love with', the 'health of your child', 'safe pregnancy', or 'other issues'. As a way of further encouraging the partner to attend the clinic, he is informed that 'when you arrive at the clinic you do not have to wait in the line, but you will be attended promptly if you bring this letter with you'.

As the resident doctor suggested: *"We hope that by offering this incentive we will be able to encourage more male partners to attend this clinic with their wife or girlfriend – especially the working men who cannot afford to wait in line for long."*

Key actions to implement the strategy

Key actions can be taken to implement this strategy at the policy, systems, and service delivery levels by policy-makers, programme managers, health providers and other community members. Links to documents for carrying out these actions are provided (see corresponding set of reference numbers) in *References to Key Strategies and Actions, and Packages of Essential Services*.

Recommended key actions

Policy

- Advocate among policy-makers, health managers and providers for greater attention to the SRH and HIV needs of men. 3, 19, 21, 24, 48, 50, 58, 60, 61, 89, 90
- Develop and support the implementation of policies and programmatic approaches that include involvement of men in SRH and HIV services. 21, 24, 50, 89, 90
- Advocate for labour laws and workplace policies that enable male participation in MNCH and other SRH and HIV services, including with their partner (e.g. eliminating workforce penalties for absentees when attending health services for their own health or with their pregnant partner). 24, 50
- Address cultural and socioeconomic factors that keep male involvement low, including financial barriers such as transport costs and user fees. 78, 89

Systems

- Review and strengthen operational guidance on involving and caring for men in SRH and HIV services. 20, 21, 22, 24, 39, 52, 89
- Establish services for men within SRH that are not limited to condom use or STI prevention and management, and male circumcision, but which also address their other health-related needs, including alcohol and substance use; HIV testing, prevention and treatment; information on male SRH; safer pregnancy preparedness; and the role of male parents in the health and well-being of their children. 20, 21, 22, 23, 36, 52, 89
- Utilize all entry points, including MNCH, to encourage HIV counselling and testing for men with partners, and support couples counselling. 17, 20, 21, 28, 29, 33, 35, 47, 59, 84, 89
- Develop male-friendly counselling support tools to be utilized within MNCH, family planning, and other SRH and HIV services. 20, 21, 47, 89
- Expand availability of HIV counselling and testing services and ART sites for men, and strengthen ART compliance programmes. 21, 42, 62, 89
- Establish capacity building programmes to support men to eliminate gender-based violence. 14, 19, 20, 21, 48, 58, 60, 61, 62, 74, 89, 91

Service delivery

- Assess the receptivity of staff to working with men, and undertake values clarification and health provider capacity building to foster favourable gender equitable attitudes and communication skills to counsel men with or without their partners. 20, 21, 36, 70, 75, 88, 89
- Establish male-friendly models for delivering HIV services within MNCH and other SRH services e.g. employ male peer educators and counsellors; and address barriers to access such as waiting times and operating hours. 14, 20, 21, 52, 62, 88, 89 see also *Section 9 Key Strategies and Actions, Strategy 2*
- Provide voluntary couples HIV counselling and testing at all MNCH service entry points. 17, 28, 29, 35, 38, 59, 84, 89
- Establish male support groups within SRH and HIV services that foster opportunities for men to discuss gender norms and attitudes, and sexuality, and understand the risks and benefits of various behaviours for themselves, partners and families, including alcohol and substance use. 14, 20, 21, 52, 62, 89



STRATEGY 4: ENGAGE ORGANIZATIONS OF PEOPLE LIVING WITH HIV

The greater involvement of people living with HIV (GIPA) is recognized as a core principle of the HIV response, and is fundamental to eMTCT programming.¹¹² People living with HIV are not just recipients of services; they can also be a valuable resource in service provision and provide useful feedback to improve services, including eradicating stigma and discrimination.

Key points

- All people living with HIV must be provided with accurate, non-judgmental information, counselling and other services, enabling them to exercise their rights and protect their SRH-related services. Preventing unintended pregnancies in women living with HIV is a rights-based approach to ensure that women living with HIV, as with all women, can fulfil their reproductive rights, including whether to become pregnant or not, and includes providing information on safe conception and addressing the needs of an infertile couple, one or both of whom may be living with HIV.¹¹³ It should be a part of a broader package of SRH services.
- Meaningful involvement of people living with HIV requires investing in the development of organizations and groups of people living with HIV (see *Section 9 Key Strategies and Actions, Strategy 2*). It is the surest and most effective way to ensure accountability¹¹⁴ and is the cornerstone of any rights-based approach to eMTCT.¹¹⁵
- Peer counsellors and support groups play a vital role in successful eMTCT and in maximizing outcomes for families living with HIV. These individuals and groups do not function in isolation, but are linked to larger networks of people living with HIV who provide support and ensure that the realities on the ground are translated to stakeholders.¹¹⁶

In addition to working with networks of people living with HIV, policy-makers and implementers should engage women's groups and networks of key populations to ensure that the drive to increase testing for young women does not create an atmosphere of hostility and fear.¹¹⁷

BOX 13: VITAL VOICES: CONSULTATIONS WITH PEOPLE LIVING WITH HIV ON THE STRATEGIC FRAMEWORK FOR PMTCT PRONGS 1 AND 2¹¹⁸

From December 2010 to March 2011, ICW Global and GNP+ conducted a series of consultations to solicit evidence, personal experiences and perspectives from people living with HIV to strengthen this framework.¹¹⁹

The consultations concluded that greater uptake of PMTCT services is facilitated by:

- the decentralization of services to communities
- the provision of accurate information, in a non-judgmental and supportive manner to people living with HIV and their partners
- the recognition and awareness of individual rights when testing for HIV
- the presence of peer support as part of post-test counselling and PMTCT programming
- the education of health care providers on the rights of individuals accessing services
- the responsible use of language on sexual and reproductive health and PMTCT/eMTCT.

The consultations also showed that stigmatization and health care workers' negative attitudes towards people living with HIV continue to disrupt access to services and act as a barrier to successful interventions. Moreover, the consultations showed an alarming level of human rights violations, in particular coercive disclosure of HIV-positive status and extreme stigmatization of individuals' sexual and reproductive health options, such as coercive sterilization, refusal to provide contraception, insistence on lifelong abstinence as a public health obligation on the part of people living with HIV, and coerced terminations of pregnancy. This came out particularly strongly during the online survey in which almost 75% of respondents had experienced stigma within the health care setting and 25% had been coerced to make a decision about their sexual and reproductive health by a health care worker, largely related to terminating or preventing a pregnancy (see also *Strategy 5*).

Key actions to implement the strategy

Key actions can be taken to implement this strategy at the policy, systems, and service delivery levels by policy-makers, programme managers, health providers and other community members. Links to documents for carrying out these actions are provided (see corresponding set of reference numbers) in *References to Key Strategies and Actions, and Packages of Essential Services*.

Recommended key actions

Policy

- Advocate among policy-makers, health managers and providers for greater understanding of and attention to the SRH and HIV-related needs of people living with HIV and key populations. 4, 5, 6, 7, 14, 34, 49, 52, 63, 65, 74, 75, 81, 82
- Establish targets to monitor achievement of the meaningful engagement of people living with HIV. 52
- Review eMTCT programme policies and implementation plans to ensure that they:
 - > respect the GIPA Principle 4, 5, 6, 7, 14, 34, 52, 63, 74, 75, 81, 82
 - > monitor the levels of stigma and discrimination in programming. 4, 5, 6, 7, 34, 49, 52, 65, 74, 75, 82, see *Strategy 5*

Systems

- Develop links and formal partnerships with organizations, networks or groups of people living with HIV ensuring their active engagement in all aspects of policy-making and programming, and invest in capacity development. 6, 14, 52, 63, 82
- Meaningfully involve people living with HIV and key populations in all aspects of decision-making through their membership in coordinating bodies at the national, district and community levels. 6, 52, 73, 81

Service delivery

- Establish support mechanisms for women living with HIV and their partners through peer support programmes, including providing a model of care for pregnant women and new mothers living with HIV and their partners. 4, 5, 6, 7, 52, 62, 74, 82 see also *Strategy 2*
- Provide training opportunities for people living with HIV to become peer educators. 14, 52, 62, 74, 91
- Train and support health workers, other clinic staff, and young people, including young people living with HIV, to strengthen the provision of effective and appropriate services to adolescents living with HIV. 24, 39, 4, 70, 75



STRATEGY 5: ENSURE NON-DISCRIMINATORY SERVICE PROVISION IN STIGMA- FREE SETTINGS

Stigma and discrimination against people living with HIV and key populations at higher risk are among the most significant obstacles to an effective HIV response, yet are often neglected elements of programming, including in PMTCT/eMTCT.

Key points

- Women may experience greater stigma and discrimination than men, be subjected to more severe forms, and have fewer avenues for recourse.¹²⁰
- In the context of eMTCT, stigma can: prevent women and their partners from seeking HIV counselling and testing and knowing their status; reduce access to other essential SRH and HIV services; inhibit disclosure of HIV status to partners and health providers; interfere with safer sexual practices; result in abandonment, violence, and other forms of abuse against mothers and their children; compromise treatment adherence; and limit fulfilment of human rights, including reproductive rights.¹²¹
- Violations against women living with HIV and other key populations at higher risk (e.g. sex workers and women who use/inject drugs) have included all forms of violence, coerced abortion and sterilization, denial of services, failure to respect fertility choices, and judgmental and inaccurate counselling that limits access to services and enjoyment of rights.¹²²
- Stigma and discrimination tarnish young people's experiences of health services, from the first visit and onwards into care and treatment. In particular, young people who become HIV-positive through sexual activity often find that health care workers are judgmental, which can be an obstacle to continued use of health services.¹²³
- Sex workers living with HIV who become pregnant need to be given a full range of options and not coerced to have terminations.¹²⁴
- In the social and economic contexts where women find it difficult to access appropriate psychosocial and medical support when identified as 'HIV-positive' and/or as a 'drug user', the coincidence of these conditions with pregnancy is likely to expose them to severe stigma and discrimination.¹²⁵
- While broad-based services are well suited to address the general population's needs, in areas with high levels of stigma or legal barriers, dedicated (user-friendly) services for populations at higher risk of HIV acquisition such as

sex workers and people who use drugs, as well as for vulnerable populations such as adolescents may need to be offered to ensure adequate access to eMTCT services for both them and their partners.¹²⁶

BOX 14: PEOPLE LIVING WITH HIV STIGMA INDEX

The People Living with HIV Stigma Index provides a tool that measures and detects changing trends in relation to stigma and discrimination as experienced by people living with HIV.

The Index is a joint initiative of organizations who have worked together since 2004 to develop this survey. These include:

- The Global Network of People Living with HIV (GNP+)
- The International Community of Women Living with HIV/AIDS (ICW)
- The International Planned Parenthood Federation (IPPF)
- The Joint United Nations Programme on HIV/AIDS (UNAIDS).

People living with HIV are at the centre of the process as both interviewers and interviewees and as drivers of how the information is collected, analyzed and used. The Index is designed to increase the understanding of how stigma and/or discrimination is experienced by people living with HIV. The data gained can then be used by the national implementing partners to shape future programmatic interventions and policy change. For more information visit www.stigmaindex.org

Key actions to implement the strategy

Key actions can be taken to implement this strategy at the policy, systems, and service delivery levels by policy-makers, programme managers, health providers and other community members. Links to documents for carrying out these actions are provided (see corresponding set of reference numbers) in *References to Key Strategies and Actions, and Packages of Essential Services*.

Recommended key actions

Policy

- Advocate among policy-makers, health managers and providers for greater understanding of and attention to the stigma and discrimination faced by people living with HIV and key populations. 4, 5, 6, 7, 14, 24, 34, 49, 52, 63, 65, 75, 79, 81, 82, 83
- Review eMTCT-related programming in national HIV and SRH strategies to ensure that they address and monitor stigma and discrimination, and revise as needed. 52, 63, 65, 82, 83
- Introduce or reform policies that promote and innovatively reach key populations and young people to increase their access to eMTCT services. 4, 5, 6, 7, 14, 24, 34, 49, 52, 63, 65, 79
- Review and, as appropriate, advocate using existing evidence for the repeal of laws, policies, and practices such as those that:
 - > criminalize HIV transmission or exposure, including perinatal transmission
 - > prohibit young people or women from accessing SRH or HIV testing services without parental, guardian or spousal consent
 - > criminalize same-sex relationships, use and possession of drugs (for personal use), and sex work.
- Point out the deleterious effects that each of these laws, policies and practices has on human rights, HIV prevention and public health in general, and specifically in the context of eMTCT. 4, 5, 6, 7, 24, 34, 49, 52, 65, 81, 83

System

- Ensure that there is representation from people living with HIV and key populations on coordinating bodies to enable sufficient attention to stigma and discrimination in health services and communities. 14, 49, 52, 63, 81
- Review and update, if needed, protocols to ensure they are rights-based and include pre-service training for health care workers as well as in-service training refresher courses for health providers, managers and other health facility staff to foster non-judgmental and non-discriminatory practices. 14, 24, 34, 52, 65, 75, 79
- Consult with networks of people living with HIV to measure stigma and discrimination in the community and health services, and progress towards its elimination, using existing tools such as *The People Living with HIV Stigma Index*, see Box 14. 49, 65
- Strengthen the health sector response to meet the needs of young people living with HIV by:
 - > developing standards for the provision of health services for young people living with HIV

- > developing minimum treatment and care packages
- > providing psychosocial support, which is particularly important for disclosure, adherence, responding to stigma and discrimination, coping with isolation and loss, and preventing high-risk behaviours
- > orientation and training of health staff to provide appropriate information and services to young people living with HIV i.e. make health services adolescent/youth-friendly
- > providing training and support for young people living with HIV to strengthen their capacity to contribute to health-sector activities
- > linking with other sectors to strengthen the health-sector response.¹²⁷ 4, 5, 6, 7, 24, 39, 46, 54, 58, 62

Service delivery

- Identify the causes of stigma and discrimination within health care settings, and devise a plan to address them. 36, 46, 49, 65, 75, 83
- Transform stigmatizing attitudes and discriminatory behaviours of individual health care providers through values clarification and other forms of relevant capacity building to eliminate stigma and discrimination against people living with HIV and key populations. 34, 36, 49, 65, 70, 74, 75, 83
- Train health care workers, based in facilities and in communities, to recognize the signs of violence and the role that the threat of violence plays in both women's and men's decision-making. 3, 19, 58, 61, 60
- Provide gender-responsive (user-friendly) services for sex workers. 7, 11, 52, 62, 79, 87
- Provide gender-responsive (user-friendly) services for women who use drugs through a comprehensive approach, addressing their needs for:
 - > community outreach particularly peer outreach by female peer educators
 - > gender-sensitive HIV prevention and care materials
 - > specialized gender-responsive drug dependence treatment, including substitution treatment, for female drug users with and without children
 - > access to essential prevention commodities such as male and female condoms, and sterile needles and syringes
 - > voluntary HIV counselling and testing
 - > diagnosis and treatment of sexually transmitted infections
 - > PMTCT and ART for women who use drugs.¹²⁸ 4, 9, 11, 29, 33, 34, 52, 62



ELIMINATION OF MTCT MONITORING FRAMEWORK FOR 2015: TARGETS AND INDICATORS

Overall targets¹²⁹

1. Reduce the number of new paediatric HIV infections by 90%
2. Reduce the number of AIDS-related maternal deaths by 50%
3. Reduce population-level mother-to-child transmission rate to <5%

Prong 1 target

Reduce HIV incidence in women 15–49 (and 15–24) by 50%

Prong 2 target

Reduce unmet need for family planning to zero

Prong 3 target

Reduce mother-to-child transmission to 5%

Prong 4 target

Reduce HIV associated maternal, infant and child deaths by 90%

↓ Number of HIV-positive women delivering

Key prong 1 indicator

% of pregnant women who know their status

Key prong 2 indicator

% unmet need for family planning for all women (MDG 5b)

Key prong 3 indicator

% of HIV-infected pregnant women who received effective ARVs to reduce mother-to-child transmission (disaggregated by regimen)

Key prong 4 indicator

% of infants born to HIV-infected women receiving a virological test for HIV within two months of birth

Other prong 1 indicators

% of pregnant women whose male partner was tested for HIV

% of males and females aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

Other prong 2 indicators

% of reproductive age women attending HIV care and treatment services with unmet need for family planning (being pilot tested)

Other prong 3 indicators

% of HIV-infected pregnant women who were assessed for eligibility for ART (CD4 cell count or clinical staging)

% of infants born to HIV-infected women who are breastfeeding provided with antiretroviral drugs (either mother or infant) to reduce the risk of HIV transmission during the breastfeeding period

Other prong 4 indicators

% of infants born to HIV-infected women who are started on co-trimoxazole prophylaxis within two months of birth

Distribution/% of HIV-exposed infants who are exclusively breastfeeding, replacement feeding or mixed feeding at DPT3 visit

% of HIV-infected children aged 0–14 who are currently receiving ART

Key maternal and child health indicators linked to elimination of MTCT and the MDGs

Given the critical importance of improving MCH services for eMTCT, and the contribution they make to each other, selected key MCH indicators will be monitored.

11

OPERATIONAL RESEARCH

The need for further operational research on PMTCT prongs 1 and 2 has been clearly recognized.¹³⁰ A 2009 evidence review of 58 studies (35 peer-reviewed studies and 23 promising practices)¹³¹ of SRH and HIV linkages, found that few or no studies addressed:

- linked services targeting men and boys
- gender-based violence prevention
- stigma and discrimination
- comprehensive SRH services for people living with HIV, including addressing unintended pregnancies and planning for safe, desired pregnancies.

These gaps need to be addressed in future research.

Other areas for further research include:

- documenting seroconversion rates among pregnant, postpartum and breastfeeding women and examining what contributes to seroconversion and preventing it during this period
- improving the understanding of what enables some pregnant, postpartum and breastfeeding women to use condoms and other modalities of safer sex
- identifying community strategies to effectively increase eMTCT uptake
- identifying the best models for increasing male participation in MNCH/family planning/STI and related services¹³²
- identifying the best models for community engagement
- defining the role of community actors in service provision
- better assessing the eMTCT needs unique to adolescents and barriers to accessing services. For example, whether adolescents are less likely to seek services, and whether they are less likely to receive quality care compared to older age groups¹³³
- how to best link SRH and HIV in low and concentrated epidemic settings
- innovative approaches to service delivery in areas with weak health systems, including areas affected by humanitarian crises¹³⁴
- strategies to improve coverage and reach underserved populations i.e. in which types of epidemic conditions is it important to reach underserved populations? Which mechanisms are most effective? What level of infrastructure is required to implement the interventions, or to scale up the interventions? If strategies to reach rural, remote and underserved urban populations are not cost-effective or are less cost-effective than those for other groups, are there ethical or pragmatic reasons that they should nonetheless be implemented?
- cost effectiveness analyses¹³⁵
- identifying optimal stigma reduction modalities.¹³⁶

In undertaking operational research, an important question to consider is how to link the results with country programming. Capacity building for operational research should be included as an integral part of programme implementation.

12

ENDNOTES

1. See *Note on Terminology* for discussion of terminology relating to elimination of mother-to-child transmission of HIV.
 2. Countdown to zero. Global plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive. UNAIDS, 2011.
www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf
 3. Countdown to zero. Global plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive. UNAIDS, 2011.
www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf
 4. Countdown to zero. Global plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive. UNAIDS, 2011.
www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf
 5. Countdown to zero. Global plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive. UNAIDS, 2011.
www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf
 6. Antiretroviral Therapy for HIV Infection in Adults and Adolescents – recommendations for a Public Health Approach – 2010 revision. WHO, 2010.
www.who.int/hiv/pub/arv/adult2010/en/index.html
Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access. Recommendations for a public health approach. WHO, 2010.
www.who.int/hiv/pub/mtct/antiretroviral2010/en/index.html
 7. Mahy M. What will it take to “virtually eliminate” MTCT? Unpublished presentation November 2010 in Report from the Technical Consultation on the Elimination of Mother-to-Child Transmission of HIV. 9-11 November 2010, Geneva, Switzerland. UNAIDS, UNFPA, UNICEF, WHO, 2011. Appendix 3: Modelling the UNAIDS Business Case.
 8. Documents are listed by year of publication.
 9. We resolve to work towards the elimination of new HIV infections among children and keeping their mothers alive by the following:
 - All women, especially pregnant women, have access to quality life-saving HIV prevention and treatment services – for themselves and their children.
 - The rights of women living with HIV are respected and women and their families and communities are empowered to fully engage in ensuring their own health and especially the health of their children.
 - Adequate resources – human and financial – are available from both national and international sources in a timely and predictable manner while acknowledging that success is a shared responsibility.
 - HIV, maternal health, newborn and child health, and family planning programmes work together, deliver quality results and lead to improved health outcomes.
 - Communities, in particular women living with HIV, enabled and empowered to support women and their families to access the HIV prevention, treatment and care that they need.
 - National and global leaders act in concert to support country-driven efforts and are held accountable for delivering results.
- Countdown to zero. Global plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive. UNAIDS, 2011.
www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf
10. Rapid assessment tool for sexual and reproductive health and HIV linkages: Generic guide. IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, Young Positives, 2009.
www.who.int/reproductivehealth/publications/rtis/91825/en/index.html
 11. Women and health: today’s evidence tomorrow’s agenda. WHO, 2009.
http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf
 12. Opening remarks at press conference to launch the joint effort on Women’s and Children’s Health. United Nations Secretary-General Ban Ki-moon, UNHQ, 14 April 2010.
www.un.org/apps/news/infocus/sgspeeches/statments_full.asp?statID=789
 13. Globally HIV is the leading cause of death among women of childbearing age, and contributes significantly to maternal mortality – in 2009, an estimated 60,000 pregnant women died of HIV-related causes.
Women and health: today’s evidence tomorrow’s agenda. WHO, 2009.
http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf
Trends in Maternal Mortality: 1990–2008. Estimates developed by WHO, UNICEF, UNFPA and the World Bank (WHO 2010)
http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf
Countdown to zero. Global plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive. UNAIDS, 2011.
www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf

14. If a mother living with HIV progresses to the late stages of AIDS, her children are 3.5 times more likely to die, irrespective of their infection status, and more than four times as likely to die when the mother herself dies. Newell ML, Coovadia H, Cortina-Borja M, et al. 2004. Mortality of infected and uninfected infants born to HIV-infected mothers in Africa: a pooled analysis. *Lancet*. 364:1236-1243.
15. This rate can be 50% or higher in breast-feeding populations; approximately one third of infants whose mothers seroconvert following delivery will become infected through breast-feeding alone.
- Van de Perre P, Simonon A, Msellati P, et al. 1991. Postnatal transmission of human immunodeficiency virus type 1 from mother to infant. A prospective cohort study in Kigali, Rwanda. *N Engl J Med*. 325:593-598.
- Dunn DT, Newell ML, Ades AE, Peckham CS. 1992. Risk of human immunodeficiency virus type 1 transmission through breastfeeding. *Lancet*. 340(8819):585-588.
- Liang K, Gui X, Zhang YZ, et al. 2009. A case series of 104 women infected with HIV-1 via blood transfusion postnatally: high rate of HIV-1 transmission to infants through breastfeeding. *J Infect Dis*. 200:682-686.
16. Palasanthiran P, Ziegler JB, Stewart GJ, et al. 1993. Breastfeeding during primary maternal human immunodeficiency virus infection and risk of transmission from mother to infant. *J Infect Dis*. 167:441-444.
- These high transmission rates are explained by:
- maternal viral load being the most consistent predictor of MTCT

Gray RH, Li X, Kigozi G, et al. 2005. Increased risk of incident HIV during pregnancy in Rakai, Uganda: a prospective study. *Lancet*. 366:1182-1188. Cao Y, Krogstad P, Korber BT, et al. 1997. Maternal HIV-1 viral load and vertical transmission of infection: the Ariel Project for the prevention of HIV transmission from mother to infant. *Nat Med*. 3:549-552.
 - acute HIV infection being associated with very high viral loads

Garcia PM, Kalish LA, Pitt J, et al. 1999. Maternal levels of plasma human immunodeficiency virus type 1 RNA and the risk of perinatal transmission. *Women and Infants Transmission Study Group*. *N Engl J Med*. 341:394-402. Lindback S, Karlsson AC, Mittler J, et al. 2000. Viral dynamics in primary HIV-1 infection. *Karolinska Institute Primary HIV Infection Study Group*. *AIDS*. 14:2283-2291.
- Acute maternal HIV infection during pregnancy appears to lead to increased risk of MTCT. In 2006, a study in Zimbabwe found that breastfeeding-associated MTCT was very high among women who seroconverted during late pregnancy and breastfeeding.
- Humphrey J, Marinda E, Moulton L, et al. 2006. Breastfeeding-associated HIV transmission among women who seroconvert during late pregnancy and during breastfeeding. 16th International AIDS Conference, 13-18 August, 2006, Toronto, Canada. Abstract No. MoPE0384, 2006.
- A 1992 review of 9 studies on HIV transmission through breastfeeding showed an increased risk of MTCT when the mother acquired HIV postnatally as compared to prenatally (29% vs. 14%, respectively).
- Dunn DT, Mewell, ML, Ades AE, Peckham CS. 1992. Risk of human immunodeficiency virus type 1 transmission through breastfeeding. *Lancet*. 340(8819):585-8.
- A case series of 104 women infected with HIV via blood transfusion postnatally in China demonstrated that 35.8% of exposed infants became HIV-infected, perhaps due to the higher viraemia during the acute phase of maternal infection (Liang et al, 2009).
- Liang K, Gui X, Zhang YZ, et al. 2009. A case series of 104 women infected with HIV-1 via blood transfusion postnatally: high rate of HIV-1 transmission to infants through breast-feeding. *Journal of Infections Diseases*. 200:682-6.
17. A number of studies show that pregnant and lactating women are at increased risk of HIV acquisition and that HIV incidence during pregnancy and in the postpartum period is often higher than in non-pregnant and non-lactating populations.
- A prospective study of 3,321 African HIV serodiscordant couples evaluated the relationship between pregnancy and the risk of HIV acquisition among women finding a two-fold increased risk. Mugo NR, Heffron R, Donnell D, et al. 2011. Increased risk of HIV-1 transmission in pregnancy: a prospective study among African HIV-1-serodiscordant couples. *AIDS*. 25:1887-1895.
 - Mugo N et al. 2010. Pregnancy is associated with an increased risk for HIV transmission among African HIV-1 sero-discordant couples. Abstract. International Microbicides Conference 2010 (22-25 May), Pittsburgh, USA (<http://microbicides2010.org/files/pregnancy%20Mugo%20abstract.pdf>)
 - Moodley and colleagues reported that 3% of initially HIV-negative women in South Africa seroconverted during pregnancy and that HIV incidence during pregnancy was four times higher than in the non-pregnant population. Moodley D, Esterhuizen TM, Pather T, et al. 2009. High HIV incidence during pregnancy: compelling reason for repeat HIV testing. *AIDS*. 23:1255-9.
 - Using longitudinal data from Rakai, Uganda, Gray and colleagues (2005) showed that women had a significantly higher risk of HIV acquisition during pregnancy compared to breastfeeding and non-pregnant, non-breastfeeding women. Gray RH, Li X, Kigozi G, et al. 2005. Increased risk of incident HIV during pregnancy in Rakai, Uganda: a prospective study. *Lancet*. 366:1182-8.
 - A study from Botswana (Lu, et al 2009) estimated that incident HIV in pregnant and postpartum women accounted for 43% of infant HIV infections in the country. However, conflicting results were found by Morrison and colleagues (2007), who concluded that neither pregnancy nor lactation put women at increased risk of HIV acquisition in their study in Uganda and Zimbabwe. Lu L, Legwaila K, Motswe C, et al. 2009. HIV incidence in pregnancy and the first post-partum year and implications for PMTCT programs, Francistown, Botswana, 2008. 16th Conference on Retroviruses and Opportunistic Infections, 8-11 February, 2009, Montréal, Canada. Session 23, Abstract 91. Morrison CS, Wang J, Van der Pol B, et al. 2007. Pregnancy and the risk of HIV-1 acquisition among women in Uganda and Zimbabwe. *AIDS*. 21:1027-1034.
18. Hormonal and other biological changes during pregnancy: women experience significant hormonal changes during pregnancy, including higher concentrations of oestrogens. Studies of hormonal contraceptive users' risk of HIV acquisition give insight into the mechanisms by which sex steroids affect mucosal immunity and potentially contribute to increased risk of HIV infection.
- Morrison CS, Richardson BA, Mmiro F, et al. 2006. Hormonal contraception and the risk of HIV acquisition. *AIDS*. 21:85-95.
- Brabin L. 2002. Interactions of the female hormonal environment, susceptibility to viral infections, and disease progression. *AIDS Patient Care and STDs*. 16:211-21.
19. For example, male partners' sexual networks and exposure to HIV during his partners' pregnancy or postpartum period (when abstinence may be practiced with his primary partner).

- Lockman, S. 2010. Acute Maternal HIV Infection During Pregnancy and Breast-feeding: Preventing Mother-to-Child Transmission in Resource-Limited Settings. *Medscape*, 03/26/2010. www.medscape.com/viewarticle/718849
- Other behavioural risks include:
- sexual behaviour during pregnancy;
 - period of postpartum abstinence and return to sexual activity;
 - knowledge and use of HIV risk reduction strategies during pregnancy; and
 - intimate partner violence and sexual coercion.
20. Lockman S. 2010. Acute Maternal HIV Infection During Pregnancy and Breast-feeding: Preventing Mother-to-Child Transmission in Resource-Limited Settings. *Medscape*, 03/26/2010. www.medscape.com/viewarticle/718849
- Mbizvo MT, Kasule J, Mahomed K, Nathoo K. 2001. HIV-1 seroconversion incidence following pregnancy and delivery among women seronegative at recruitment in Harare, Zimbabwe. *Cent Afr J Med*. 47(5):115-8.
21. Msuya SE et al. 2008. Low male partner participation in antenatal HIV counselling and testing in northern Tanzania: implications for preventive programs. *AIDS Care*. 20:700-709.
22. Allen S, et al. 2003. Sexual Behavior of HIV Discordant Couples after HIV Counseling and Testing. *AIDS* 17(5): 733-40. DeZoysa, I, et al. 2000. The Voluntary HIV-1 Counseling and Testing Efficacy Study Group. Efficacy of Voluntary HIV-1 Counseling and Testing in Individuals and Couples in Kenya, Tanzania, and Trinidad: A Randomised Trial. *Lancet*. 356:103-12. Cited in: Spino A, Clark M, and Stash S. 2010. HIV Prevention for Sero-discordant Couples. Arlington, VA. USAID, AIDS Support and Technical Assistance Resources, AIDSTAR-One Task Order 1.
23. Farquhar C et al. 2004. Antenatal couple counselling increases uptake of interventions to prevent HIV-1 transmission. *Journal of Acquired Immune Deficiency Syndromes*. 37:1620-1626.
24. Guidance on global scale-up of the prevention of mother-to-child transmission of HIV: Towards universal access for women, infants and young children and eliminating HIV and AIDS among children. IATT on Prevention of HIV Infection in Pregnant Women, Mothers and their Children, 2007. Guiding Principle 9. www.who.int/hiv/pub/mtct/pmtct_scaleup2007/en/index.html
- See Table 1: HIV-related services recommended for implementation of provider-initiated HIV testing and counselling in health facilities in Guidance on provider-initiated HIV testing and counselling in health facilities. UNAIDS, WHO, 2007 at 40. www.who.int/hiv/pub/vct/pitc/en/index.html
- WHO and its Office for the African Region (WHO AFRO) held a consultation in Harare, Zimbabwe, on 9-11 February 2011, with key scientific experts to review existing evidence on HIV counselling and testing for discordant couples and develop initial recommendations for policy-making in countries. The findings at the meeting will guide the development of the first-time WHO recommendations on HIV counselling and testing for couples. Experts to discuss HIV counselling and testing for discordant couples. 9-11 February 2011, Harare, Zimbabwe. www.who.int/hiv/events/testing_counselling/en/index.html
25. Lockman S. 2010. Acute Maternal HIV Infection During Pregnancy and Breast-feeding: Preventing Mother-to-Child Transmission in Resource-Limited Settings. *Medscape*, 03/26/2010. www.medscape.com/viewarticle/718849
26. Delivering HIV test results and messages for re-testing and counselling in adults. WHO, 2010. http://whqlibdoc.who.int/publications/2010/9789241599115_eng.pdf
27. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW, GNP+, 2011. www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf
28. Namely post-test counselling, the need for periodic re-testing, the needs of serodiscordant couples, susceptibility to infection during pregnancy and postpartum, treatment of anaemia in pregnant women, management of STIs, reproductive rights, the possibility of HIV testing resulting in gender-based violence, and providing non-stigmatizing and non-discriminatory services (see *Strategy 5*).
29. Guidance on provider-initiated HIV testing and counselling in health facilities. UNAIDS, WHO, 2007. www.who.int/hiv/pub/vct/pitc/en/index.html
30. Groundbreaking trial results confirm HIV treatment prevents transmission of HIV. Press Release. UNAIDS, WHO, 12 May 2011. [www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011may/20110512pstrialresults/Initiation_of_Antiretroviral_Treatment_Protects_Uninfected_Sexual_Partners_from_HIV_Infection_\(HPTN_Study_052\)](http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011may/20110512pstrialresults/Initiation_of_Antiretroviral_Treatment_Protects_Uninfected_Sexual_Partners_from_HIV_Infection_(HPTN_Study_052).). Press Release. HIV Prevention Trials Network, 12 May 2011. www.hptn.org/web%20documents/PressReleases/HPTN052PressReleaseFINAL5_12_118am.pdf
31. The study, known as HPTN 052, was designed to evaluate whether immediate versus delayed use of ART by HIV-infected individuals would reduce transmission of HIV to their HIV-negative partners and potentially benefit the HIV-positive individual as well. HPTN 052 began in April 2005 and enrolled 1,763 HIV-serodiscordant couples (couples that have one member who is HIV-positive and the other who is HIV-negative), the vast majority of which (97%) were heterosexual. The study was conducted at 13 sites across Africa, Asia and the Americas. Among the 877 couples in the delayed ART group, 27 HIV transmissions occurred. This was in contrast to only one transmission that occurred in the immediate ART group. This difference was highly statistically significant.
32. Of the originally HIV-positive individuals themselves, 17 cases of extrapulmonary TB occurred in the delayed ART group, compared with three cases in the immediate ART group, also a statistically significant finding. There were also 23 deaths during the study. 13 occurred in the delayed ART group and 10 in the immediate ART group.
33. Linking Sexual and Reproductive Health and HIV/AIDS, Gateways to Integration: A case study from Swaziland. Prepared and published by WHO, UNFPA, UNAIDS, IPPF, 2011.
34. Family Life Association of Swaziland (FLAS): NGO focusing on youth-friendly SRH services; Baylor College of Medicine Children's Foundation – Swaziland: NGO focusing on paediatric HIV care; King Sobhuza II clinic: urban government primary level care facility; and Tikuba clinic: rural government primary level care facility.
35. Essential Prevention and Care Interventions for Adults and Adolescents Living with HIV in Resource-Limited Settings. WHO, 2008.
36. Position Statement. Condoms and HIV Prevention. UNFPA, WHO, UNAIDS, 2009.
37. Sexual violence and abuse early in life can later contribute to sexual behaviours such as early sexual onset, multiple partners and transactional sex that can increase the risk of acquiring STIs/HIV.
- Globally, 20% of girls and 10% of boys experience sexual abuse as a child and 20% to 50% of women indicate that their first sexual experience was forced. UNICEF, Child Protection Information Sheet, Violence against Children, 2006.

- www.unicef.org/publications/files/Child_Protection_Infomation_Sheets/pdf
- Women who are marginalized (such as female sex workers, women and girls from racial or ethnic minorities, indigenous women and girls, domestic or migrant workers, women in conflict settings, women and girls living with HIV, women in prison, drug users) often find themselves targets of violence, including rape, and at high risk for HIV and STIs. Violence or even fear of violence may compromise their ability to access health, social, and legal services. *Gender-based Violence and HIV*, Programme on International Health and Human Rights Harvard School of Public Health, Inter-agency working group on Gender-based Violence and HIV, forthcoming.
38. International Conference on Population and Development, Cairo, 1994.
www.un.org/popin/icpd/conference/offeng/poa.html
 39. Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV. GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, 2009.
www.gnppplus.net/images/stories/SRHR/090811_sshr_of_plhiv_guidance_package_en.pdf
 40. Adding it up: The costs and benefits of investing in family planning and maternal and newborn health. UNFPA, Guttmacher, 2009.
www.unfpa.org/webdav/site/global/shared/documents/publications/2009/adding_it_up_report.pdf
 41. In 2007, while globally the unmet need for family planning was estimated at 11%, it was estimated to be more than 24% in the least developed countries, and ranged from 21% to 29% in 22 sub-Saharan countries.

How Universal is Access to Reproductive Health? A Review of the Evidence. UNFPA, 2010.
www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal_rh.pdf
 42. Studies from Côte d'Ivoire, Uganda and South Africa have reported rates of unintended pregnancy ranging from 51% to more than 90% in populations of women living with HIV, while in the general population the rate was 40%. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: Progress Report. WHO, UNAIDS, UNICEF, 2009 (at 96).
www.who.int/hiv/pub/2009progressreport/en/
 43. Report from the Technical Consultation on the Elimination of Mother-to-Child Transmission of HIV. 9–11 November 2010, Geneva, Switzerland. WHO, UNFPA, UNICEF, WHO, 2011.
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 47. Mugo NR, Heffron R, Donnell D, et al. 2011. Increased risk of HIV-1 transmission in pregnancy: a prospective study among African HIV-1-serodiscordant couples. *AIDS*. 25:1887–1895. The authors noted that the finding requires further studies to understand the possible biologic mechanisms.
 48. See *Annex 1*.
 49. Positive Health, Dignity and Prevention Policy Framework. UNAIDS, GNP+, 2011.
www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110701_PHDP.pdf
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http://whqlibdoc.who.int/hq/2010/WHO_FCH_10.06_eng.pdf
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http://whqlibdoc.who.int/hq/2010/WHO_FCH_10.06_eng.pdf
 52. ACTG 076; Zorilla, 2000; Carvalho and Piccinini, 2006; Sandelowski and Barroso, 2003; Sherr and Barry, 2004. In *Sexual and Reproductive Health and Rights of Women and Girls Living with HIV: Summary of key issues*. UNAIDS, UNFPA, UN Women, 2010.
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www.hiv-druginteractions.org

Also some drugs used to treat opportunistic infections, such as rifampicin for tuberculosis, reduce the effectiveness of certain oral contraceptives.
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www.who.int/reproductivehealth/publications/family_planning/9789241563888/en/index.html
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HIV-positive women and men are more likely to be infected with oncogenic HPV types and to have cervical intraepithelial neoplasia (CIN) or anal intraepithelial neoplasia (AIN), lesions that may lead to invasive cervical and anal cancer, respectively.
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62. Making the case for interventions linking sexual and reproductive health and HIV in proposals to the Global Fund to fight AIDS, Tuberculosis and Malaria. WHO, 2010. http://whqlibdoc.who.int/hq/2010/WHO_RHR_10.02_eng.pdf
63. Linking Sexual and Reproductive Health and HIV/AIDS, Gateways to Integration: A case study from Swaziland. Prepared and published by WHO, UNFPA, UNAIDS, IPPF, 2011.
64. Family Life Association of Swaziland (FLAS): NGO focusing on youth-friendly SRH services; Baylor College of Medicine Children's Foundation – Swaziland: NGO focusing on paediatric HIV care; King Sobhuza II clinic: urban government primary level care facility; and Tikuba clinic: rural government primary level care facility.
65. Buchacz K, Patel P, Taylor M, et al. 2004. Syphilis increases HIV viral load and decreases CD4 cell counts in HIV-infected patients with new syphilis infections. *AIDS*. 18(15):2075-2079.
66. Mwapas V, Rogerson S, Kwiek J, et al. 2006. Maternal syphilis infection is associated with increased risk of mother-to-child transmission of HIV in Malawi. *AIDS*. 20(14):1869-1877.
67. Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health. WHO, UNFPA, UNICEF, World Bank, 2010. http://whqlibdoc.who.int/hq/2010/WHO_FCH_10.06_eng.pdf
68. Guidance on Global Scale-Up of the Prevention of Mother-to-Child Transmission of HIV. Inter-agency Task Team, 2007. www.unicef.org/aids/files/PMTCT_enWEBNov26.pdf
69. These include:
- child immunization and services for under 5s
 - tuberculosis treatment and care
 - primary health care providers
 - post-abortion care
 - gender-based violence prevention and management
 - youth-friendly/youth-centred
 - male SRH services (e.g. male circumcision)
 - services specifically tailored to sex workers
 - harm reduction for drug users
 - community-based outreach
 - organizations of people living with HIV and populations at higher risk, including support groups
 - workplace (i.e. clinics and/or health education services)
 - schools and tertiary educational institutions (i.e. comprehensive sexuality education. See International Guidelines on Sexuality Education: An evidence informed approach to effective sex, relationships and HIV/STI education. United Nations Educational, Scientific and Cultural Organization, 2009. <http://unesdoc.unesco.org/images/0018/001832/183281e.pdf>).
70. Mugo NR, Heffron R, Donnell D, et al. 2011. Increased risk of HIV-1 transmission in pregnancy: a prospective study among African HIV-1-serodiscordant couples. *AIDS*. 25:1887-1895.
71. 36% of respondents indicated a preference for services in HIV clinics and 32% in community-based facilities. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW, GNP+, 2011. www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf
72. Key bottlenecks include both constraints related to the supply side of services (availability of services, geographical access, human resource constraints, availability of drugs and diagnostics and health information and M&E systems issues) and the demand side (financial and socio-cultural barriers, gender roles, discrimination and marginalization, poor treatment in health facilities, etc). These constraints can be grouped at the level of service coverage, the quality of services and uptake of those services. A Global Action Framework for Elimination of Mother-to-Child Transmission of HIV. IATT, 2011.
73. A Global Action Framework for the Elimination of Mother to Child Transmission of HIV. IATT, 2011.
74. These 10 points are mostly applicable to the 22 priority countries. Other countries with low and concentrated epidemics should adapt these to their local contexts.
75. Countdown to zero. Global plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive. UNAIDS, 2011. www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf
76. A Global Action Framework for the Elimination of Mother to Child Transmission of HIV. IATT, 2011.
77. The Table is adapted from:
- A Global Action Framework for the Elimination of Mother to Child Transmission of HIV. IATT, 2011.
 - Enhancing Linkages and Integration between Reproductive, Maternal, Newborn and Child Health and HIV/AIDS Programmes: Towards Elimination of Mother-to-Child Transmission of HIV. Draft Outline of Background Paper on Integration for PMTCT IATT Meeting, 2-3 May 2011.
 - Preventing HIV and Unintended Pregnancies: Strategic Framework 2011-2015. In Support of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive. IATT, 2011.
78. Identify bottlenecks to programme performance and solutions:
- ✓ Build national capacity to review programme performance through bottleneck and equity analysis and support identification and prioritization of specific bottlenecks hampering PMTCT scale-up with special attention to ensuring equitable access.
 - ✓ Analyse barriers to uptake of services and overall progress. The analytic process should encompass the policy environment, financing mechanisms, partnerships, the performance of the MNCH platform, and specific PMTCT programmatic elements and opportunities.
 - ✓ Accurately identify and address geographical, social, cultural, gender and economic barriers to access to and utilization of services.
 - ✓ Develop a country technical support plan on the basis of findings from the initial bottleneck and equity analysis. This technical support plan should include priority actions and interventions to overcome the most critical gaps and bottlenecks, timelines, target groups, roles and responsibilities of key stakeholders, budget, key indicators and progress tracking mechanisms.
 - ✓ Develop and implement policies and mechanisms that enable effective decentralization and devolution to sub-national levels.
- A Global Action Framework for Elimination of Mother-to-Child Transmission of HIV. IATT, 2011.
79. Maternal and Newborn Health National Plans (Road Map) Assessment. African MNH Road Maps Assessment Report. UNFPA, 2009. www.unfpa.org/public/cache/offonce/home/publications/pid/4197

80. Transformative scale up of health professional education. An effort to increase the numbers of health professionals and to strengthen their impact on population health. WHO, 2011. www.who.int/hrh/resources/transformative_education/en/index.html
Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines. PEPFAR, UNAIDS, WHO, 2008. www.who.int/healthsystems/TTR-TaskShifting.pdf
81. Recent policy guidance (see *Annex 1*) advocates for the recognition of the human rights and fulfilment of the sexual and reproductive health needs of people living with HIV. People living with HIV networks have led this process, in collaboration with UN agencies and civil society, to develop and implement effective rights-based SRH programming for women living with HIV, including, but not limited to, family planning.
82. Sexual and reproductive health and HIV/AIDS: a framework for priority linkages. WHO, 2006. www.who.int/reproductivehealth/publications/linkages/HIV_05_5/en/index.html
83. Sexual and reproductive health and HIV/AIDS: a framework for priority linkages. WHO, 2006. www.who.int/reproductivehealth/publications/linkages/HIV_05_5/en/index.html
84. Rapid assessment tool for sexual and reproductive health and HIV linkages: Generic guide. IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, Young Positives, 2009. www.who.int/reproductivehealth/publications/rtis/91825/en/index.html
Sexual & reproductive health and HIV linkages: evidence review and recommendations. IPPF, UCSF, UNAIDS, UNFPA, WHO, 2009. www.who.int/reproductivehealth/publications/linkages/hiv_2009/en/index.html
Thematic Segment: Sexual and Reproductive Health (SRH) services with HIV interventions in practice. Background Paper. 26th Meeting of the UNAIDS Programme Coordinating Board, Geneva, Switzerland, 22-24 June 2010. www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2010/20100604_26thpcbthematicbackground_final_en.pdf
85. Integration:
- For the user means health care that is seamless, smooth and easy to navigate. Users want a coordinated service which minimizes both the number of stages in an appointment and the number of separate visits required to a health facility.
 - For providers means that separate technical services, and their management support systems, are provided, managed, financed and evaluated either together, or in a closely coordinated way.
 - At the macro level of senior health managers and policy-makers, happens when decisions on policies, financing, regulation or delivery are not inappropriately compartmentalized.
86. Sexual and reproductive health and HIV linkages: evidence review and recommendations. IPPF, UCSF, UNAIDS, UNFPA, WHO, 2009. www.who.int/reproductivehealth/publications/linkages/hiv_2009/en/index.html
87. Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS. Resolution adopted by the UN General Assembly on 10 June 2011, paragraph 21. www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf
88. Linking Sexual and Reproductive Health and HIV/AIDS: Gateways to Integration: A case study from Kenya. WHO, UNAIDS, UNFPA, IPPF, 2008. www.unfpa.org/webdav/site/global/shared/documents/publications/2008/hiv_integration_kenya.pdf
89. Toolkit on HIV-Related Stigma Reduction in Health Care Settings. EngenderHealth, GNP+, International HIV/AIDS Alliance, International Center for Research on Women, ICW, International Confederation of Midwives, International Council of Nurses, International Labor Organization, International Planned Parenthood Federation, International Treatment Preparedness Coalition, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, WHO, World Medical Association, 2011. www.stigmaactionnetwork.org
90. Rapid assessment tool for sexual and reproductive health and HIV linkages: Generic guide. IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, Young Positives, 2009. www.who.int/reproductivehealth/publications/rtis/91825/en/index.html
91. Integrating HIV/AIDS treatment and care services into a family planning setting. IPPF, 2006. www.ipfwhr.org/en/node/289
92. Mullick S, Khoza D, Askew I, et al. 2006. Integrating counseling and testing into family planning services: what happens to the existing quality of family planning when HIV services are integrated in South Africa? Presentation at Linking Reproductive Health, Family Planning, and HIV/AIDS in Africa, Addis Ababa; 9-10 October 2006. www.fhi.org/NR/rdonlyres/ezk2qek52pa6ai2lbgex43gprvgh3ia-c7rzeyd2qji2mgisksbkh7iufkrbq67cibr4laeejyet7o/EFHR-11global1.pdf
93. Integrating HIV/AIDS treatment and care services into a family planning setting. IPPF, 2006. www.ipfwhr.org/en/node/289
94. Thematic Segment: Sexual and Reproductive Health (SRH) services with HIV interventions in practice. Background Paper. 26th Meeting of the UNAIDS Programme Coordinating Board, Geneva, Switzerland, 22-24 June 2010. www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2010/20100604_26thpcbthematicbackground_final_en.pdf
95. Rapid plasma regain (RPR) and venereal disease research laboratory (VDRL) tests.
96. Guidance on global scale-up of the prevention of mother-to-child transmission of HIV: Towards universal access for women, infants and young children and eliminating HIV and AIDS among children. UNICEF, WHO, IATT on Prevention of HIV Infection in Pregnant Women, Mothers and their Children, 2007. www.who.int/hiv/pub/mtct/pmtct_scaleup2007/en/index.html
97. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW and GNP+, 2011. www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf
98. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW, GNP+, 2011. www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf
99. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW, GNP+, 2011. www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf

100. UNAIDS Expanded Business Case: Enhancing Social Protection. UNAIDS, 2010.
http://data.unaids.org/pub/BaseDocument/2010/jc1879_social_protection_business_case_en.pdf
101. Kenya, Lesotho, Malawi, South Africa, Swaziland, Tanzania, Uganda and Zambia.
102. Loewenberg S and Besser M. 2010. Helping mothers with HIV become mentors. *The Lancet*. 377(9772):1145.
103. Community Systems Strengthening Framework. Global Fund to fight AIDS, Tuberculosis and Malaria, 2010.
www.theglobalfund.org/documents/civilsociety/CSS_Framework.pdf
The Framework defines the terminology of CSS and discusses the ways in which community systems contribute to improving health outcomes. It provides a systematic approach for understanding the essential components of community systems and for the design, implementation, monitoring and evaluation of interventions to strengthen these components. For each of the core components described in the Framework, potential CSS interventions and activities are grouped within specific service delivery areas (SDAs), with a rationale and a non-exclusive list of activity examples for each of these SDAs. The Framework provides guidance on the steps required to build or strengthen a system for CSS interventions, including a number of recommended CSS indicators for each SDA with detailed definitions for each of them, and are designed to enable measurement of progress over time. Note that the Framework was developed to cover HIV, tuberculosis, malaria and other major health challenges.
104. Community Systems Strengthening Framework. Global Fund to fight AIDS, Tuberculosis and Malaria, 2010.
www.theglobalfund.org/documents/civilsociety/CSS_Framework.pdf
105. Based on presentation at the Elimination of Mother-to-Child-Transmission: Country-Level Implementation PMTCT IATT Meeting, May 2–3, 2011. Stephen A. Spector, MD., Office of the Global AIDS Coordinator U.S. Department of State, 2011.
106. Barker G, Ricardo C, Nascimento M, et al. 2009. Questioning gender norms with men to improve health outcomes: Evidence of impact. *Glob Public Health*. 9:1-15.
Ramirez Ferrero E. 2011. Moving Towards Gender Transformative Programming: Male Involvement in the Prevention of Mother-To-Child Transmission of HIV. Background Paper (draft).
107. Engaging men and boys in changing gender-based inequity in health: Evidence from program interventions. WHO, 2007.
www.who.int/gender/documents/Engaging_men_boys.pdf
Ramirez Ferrero E. 2011. Moving Towards Gender Transformative Programming: Male Involvement in the Prevention of Mother-To-Child Transmission of HIV. Background Paper (draft).
108. Ramirez Ferrero E. 2011. Moving Towards Gender Transformative Programming: Male Involvement in the Prevention of Mother-To-Child Transmission of HIV. Background Paper (draft).
109. Barker G, Ricardo C, Nascimento M, et al. 2009. Questioning gender norms with men to improve health outcomes: Evidence of impact. *Glob Public Health*. 9:1-15.
Ramirez Ferrero E. 2011. Moving Towards Gender Transformative Programming: Male Involvement in the Prevention of Mother-To-Child Transmission of HIV. Background Paper (draft).
110. Maman S, Moodley D and Groves A. 2011. Defining Male Support During and After Pregnancy From the Perspective of HIV-Positive and HIV-Negative Women in Durban, South Africa. *Journal of Midwifery and Women's Health*. 56(4).
This article argues that a broader understanding is needed of the kind of support that men provide during pregnancy and the postpartum period and the effects of such support to identify ways to engage men.
- Barker G, Ricardo C, Nascimento M, et al. 2009. Questioning gender norms with men to improve health outcomes: evidence of impact. *Global Public Health*. 5:539–553.
- Ramirez Ferrero E. 2011. Moving Towards Gender Transformative Programming: Male Involvement in the Prevention of Mother-To-Child Transmission of HIV. Background Paper (draft).
111. See Boxes 5, 7 and 8: *Linking Sexual and Reproductive Health and HIV/AIDS, Gateways to Integration: A case study from Swaziland*. Prepared and published by WHO, UNFPA, UNAIDS, IPPF, 2011.
112. UNAIDS Policy Brief: The Greater Involvement of People Living with HIV (GIPA). UNAIDS, 2007.
http://data.unaids.org/pub/Report/2007/JC1299-PolicyBrief-GIPA_en.pdf
113. A number of documents have been produced to guide responses that address the sexual and reproductive health needs of people living with HIV. See *Annex 1*.
114. When multilateral institutions or international non-governmental organizations, or donor nations acting in concert with host nations, implement PMTCT policies without consulting local communities there is no direct way for those who receive these services to hold them accountable for their actions. At best, democratic nations receiving aid may be held accountable through their own country's democratic process. Networks of people living with HIV, however, are directly accountable to and act on behalf of their constituents. Without their involvement, even the best of programmes are tinged with paternalism.
115. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW, GNP+, 8 April 2011.
www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf
116. Depending on the context and the programme, peer-to-peer educators can play a number of important roles in service delivery for prongs 1 and 2, including but not limited to: providing individual counselling (post-test, adherence preparation, adherence follow-up, disclosure, sexual and reproductive health, positive living, etc.) at ANC, SRH and HIV clinics; assisting patients with referrals from place to place within or between health facilities; providing referrals and linkages to community-based services and support; tracing patients who miss appointments or who have been lost to follow-up; serving as a communication link between patients and health care workers; and participating in HIV-related outreach and education activities in the community.
117. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW, GNP+, 2011.
www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf
118. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW, GNP+, 2011.
www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf
Appendix B (1): E-consultation.
www.gnpplus.net/images/stories/Empowerment/consultations/Appendix_B1_PMTCT_E-consultation_Report_April_2011.pdf
Appendix B (2): Focus Group Discussions.
www.gnpplus.net/images/stories/Empowerment/consultations/Appendix_B2_PMTCT_FDGs_Report_April_2011.pdf
Appendix B (3): E-survey.

www.gnpplus.net/images/stories/Empowerment/consultations/Appendix_B3_PMTCT_E-survey_Report_April_2011.pdf

Appendix B (4): Expert teleconference

www.gnpplus.net/images/stories/Empowerment/consultations/Appendix_B4_PMTCT_Experts_Teleconference_Report_April_2011.pdf

119. The process adopted a mixed methods approach, combining qualitative and quantitative evidence gathering methodologies: a moderated online consultation among individuals living with HIV (66 participants from 16 countries); three facilitated focus group discussions (27 men and women living with HIV in Jamaica); an e-survey for people living with and affected by HIV (591 respondents from 58 countries); and, an expert panel (22 participants) to discuss the content and accessibility of the framework.
 120. Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes. A resource for national stakeholders in the HIV response. UNAIDS, 2007.
http://data.unaids.org/pub/Report/2008/JC1521_stigmatisation_en.pdf
 121. Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes A resource for national stakeholders in the HIV response. UNAIDS, 2007.
http://data.unaids.org/pub/Report/2008/JC1521_stigmatisation_en.pdf
 122. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW, GNP+, 2011.
www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf
 123. More positive living: Strengthening the health sector response to young people living with HIV. UNICEF, WHO, 2008.
http://whqlibdoc.who.int/publications/2008/9789241597098_eng.pdf
 124. Advancing the Sexual and Reproductive Health and Human Rights of Sex workers living with HIV. GNP+, NSWP, 2010.
www.gnpplus.net/en/resources/sexual-and-reproductive-health-and-rights/item/75-advancing-the-sexual-and-reproductive-health-and-human-rights-of-sex-workers-living-with-hiv
 125. HIV/AIDS prevention and care for female injecting drug users. UNODC, 2006.
www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf
 126. Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A Guidance Package. GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, 2009.
http://data.unaids.org/pub/Manual/2009/20090730_srhiv_of_plhiv_guidance_package_en.pdf
 127. Global Guidance Briefs: HIV Interventions for Young People. Overview of HIV Interventions for Young People. UNAIDS IATT on HIV and Young People, 2008.
www.unfpa.org/public/home/publications/pid/2850
 128. HIV/AIDS prevention and care for female injecting drug users. UNODC, 2006.
www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf
 129. Global Monitoring Framework and Strategy for the Elimination of New Paediatric HIV Infections by 2015. Draft. IATT, May 2011.
 130. Expert consultation on operations research on the prevention of mother to child transmission and pediatric HIV care, support and treatment. Washington, D.C. September 9-11, 2009. UNICEF, UNAIDS, PEPFAR, George Washington University, Elizabeth Glaser Foundation and IAS, 2009.
www.unicef.org/aids/files/OR_Consultation_Report_FINAL2.doc
 131. 36 Africa, 11 UK or USA, 11 Asia, Eastern Europe, Latin America and the Caribbean. Nearly 80% of the promising practices were based in Africa.
- Studies included:
- 34 studies integrated HIV services into existing SRH programmes;
 - 14 studies integrated SRH services into existing HIV programmes; and
 - 10 studies integrated HIV and SRH services concurrently.
132. Montgomery E, van der Straten A and Torjesen K. 2011. Male Involvement in Women's and Children's HIV Prevention Challenges in Definition and Interpretation. *JAIDS*. 57(5):e114-e116.
 133. Final report: UNAIDS/WHO Consultation: PMTCT Needs of Adolescents: Lessons from Adolescent Pregnancy Prevention. UNAIDS/WHO Geneva, Jan 11, 2011.
 134. Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015. In Support of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive. IATT, 2011.
 135. The cost-effectiveness of preventing mother-to-child transmission of HIV in low- and middle-income countries: systematic review. Johri M, Ako-Arrey D. 2011. The cost-effectiveness of preventing mother-to-child transmission of HIV in low- and middle-income countries: systematic review. *Cost Effectiveness and Resource Allocation*. 9(3):1-16.
www.resource-allocation.com/content/9/1/3
- Contraception is a cost-effective way to prevent HIV infections in infants:
- Reynolds H, Janowitz B, Homan R, Johnson L. 2006. The value of contraception to prevent perinatal HIV transmission. *Sex Transm Dis*. 33(6):350-6. This study found that dollar for dollar, family planning programmes have the potential to prevent nearly 30% more HIV-positive births than eMTCT programmes that provide prophylaxis with nevirapine.
 - Recent modelling has demonstrated cost-effectiveness and overall intensified impact of implementing eMTCT prong 2 by linking family planning with eMTCT programmes.
 - Halperin DT, Stover J and Reynolds HW. 2009. Benefits and costs of expanding access to family planning programs to women living with HIV. *AIDS*. 23(S1):S123–130.
 - Hladik W, Stover J, et al. 2009. The Contribution of Family Planning towards the Prevention of Vertical HIV Transmission in Uganda. *PLoS ONE* 4(11): e7691. doi:10.1371/journal.pone.0007691
 - The 2009 Hladik study estimated that the cost per vertical infection averted by antiretroviral prophylaxis in 14 countries with the largest number of HIV-positive pregnant women is US\$543 (assuming the availability of the most efficacious antiretroviral prophylaxis regimens). However, a benefits and costs analysis (Halperin) found that if all HIV-positive women in these same 14 countries who wanted to avoid unintended pregnancy could do so, this would translate to \$359 per HIV infection averted, costing \$184 less than the provision of the most efficacious antiretroviral prophylaxis regimens.
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ANNEXES

ANNEX 1 GLOBAL INITIATIVES ON THE HEALTH OF WOMEN, NEWBORNS AND CHILDREN

GLOBAL INITIATIVE	DESCRIPTION
Millennium Development Goals:	multiple areas of overlap with MDGs 3 (gender equality), 4 (child health), 5 (maternal health), and 6 (combat HIV/AIDS). ¹
UN Secretary General's Global Strategy on Women's and Children's Health:	a collaborative commitment to improve the health of women and children in the world's lowest income countries. Key elements of the strategy are to jointly support country-led health plans, a comprehensive, integrated package of essential interventions and services, integrated care, health systems strengthening, and health workforce capacity building. ²
H4+/H5:	the H4+/H5 (UNFPA, UNICEF, WHO, World Bank and UNAIDS) is a coordinating mechanism to work jointly in the area of maternal and newborn health in 25 high focus countries with the highest burden of maternal mortality. The scope of work of the H4+/H5 partners focuses on the following seven agreed programme components: i) Support needs assessments to identify constraints to improving reproductive, maternal and neonatal health in countries; ii) Develop and cost national plans; iii) Scale up quality health services; iv) Address the urgent need for skilled health workers; v) Address financial barriers to access; vi) Tackle the root causes of maternal mortality and morbidity; vii) Strengthen monitoring and evaluation systems. Overall, the H4+/H5 is supporting the first wave of 25 countries ³ to carry out activities to fulfil their commitments and will assist 24 additional countries to articulate their commitments to the Global Strategy. ⁴
The Global Fund to Fight AIDS, TB and Malaria:	is currently looking at how to finance broader interventions to benefit women and children. ⁵
The Muskoka Initiative on Maternal, Newborn and Child Health, commitment of the G8 to address MDGs 4 and 5:	is a funding initiative announced at the 36th G8 summit which commits member nations to collectively spend an additional US\$5 billion between 2010 and 2015 to accelerate progress toward the achievement of MDGs 4 and 5, the reduction of maternal, infant and child mortality in developing countries. ⁶
The United States Government Global Health Initiative (GHI):	GHI seeks to achieve significant health improvements and foster sustainable effective, efficient and country-led public health programmes that deliver essential health care. To achieve maximum impact, GHI has a special focus on improving the health of women, newborns and children by combating infectious disease, delivering clean water, and focusing on nutrition and maternal, newborn, and child health. ⁷
Global Elimination of Congenital Syphilis:	the Global Campaign, based on strengthening the underlying maternal health platform, was launched in 2007 and has been implemented as dual elimination with MTCT of HIV in the Americas and the Asia Pacific regions. ⁸
STOP TB Partnership:	the Partnership comprises of a network of international organizations, countries, donors from the public and private sectors, governmental and non-governmental organizations that work together to realize the goal of eliminating tuberculosis (TB) as a public health problem. TB can cause infertility and contributes to other poor reproductive health outcomes especially for people living with HIV. ⁹
Elimination of Neonatal Tetanus:	key component of a comprehensive reproductive and MNCH package. ¹⁰
Global Malaria Control and Elimination:	this is a major initiative focusing on the same population of pregnant women and young children, and it recognizes the importance of strengthening reproductive and MNCH systems. ¹¹

ANNEX 2 ANNOTATED BIBLIOGRAPHY OF SUPPORTING POLICY AND PROGRAMMING GUIDANCE

Elimination of mother-to-child transmission: Overarching documents

Countdown to zero. Global plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive. UNAIDS, 2011.

www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf

There is global consensus that virtual elimination of new HIV infections among children everywhere can be achieved by 2015. This plan focuses on reaching HIV-positive pregnant women and their children from the time of the mother's pregnancy and until she stops breastfeeding. This will be achieved within the existing continuum of comprehensive programmes to provide access to HIV prevention, treatment, care and support for men, women and children.

A global action framework for elimination of mother-to-child transmission of HIV. IATT, 2011.

The present global action framework has been developed as a response to a pressing need to provide a platform for concerted action that synthesizes a wide range of recent global, regional and country level commitments into a coherent response for effective delivery on the collective commitment to eMTCT. The framework provides a common and well-coordinated position to support country level efforts toward eMTCT in the broader context of global health. Its goal is to galvanize and harmonize support for the implementation of the eMTCT agenda among national government, development and implementing partners, and civil society.

Global Strategy for Women's and Children's Health, UN Secretary-General, 2010.

www.un.org/sg/hf/Global_StrategyEN.pdf

This road map, led by the UN Secretary-General, identifies the finance and policy changes needed as well as critical interventions that can and do improve health and save lives. The Global Strategy lays out an approach for global, multi-sector collaboration.

Priority interventions: HIV/AIDS prevention, treatment and care in the health sector (2010 version). WHO, 2010.

www.who.int/hiv/pub/guidelines/9789241500234/en/index.html

The priority interventions described in this document are the complete set of interventions recommended by WHO to mount an effective and comprehensive health sector response to HIV and AIDS. The document aims to:

- describe the priority health sector interventions that are needed to achieve universal access to HIV prevention, treatment and care
- summarize key policy and technical recommendations developed by WHO and its partners and related to each of the priority health sector interventions
- guide the selection and prioritization of interventions for HIV prevention, treatment and care

- provide links to the key WHO resources and references containing the best available information on the overall health sector response to HIV and AIDS and on the priority health sector interventions with the aim of promoting and supporting rational decision-making in designing and delivering HIV-related services.

Reducing inequities: Ensuring universal access to family planning as a key component of sexual and reproductive health. UNFPA, 2009.

www.unfpa.org/public/site/global/lang/en/pid/4770

This brochure reflects a consensus of 40 international experts who convened in New York on the occasion of the 15th anniversary of the International Conference on Population and Development. Together they reviewed evidence and developed recommendations on how to reduce inequities in access to family planning and other sexual and reproductive health services, particularly for disadvantaged populations. These actions are urgently needed to accelerate progress towards achieving the MDGs by 2015.

Rapid assessment tool for sexual and reproductive health and HIV linkages: Generic guide. IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, Young Positives, 2009.

www.who.int/reproductivehealth/publications/rtis/91825/en/index.html

The objective of this adaptable tool is to assess HIV and SRH bi-directional linkages at the policy, systems and service delivery levels. It is intended also to identify gaps, and ultimately contribute to the development of country-specific action plans to forge and strengthen these linkages. This tool focuses primarily on the health sector, though it can be adapted for other sectors e.g. education, social services, and labour.

Guidance on global scale-up of the prevention of mother-to-child transmission of HIV: Towards universal access for women, infants and young children and eliminating HIV and AIDS among children. UNICEF/WHO/Inter-agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children, 2007.

www.who.int/hiv/pub/mtct/pmtct_scaleup2007/en/index.html

This global guidance was developed in response to the slow, overall progress in the scale-up of PMTCT in resource-constrained settings. It provides a framework for concerted partnerships and guidance to countries on specific actions to take to accelerate the scale-up of PMTCT.

Practical guidelines for intensifying HIV prevention: Towards Universal Access. UNAIDS, 2007.

www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf

These Guidelines are designed to provide policy-makers and planners with practical guidance to tailor their national HIV prevention response so that they respond to the epidemic dynamics and social context of the country and populations

who remain most vulnerable to and at risk of HIV infection. These guidelines encourage countries to “know your epidemic and your current response”, which enables countries to “match and prioritize your response” by identifying, selecting and funding those HIV prevention measures that are most appropriate and effective in relation to its specific epidemic scenario(s) and settings. These allow countries to “set ambitious, realistic and measurable prevention targets”. Furthermore, these guidelines provide a synthesis of essential prevention measures required for countries to “tailor your prevention plans” in relation to the epidemic scenarios. Finally, to be effective, programmes need to continually gather and use strategic information to track and report on progress and to ensure accountability through verifying the allocation, use and impact of AIDS spending. As such, these guidelines provide building blocks aimed at supporting countries to prioritize, and sequence their investments to effectively scale up their national HIV prevention response.

PMTCT prong 1: Primary prevention of HIV among women of childbearing age

Preventing HIV and Unintended Pregnancies. Strategic Framework 2011–2015. In Support of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive. The Inter-agency Task Team for Prevention of HIV Infection in Pregnant Women, Mothers, and their Children, 2011.

Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people. Recommendations for a public health approach 2011. WHO, 2011.

http://whqlibdoc.who.int/publications/2011/9789241501750_eng.pdf

The guidelines focus on the prevention and treatment of HIV and other STIs among MSM and transgender people. They include evidence-based recommendations, the summary and grading of evidence, implementation issues and key research gaps. Although the focus of this guidance is on low- and middle-income countries, WHO recommends that this guidance be available for MSM and transgender people in high-income countries as well. The document presents good practice recommendations that focus on ensuring an enabling environment for the recognition and protection of the human rights of MSM and transgender people. Without such conditions, implementation of the more specific technical recommendations is problematic.

Delivering HIV test results and messages for re-testing and counselling in adults. WHO, 2010.

www.who.int/hiv/pub/vct/hiv_re_testing/en/index.html

This WHO publication explains when HIV re-testing should and should not be recommended. It is intended to serve as a complement to the WHO/UNAIDS guidance on provider-initiated HIV counselling and testing in health facilities. The document aims to help HIV policy-makers, programme and site managers, trainers, and testing and counselling providers in all settings to detect HIV earlier among people with recent exposure to, or ongoing risk of, HIV infection; and to promote earlier referral of HIV-positive people to HIV prevention, treatment and care, including PMTCT, services.

UNAIDS guidance note on HIV and sex work. UNAIDS, 2009.

www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2009/jc1696_guidance_note_hiv_and_sexwork_en.pdf

This guidance note was developed to provide the UNAIDS Co-sponsors and Secretariat with a coordinated human-rights-based approach to promoting universal access to HIV prevention, treatment, care and support in the context of adult sex work. It provides clarification and direction regarding approaches by the Joint United Nations Programme on HIV/AIDS to reduce HIV risk and vulnerability in the context of sex work, providing a policy and programmatic emphasis that rests on three interdependent pillars:

- access to HIV prevention, treatment, care and support for all sex workers and their clients
- supportive environments and partnerships that facilitate universal access to needed services, including life choices and occupational alternatives to sex work for those who want to leave it
- action to address structural issues related to HIV and sex work.

Guidance on testing and counselling for HIV in settings attended by people who inject drugs: improving access to treatment, care and prevention. UNODC Regional Centre for Asia and the Pacific and WHO WPRO and SEARO, 2009.

www.who.int/hiv/pub/idu/searo_wpro_tc/en/index.html
See Prong 2.

Operational guidance for scaling up male circumcision services for HIV prevention. WHO and UNAIDS, 2009.

www.who.int/hiv/pub/malecircumcision/op_guidance/en/index.html

This document can be used in countries or regions at various stages of scaling up, ranging from considering how to scale up to being in the process of doing so. It is intended to provide operational and programmatic guidance to decision-makers, programme managers and technical support agencies, and could also provide useful guidance to funders. It is relevant to the scaling up of programmes in both the public and private sectors. For other technical guidance on male circumcision see: www.who.int/hiv/topics/malecircumcision/technical/en/index.html

Position statement on condoms and HIV prevention.

UNFPA/UNAIDS/WHO, 2004. Updated 2009.

www.who.int/hiv/pub/condoms/20090318_position_condoms.pdf

UNFPA, WHO and UNAIDS released this revised position statement on condoms and HIV prevention.

Global guidance briefs: HIV interventions for young people. UNAIDS Inter-agency Task Team on HIV and Young People, 2008.

www.unfpa.org/public/home/publications/pid/2850

A series of seven guidance briefs was developed by the task team. They aim to help decision-makers (including development practitioners, governments, donors and CSOs) understand what needs to be done, based on the latest global evidence on effective interventions for young people.

- Overview of HIV interventions for young people
- HIV interventions for most-at-risk young people
- HIV interventions for young people in humanitarian emergencies
- Community-based HIV interventions for young people
- HIV interventions for young people in the education sector
- HIV interventions for young people in the health sector
- HIV interventions for young people in the workplace

Guidance on provider-initiated HIV testing and counselling in health facilities. UNAIDS, WHO, 2007.

www.who.int/hiv/pub/vct/pitc/en/index.html

The WHO/UNAIDS guidance was prepared in light of increasing evidence that provider-initiated testing and counselling can increase uptake of HIV testing, improve access to health services for people living with HIV, and may create new opportunities for HIV prevention. Provider-initiated HIV testing and counselling involves the health care provider specifically recommending an HIV test to patients attending health facilities. In these circumstances, once specific pre-test information has been provided, the HIV test would ordinarily be performed unless the patient declines.

Practical guidelines for intensifying HIV prevention: Towards Universal Access. UNAIDS, 2007.

http://data.unaids.org/pub/Manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf

These guidelines build on *Intensifying HIV prevention: UNAIDS policy position paper* and the *UNAIDS action plan on intensifying HIV prevention*. The guidelines aim to assist policy-makers and planners in countries to strengthen their national HIV prevention response. The guidelines call on National AIDS Authorities – in the spirit of the Three Ones Principles – to provide leadership in coordinating and strengthening their national HIV prevention efforts. To strengthen national efforts countries are being encouraged to ‘know your epidemic’ by identifying the behaviours and social conditions that are most associated with HIV transmission, that undermine the ability of those most vulnerable to HIV infection to access and use HIV information and services. Knowing your epidemic provides the basis for countries to ‘know your response’, by recognizing the organizations and communities that are, or could be, contributing to the response, and by critically assessing the extent to which the existing response is meeting the needs of those most vulnerable to HIV infection.

HIV/AIDS and injecting drug users: WHO Evidence for Action series – technical guidance and policy briefs.

www.who.int/hiv/pub/idu/evidence_for_action/en/index.html

WHO has reviewed the scientific evidence for the effectiveness of the key components of the comprehensive package of interventions in the Evidence for Action series, which consists of two types of documents: technical papers and policy briefs.

- The Evidence for Action technical papers summarize the evidence in more detail and will be useful for service providers and planners.
- The Evidence for Action policy briefs can be used for advocacy purposes for policy-makers regarding the importance of these interventions.

Topics include collaborative tuberculosis and HIV services, antiretroviral therapy, community-based outreach, effectiveness of sterile needle and syringe programming, and of drug dependence treatment.

HIV/AIDS prevention and care for female injecting drug users. UNODC, 2006.

www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf

The intersection of unsafe injecting drug use and unsafe sexual practice is a significant factor in the increased risk for HIV infection of drug injecting females. The document explores vulnerabilities, including those of HIV-positive female drug users, barriers and needed actions, underlining the imperative of empowerment.

Preventing HIV/AIDS in young people: Evidence from developing countries on what works. LSHTM, UNICEF, UNAIDS, UNFPA, WHO, 2006.

www.unfpa.org/webdav/site/global/shared/documents/publications/2006/preventing_hiv_young.pdf

A systematic review of 80 studies was undertaken to assess the effectiveness of different HIV prevention interventions for young people delivered in schools, health services, media and communities. The report provides evidence-based recommendations for policy-makers, programme managers and researchers to guide efforts towards meeting the UN goals on HIV/AIDS and young people. Interventions have been categorized into one of four categories depending on whether the evidence is strong enough to recommend:

- **GO!** Go to scale with the intervention, now, with monitoring of coverage and quality
- **Ready:** Implement the intervention widely but evaluate it carefully
- **Steady:** Further research and development of the intervention is needed, though it shows promise of potential effectiveness
- **Do not go:** The evidence is against implementation of the intervention.

Intensifying HIV prevention: UNAIDS policy position paper. UNAIDS, 2005.

http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf

This UNAIDS policy position paper, aimed at those with a leadership role in HIV prevention, treatment and care, highlights the need for strengthening HIV prevention, key actions for an effective response and core principles underlying these actions. It also identifies how national partners can scale up HIV prevention at country level and how UNAIDS will support this process.

Condom programming for HIV prevention: A manual for service providers. UNFPA, 2004.

www.unfpa.org/public/global/pid/1291

This manual is intended for: health care workers, peer educators, and other outreach workers who counsel clients on HIV/STI prevention and condom use; others who sell condoms as part of their jobs; and the shop owners, store managers, and clinic staff who run condom outlets. It offers detailed and practical advice on how to increase the demand for and supply of condoms by following a five-step process.

Condom programming for HIV prevention: An operations manual for programme managers. UNFPA, 2004.

www.unfpa.org/public/global/pid/1292

This manual outlines a seven-step process to improve the effectiveness of existing condom programmes or to create a new condom programme. It is designed to give managers practical and specific advice on condom programming.

Rapid condom needs assessment tool for condom programming. UNFPA and Population Council, 2003.

www.unfpa.org/public/cache/offonce/publications/pid/2484;jsessionid=58F6F4134FE5E331EEC1E662592CC028

This document was developed to design and test a rapid needs assessment and data-gathering tool to improve country level condom programming for HIV prevention of which condom distribution, promotion and use are important elements.

WHO is currently developing health-sector guidance for prevention, treatment and care of sex workers as well as guidance on couples HIV counselling and testing.

PMTCT prong 2: Preventing unintended pregnancies among women living with HIV

Preventing HIV and unintended pregnancies. Strategic framework 2011–2015. In support of the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. The Inter-agency Task Team for Prevention of HIV Infection in Pregnant Women, Mothers, and their Children, 2011.

See Prong 1.

Positive health, dignity and prevention policy framework. UNAIDS, GNP+, 2011.

www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110701_PHDP.pdf

The framework recommends nine action areas (advocacy, building evidence, dissemination, policy dialogue, planning, implementation, integration, M&E, and adaptation and improvement) to move forward with the development of operational guidelines for positive health, dignity and prevention, with specific roles and responsibilities for GNP+, other networks of people living with HIV, civil society, the public and private sectors, UNAIDS Secretariat and co-sponsors, and donor agencies.

Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people. Recommendations for a public health approach 2011. WHO, 2011.

http://whqlibdoc.who.int/publications/2011/9789241501750_eng.pdf

See Prong 1.

IMAI one-day orientation on adolescents living with HIV. Participants manual and facilitator guide. WHO, 2010.

http://whqlibdoc.who.int/publications/2010/9789241598972_eng.pdf

The objectives of this course are to orient a range of health workers, including medical officers and nurses, to the special characteristics of adolescence and to identify and

practice appropriate ways of addressing important issues for adolescents living with HIV.

Antiretroviral therapy for HIV infection in adults and adolescents – recommendations for a public health approach – 2010 revision. WHO 2010.

www.who.int/hiv/pub/arv/adult2010/en/index.html

See Prong 4.

Reproductive choices for women with HIV. Rose Wilcher and Willard Cates. Bulletin of the World Health Organization 2009;87:833–839. doi: 10.2471/BLT.08.059360

www.who.int/bulletin/volumes/87/11/08-059360/en/

Includes a flow chart on the sexual and reproductive decisions faced by women with HIV, i.e. desire for pregnancy, contraceptive practices, choices about an unintended pregnancy, and prenatal and postnatal options to reduce perinatal transmission of HIV.

Advancing the sexual and reproductive health and human rights of people living with HIV: A guidance package.

GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, 2009.

http://data.unaids.org/pub/Manual/2009/20090730_srhr_of_plhiv_guidance_package_en.pdf

The guidance package outlines what stakeholders in the areas of health, policy and law, and advocacy can do to support and advance the SRH of people living with HIV. The guidance package includes a focus on health systems and the services required to meet the specific SRH needs of people living with HIV, such as the diagnosis, management, and treatment of HIV and other STIs; sex education and information; psychosocial support to cope with living with HIV; family planning; safe abortion and/or post-abortion care; services to assist conception; antenatal, delivery, and postnatal services; cancer diagnosis and treatment; services to address gender- and sexuality-based violence; counselling and treatment to address sexual dysfunction; and information, services, commodities and social support for HIV prevention. Furthermore, annexed is information on useful resources and tools related to the sexual and reproductive health and rights of people living with HIV. See also:

- **Advancing the sexual and reproductive health and human rights of injecting drug users living with HIV.** GNP+, INPUD, 2010.
www.gnpplus.net/en/resources/sexual-and-reproductive-health-and-rights/item/76-advancing-the-sexual-and-reproductive-health-and-human-rights-of-injecting-drug-users-living-with-hiv
- **Advancing the sexual and reproductive health and human rights of sex workers living with HIV.** GNP+, NSWP, 2010.
www.gnpplus.net/en/resources/sexual-and-reproductive-health-and-rights/item/75-advancing-the-sexual-and-reproductive-health-and-human-rights-of-sex-workers-living-with-hiv
- **Advancing the sexual and reproductive health and human rights of migrants living with HIV.** GNP+, 2010.
www.gnpplus.net/en/resources/sexual-and-reproductive-health-and-rights/item/72-advancing-the-sexual-and-reproductive-health-and-human-rights-of-migrants-living-with-hiv

Guidance on testing and counselling for HIV in settings attended by people who inject drugs: improving access to treatment, care and prevention. UNODC Regional Centre for Asia and the Pacific and WHO WPRO and SEARO, 2009.
www.who.int/hiv/pub/idu/searo_wpro_tc/en/index.html

This document offers basic operational guidance on HIV counselling and testing in settings attended by people who inject drugs, including pre-test information for women who are or may become pregnant, post-test counselling for a pregnant woman, and re-testing as well as information on the standard of care for pregnant women who are diagnosed HIV-positive through HIV counselling and testing in settings attended by people who inject drugs.

Position statement on condoms and HIV prevention. UNFPA/UNAIDS/WHO, 2004. Updated 2009.
www.who.int/hiv/pub/condoms/20090318_position_condoms.pdf

See Prong 1.

Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings. WHO, 2008.
www.who.int/hiv/pub/plhiv/interventions/en/index.html

This document is the result of an expert panel convened in June 2006 to review the evidence and develop recommendations for interventions to reduce illness associated with HIV infection and prevent HIV transmission. Recommendations were formulated covering thirteen areas of intervention seen as low cost and of particular importance for people living with HIV. These areas are: psychosocial counselling and support; disclosure, partner notification and testing and counselling; co-trimoxazole prophylaxis; tuberculosis; preventing fungal infections; sexually transmitted and other reproductive tract infections; preventing malaria; selected vaccine preventable diseases (hepatitis-B, pneumococcal, influenza and yellow fever vaccines); nutrition; family planning; preventing mother-to-child transmission of HIV; needle-syringe programmes and opioid substitution therapy; and water, sanitation and hygiene.

Global guidance briefs: HIV interventions for young people. UNAIDS Inter-Agency Task Team on HIV and Young People, 2008.
www.unfpa.org/public/home/publications/pid/2850
Seven Guidance Briefs. See Prong 1.

Reproductive choices and family planning for people living with HIV: counselling tool. WHO, 2007.
www.who.int/reproductivehealth/publications/family_planning/9241595132/en/index.html

This tool is designed to help health workers counsel people living with HIV on sexual and reproductive choices and family planning, and is part of the WHO materials on integrated management of adolescent and adult illness (IMA). It also is meant to help people living with HIV make and carry out informed, healthy, and appropriate decisions about their sexual and reproductive lives.

Sexual and reproductive health of women living with HIV/AIDS: guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings. WHO, 2006.
www.who.int/reproductivehealth/publications/rtis/924159425X/en/index.html

This publication provides guidance on adapting health services to address the SRH needs of women living with HIV and integrating these activities within the health system. It includes recommendations for counselling, care and other interventions based on the best available scientific evidence, accumulated programme experience and expert opinion where evidence is lacking or is inconclusive.

Preventing HIV/AIDS in young people: Evidence from developing countries on what works. LSHTM, UNICEF, UNAIDS, UNFPA, WHO, 2006.
www.unfpa.org/webdav/site/global/shared/documents/publications/2006/preventing_hiv_young.pdf
See Prong 1.

Intensifying HIV prevention: UNAIDS policy position paper. UNAIDS, 2005.
http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf
See Prong 1.

Condom programming for HIV prevention: A manual for service providers. UNFPA, 2004.
www.unfpa.org/public/global/pid/1291
See Prong 1.

Condom programming for HIV prevention: An operations manual for programme managers. UNFPA, 2004.
www.unfpa.org/public/global/pid/1292
See Prong 1.

Rapid condom needs assessment tool for condom programming. UNFPA and Population Council, 2003.
www.unfpa.org/public/cache/offnce/publications/pid/2484;jsessionid=58F6F4134FE5E331EEC1E662592CC028
See Prong 1.

WHO is currently developing health-sector guidance for prevention, treatment and care of sex workers, as well as guidance on couples HIV counseling and testing, and ART for prevention.

PMTCT prong 3: Preventing HIV transmission from a woman living with HIV to her infant

Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access. Recommendations for a public health approach (2010 version). WHO, 2010.
www.who.int/hiv/pub/mtct/antiretroviral2010/en/index.html

Since WHO issued revised guidelines in 2006, important new evidence has emerged on the use of ARV prophylaxis to prevent MTCT, including during breastfeeding, on the optimal time to initiate ART in individuals who need treatment, and on safe feeding practices for HIV-exposed infants. This evidence forms the basis for the new recommendations,

primarily developed for low- and middle-income settings, and the guidelines include information for countries to adapt the recommendations to their local settings.

Guidelines on HIV and infant feeding. Principles and recommendations for infant feeding in the context of HIV and a summary of evidence. WHO, 2010.

www.who.int/child_adolescent_health/documents/9789241599535/en/index.html

These recommendations are generally consistent with the previous guidance, they recognize the important impact of ARVs during the breastfeeding period, and recommend that national authorities in each country decide which infant feeding practice (i.e. breastfeeding with an ARV intervention to reduce transmission or avoidance of all breastfeeding) should be promoted and supported by maternal and child health services.

Where national authorities promote breastfeeding and ARVs, mothers known to be HIV-infected are now recommended to breastfeed their infants until at least 12 months of age. The recommendation that replacement feeding should not be used unless it is acceptable, feasible, affordable, sustainable and safe (AFASS) remains, but the acronym is replaced by more common, everyday language and terms. Recognizing that ARVs will not be rolled out everywhere immediately, guidance is given on what to do in their absence.

Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings. WHO, 2008.

www.who.int/hiv/pub/plhiv/interventions/en/index.html
See Prong 2.

PMTCT prong 4: Providing appropriate treatment, care and support to women living with HIV and their children and families

Antiretroviral therapy for HIV infection in adults and adolescents – recommendations for a public health approach – 2010 revision. WHO, 2010.

www.who.int/hiv/pub/arv/adult2010/en/index.html

The guidelines identify the most potent, effective and feasible first-line, second-line and subsequent treatment regimens, applicable to the majority of populations, the optimal timing of ART initiation and improved criteria for ART switching, and introduce the concept of third-line antiretroviral regimens.

The primary audiences are national treatment advisory boards, partners implementing HIV care and treatment, and organizations providing technical and financial support to HIV care and treatment programmes in resource-limited settings.

Antiretroviral therapy for HIV infection in infants and children: Towards universal access. Recommendations for a public health approach: 2010 revision. WHO, 2010.

www.who.int/hiv/pub/paediatric/infants2010/en/index.html

The new guidelines seek to address the ongoing paediatric treatment gap by making a series of bold recommendations that are focused on expanding access to testing, increasing the number of infants and children eligible for treatment, and improving the care of children with HIV. Furthermore, all

exposed infants are born to HIV-positive mothers, and many of those women will have HIV-positive partners and/or other HIV-positive children. As such, the infant is an index case that helps to identify a family living with HIV, which could be a critical route to expanding the reach of HIV testing, treatment and care.

These treatment guidelines serve as a framework for selecting the most potent and feasible first-line and second-line ART regimens for the care of HIV-infected infants and children, including addressing the diagnosis of HIV infection and consideration of ART in different situations, e.g. where infants and children are coinfecting with HIV and TB, or have been exposed to ARVs, either for PMTCT or through breastfeeding. In addition, the nutritional needs of and malnutrition in HIV-positive children, and ART-related issues such as malnutrition, adherence and resistance, are discussed. A section on ART in adolescents briefly outlines key issues related to treatment and care for this age group.

These guidelines are intended primarily for treatment advisory boards, national AIDS programme managers and other senior policy-makers involved in the planning of national and international HIV care strategies for infants and children in resource-limited countries. Elements of the guidelines such as the simplified dosing guidance (Annex E) are also designed for clinical implementation in the field.

Plus all documents under Prong 2.

MDG 3: promote gender equality and empower women

These interventions underpin the successful implementation and scale-up of each of the four PMTCT prongs.

Ending gender-based violence

Preventing intimate partner and sexual violence against women. Taking action and generating evidence. WHO and LSHTM, 2010.

http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf

This tool for violence prevention researchers, practitioners and advocates provides a planning framework for developing policies and programmes for the prevention of intimate partner and sexual violence. This guide outlines the nature, magnitude, risks and consequences of intimate partner and sexual violence; as well as strategies to prevent these forms of violence against women and describes how these can be tailored to the needs, capacities and resources of particular settings. The manual describes interventions of known effectiveness, those supported by emerging evidence, and those that could potentially be effective, but have yet to be sufficiently evaluated for their impact. It also emphasizes the importance of integrating scientific evaluation into all prevention activities in order to expand current knowledge of what works.

Addressing gender-based violence: UNFPA strategy and framework for action. UNFPA, 2009.

www.unfpa.org/public/publications/pid/1565

This publication identifies priority areas for intensified action on gender-based violence: policy frameworks, data collection and analysis, focus on SRH, humanitarian responses, adolescents and youth, men and boys, faith-based networks,

and vulnerable and marginalized populations. It is intended to provide a common platform and technical guidance for UNFPA at country, regional and global levels and effectively guide capacity-development initiatives, resources and partnerships.

Partnering with men to end gender-based violence. Practices that work from Eastern Europe and Central Asia. UNFPA, 2009.

www.unfpa.org/public/cache/offonce/home/publications/pid/4412

This report documents good practices in preventing and responding to gender-based violence. The five case studies featured within document initiatives in Armenia, Romania, Turkey and the Ukraine that were implemented by governments and other partners with the support of UNFPA. Although the reports focus on initiatives in Eastern Europe and Central Asia, the practices and lessons learned can be applied throughout the globe.

Ending violence against women. Programming for prevention, protection and care. UNFPA, 2007.

www.unfpa.org/public/global/pid/399

This handbook, intended primarily for development practitioners, provides practical points to consider when designing and implementing projects addressing violence against women. It is a collection of good practices drawn from ten case studies described in a complementary volume *Programming to Address Violence Against Women*. The approaches are based on an appreciation of culture and the role it plays in this issue.

Programming to Address Violence against Women

- Ten Case Studies. UNFPA, 2007.
<http://europe.unfpa.org/webdav/site/europe/shared/Publications/PDF%20files/Violence1.pdf>

This volume documents UNFPA's experience addressing many forms of violence against women. Intended primarily for development practitioners and others seeking to change attitudes and practices, it offers lessons that can help scale up responses. Projects in Bangladesh, Colombia, Ghana, Kenya, Mauritania, Mexico, Morocco, Romania, Sierra Leone and Turkey are discussed.

- 8 Case Studies Volume 2. UNFPA, 2009.
http://europe.unfpa.org/public/europe_pubs/pid/2041

This volume documents best practices in preventing and responding to violence against women. These eight case studies feature initiatives from Algeria, Guatemala, Honduras, India, Indonesia, Nepal, Sri Lanka and Zimbabwe, implemented by governments and other partners with support from UNFPA.

Supporting women's reproductive rights UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV. UNAIDS, 2009.

www.unfpa.org/webdav/site/global/shared/documents/publications/2010/unaid_s_action_framework.pdf

This action framework has been developed by the UNAIDS co-sponsors, the UNAIDS Secretariat and UNIFEM, to more effectively and sustainably empower women and girls and to promote gender equality as part of their collective

response to AIDS. The framework builds on past actions and accomplishments, but adopts a more strategic and prioritized approach, with greater coordination of policies and programmes and an emphasis on focused and context specific guidance to help accelerate and expand successful action at the country level.

Agenda for accelerated country action for women, girls, gender equality and HIV. Operational plan for the UNAIDS action framework: addressing women, girls, gender equality and HIV. UNAIDS, 2010.

www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf

The Agenda for Accelerated Country Action is structured around three issues:

1. knowing, understanding and responding to the particular and various effects of the HIV epidemic on women and girls
2. translating political commitments into scaled-up action to address the rights and needs of women and girls in the context of HIV
3. an enabling environment for the fulfilment of women's and girls' human rights and empowerment, in the context of HIV.

Each issue is accompanied by a recommendation, a set of results and corresponding actions, as well as the parties to be held accountable for delivering results. The 26 concrete and feasible actions aim to be catalytic in nature, generating synergies between HIV responses, and to work on the human rights of women and girls and on gender equality and to tap into the richness, expertise and diversity of the women's movement.

Increasing access to information and sexual and reproductive health services

Strategic considerations for strengthening the linkages between family planning and HIV/AIDS policies, programs, and services. WHO, United States Agency for International Development, Family Health International, 2009.

www.who.int/reproductivehealth/publications/linkages/fp_hiv_strategic_considerations.pdf

This document aims to provide programme planners, implementers, and managers (including MOH officials and other country-level stakeholders) with strategic considerations for implementing or strengthening integrated FP/HIV services. The document does not address other reproductive health issues that are also central to linked approaches, such as gender-based violence and STI management. Instead, the focus here is specifically on the intersection of FP and HIV, and thus should be used in the context of broader efforts to ensure universal access to RH services and HIV prevention, care, treatment, and support programs.

Sexual and reproductive health and HIV linkages: evidence review and recommendations. IPPF, University of California, San Francisco, UNAIDS, UNFPA, WHO, 2009.

www.who.int/reproductivehealth/publications/linkages/hiv_2009/en/index.html

In order to gain a clearer understanding of the effectiveness, optimal circumstances, and best practices for strengthening SRH and HIV linkages, a systematic review of the literature

was conducted. The findings corroborate the many benefits gained from linking SRH and HIV policies, systems and services.

Packages of interventions for family planning, safe abortion care, maternal, newborn and child health. WHO, UNFPA, UNICEF, World Bank, 2010.

www.who.int/making_pregnancy_safer/documents/fch_10_06/en/index.html

This document describes the key effective interventions organized in packages across the continuum of care through pre-pregnancy, pregnancy, childbirth, postpartum, newborn care and care of the child. The packages are defined for community and/or facility levels in developing countries and provide guidance on the essential components needed to assure adequacy and quality of care.

Medical eligibility criteria for contraceptive use, fourth edition. WHO, 2010.

www.who.int/reproductivehealth/publications/family_planning/9789241563888/en/index.html

This document reviews the medical eligibility criteria for use of contraception, offering guidance on the safety of use of different methods for women and men with specific characteristics or known medical conditions. The recommendations are based on systematic reviews of available clinical and epidemiological research. It is a companion guideline to *Selected practice recommendations for contraceptive use*. Together, these documents are intended to be used by policy-makers, programme managers, and the scientific community, to support national programmes in the preparation of service delivery guidelines.

Global elimination of congenital syphilis: rationale and strategy for action. WHO, 2007.

www.who.int/reproductivehealth/publications/rtis/9789241595858/en/index.html

The overarching global goal of the present strategy is the elimination of congenital syphilis as a public health problem. This would be achieved through reduction of prevalence of syphilis in pregnant women and by the prevention of mother-to-child transmission of syphilis. The strategy rests on four pillars: (i) ensure sustained political commitment and advocacy; (ii) increase access to, and quality of, maternal and newborn health services; (iii) screen and treat pregnant women and their partners; and (iv) establish surveillance, monitoring and evaluation systems.

Comprehensive cervical cancer control: A guide to essential practice. WHO, 2006.

www.who.int/reproductivehealth/publications/cancers/9241547006/en/index.html

This guide focuses on the knowledge and skills needed by health-care providers at different levels of care to offer quality services for prevention, screening, treatment and palliation of cervical cancer. It presents up-to-date, evidence-based recommendations covering the full continuum of care. The four levels of care referred to throughout the guide are: the community; the health centre or primary care level; the district hospital or secondary care level; and the central or referral hospital or tertiary care level. The guide does not cover programme management, resource mobilization, or the

political, legal and policy-related activities associated with cervical cancer control.

Guidelines for the management of sexually transmitted infections. WHO, forthcoming.

Engaging male partners

Engaging men and boys in gender equality and health toolkit. UNFPA, 2010.

<http://unfpa.org/public/home/publications/pid/6815>

This toolkit presents conceptual and practical information on engaging men and boys in promoting gender equality and health. Specific topics include sexual and reproductive health; maternal, newborn and child health; fatherhood; HIV and AIDS prevention, care and support; and prevention of gender-based violence. In addition to providing examples of programmes that have effectively addressed these challenges, the toolkit offers guidance on advocacy, needs-assessment, monitoring and evaluation related to efforts to engage men and boys.

Policy approaches to engaging men and boys in achieving gender equality and health equity. WHO, 2010.

http://whqlibdoc.who.int/publications/2010/9789241500128_eng.pdf

This policy brief:

- outlines the rationale for using policy approaches to engage men in achieving gender equality, reducing health inequities, and improving women's and men's health
- offers a framework for integrating men into policies that aim to reduce gender inequality and health inequities
- highlights some successful policy initiatives addressing men that have advanced gender equality and reduced health inequities by generating positive changes in men's behaviours and relations with women and with other men, including through increasing men's involvement in caring for children; interventions for men who use violence against women; male circumcision; reducing men's excessive consumption of alcohol.

Men's reproductive health curriculum. EngenderHealth, 2008.

www.EngenderHealth.org/pubs/gender/mens-rh-curriculum.php

This three-part curriculum is designed to provide a broad range of health care workers with the skills and sensitivity needed to work with male clients and provide men's reproductive health services. The curriculum includes:

1. Introduction to Men's Reproductive Health Services (Revised Edition) is designed to help sites and health care workers address organizational and attitudinal barriers that may exist when initiating, providing, or expanding a men's reproductive health services programme.
2. Counselling and Communicating with Men focuses on strengthening service providers' ability to interact with, communicate with, and counsel men – with or without their partners – on reproductive health issues.
3. Management of Men's Reproductive Health Problems provides information to clinicians and other service providers in diagnosing and managing reproductive health disorders in men.

Involving men in promoting gender equality and women's reproductive health. UNFPA, 2007.

www.unfpa.org/gender/men.htm

Summary of UNFPA's work and findings.

Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. WHO, 2007.

www.who.int/gender/documents/Engaging_men_boys.pdf

This review assesses the effectiveness of programme interventions seeking to engage men and boys in achieving gender equality and equity in health.

ANNEX 3 ADDITIONAL DISCUSSION OF GUIDING PRINCIPLES

Human rights¹²

These principles aim to guide coordinated and coherent government policy and programming so as to respect their international commitments. In so doing, PMTCT interventions integrated with maternal, newborn, and child health, and SRH programmes must be designed, implemented, monitored, and evaluated in a transparent and participatory manner, with regular dissemination of results to the public. Grounding reproductive health programming in a human rights framework clarifies the obligations and responsibilities of governments to protect, promote and fulfil reproductive rights. Although subject to progressive realization and resource constraints, some obligations have immediate effect. For example, there is a duty on the State to respect an individual's freedom to control his or her health and body. As such, there is an immediate obligation on a State not to engage in forced sterilization or discriminatory practices, which is subject to neither progressive realization nor resource availability.

Bearing in mind the human rights principles of universality, inalienability, indivisibility, interdependence, and interrelatedness, these strengthen PMTCT/MNCH/SRH programmes by emphasizing the intersections between reproductive rights and other human rights – such as the rights to education, information, privacy, food, shelter, and so forth. These intersections require that PMTCT/MNCH/SRH programmes be built upon multisectoral partnerships, and that the expertise and resources of diverse groups and ministries be combined to create truly comprehensive integrated PMTCT/MNCH/SRH programmes.

Gender equality and empowerment

A number of challenges for scaling up primary prevention of HIV in the context of PMTCT have been identified, including significant barriers for HIV-negative pregnant women to remain negative, many of which are gender-based.¹³ Women living with HIV face other barriers to accessing services, including:

- provider attitudes, particularly stigmatizing and discriminatory ones;
- consistent perception that programmes place a lower value on the mother's health and rights than those of the child;¹⁴
- a lack of respect for the reproductive rights and fertility desires of women living with HIV, including forced or coerced abortion or sterilization;
- a perceived lack of quality counselling for women living with HIV when they do not want to get pregnant;¹⁵
- a lack of pre-conception care and awareness of family planning among women (especially young women) and their partners and health providers;¹⁶
- failure to offer counselling and services in a confidential, non-judgmental and non-discriminatory manner;
- failure to provide accurate information on and access to the full range of family planning options; and
- failure to respect a person's decision to disclose her or his HIV status voluntarily, even to health care providers.

In order to make eMTCT a reality, it is essential to focus on gender equality and women's empowerment (see *Box A: Risk and Vulnerability*). This focus will help to create an enabling environment for achieving scaled up comprehensive and effective PMTCT/MNCH/SRH programmes.¹⁷ Furthermore, within the broad guiding principle 'Human Rights and Gender', the need to address gender-based violence is critical as there are clear links between gender-based violence and poorer health outcomes for both mother and child as a result of physical and mental trauma. People living with HIV have reported rampant gender based-violence. Furthermore, there are few accessible prevention and impact mitigation programmes that exist to address gender-based violence.¹⁸

These gender dimensions cannot be overlooked in programming, and influence what and how services are delivered. In recognition of the importance of tackling the gender dimensions of the AIDS epidemic the Global Fund to fight AIDS, Tuberculosis and Malaria, and UNAIDS have developed programming strategies and operational plans which recognize that gender dynamics affect women's vulnerability to HIV and its impact.^{i, 19}

Meaningfully involve people living with HIV²⁰

People living with HIV have significant knowledge, experience and insight into the issues that are important for them and for responding to the epidemic effectively (see *Section 9 Key Strategies and Actions, Strategy 4*). Participation of people living with HIV, young people, and key populations at higher risk ensures that sexual and reproductive health commodities, information and services are tailored to the needs of these groups i.e. they are available²¹, accessible²² and acceptable²³ as well as scientifically and medically appropriate and of good quality.

When this framework is applied to PMTCT/MNCH/SRH programming, it is clear that the key elements of availability, accessibility and so on are frequently absent. For example, in many countries, information on PMTCT/MNCH/SRH is not readily available and, if it is, it is not accessible to all, in particular women and adolescents, including those living with HIV or from key populations at higher risk. PMTCT/MNCH/SRH services are often geographically inaccessible to communities living in rural areas. These services are sometimes not provided in a form that is culturally acceptable

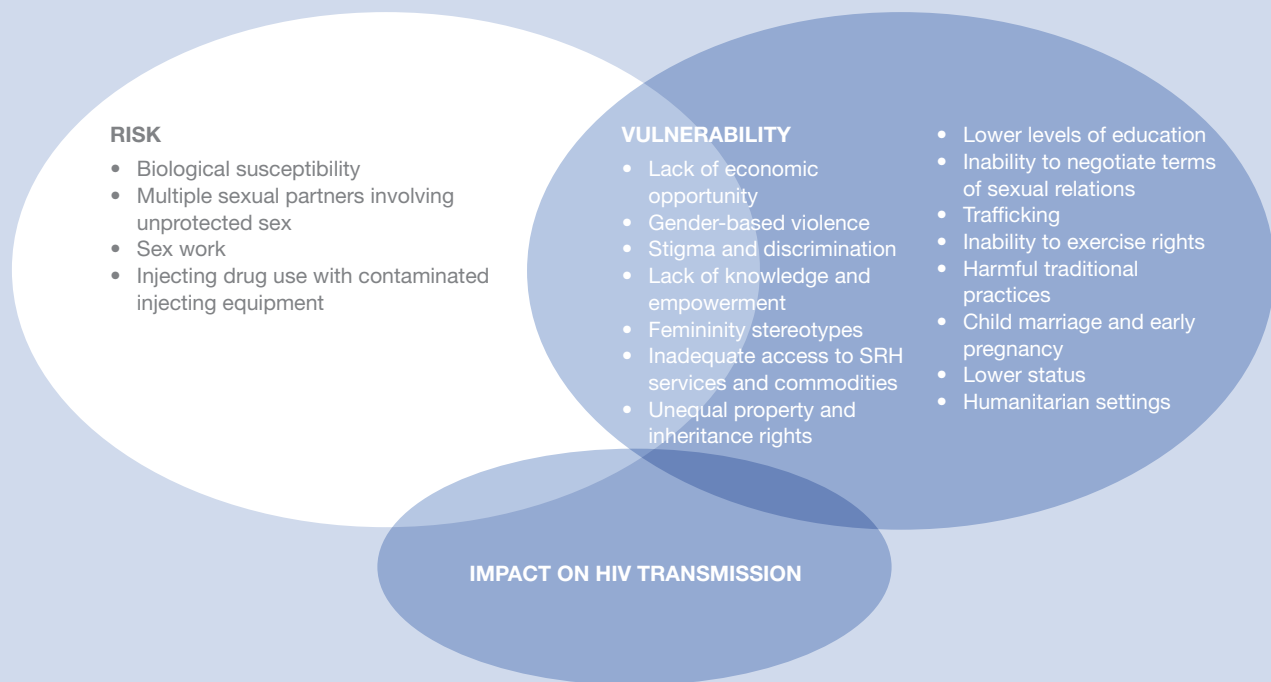
i. Gender Equality Strategy. The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2009.
www.theglobalfund.org/documents/strategy/TheGenderEqualityStrategy_en.pdf
The Global Fund Strategy in Relation to Sexual Orientation and Gender Identities. The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2009.
www.theglobalfund.org/documents/publications/other/SOGI/SOGI_Strategy.pdf
UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV. UNAIDS, August, 2009.
www.unfpa.org/webdav/site/global/shared/documents/publications/2010/un aids_action_framework.pdf
Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV. Operational plan for the UNAIDS action framework: addressing women, girls, gender equality and HIV.
www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf

BOX A: RISK AND VULNERABILITY

HIV infection is associated with specific risks, including behaviours such as unprotected sexual intercourse or injecting drug use with contaminated injecting equipment, and situations such as forced or coerced sex. Vulnerability refers to unequal opportunities, social exclusion, unemployment, or precarious employment and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS. Figure A outlines the specific risk and vulnerability factors faced by women and girls, and illustrates the relationship between risk and vulnerability and the impact on HIV transmission in the context of PMTCT.

Furthermore, harmful gender norms – including those that reinforce the submissive role of women, cross-generational sex, concurrent partnerships, and gender-based violence – are key drivers of the HIV epidemic.²⁴ Fear of violence may prevent women accessing voluntary counselling and testing, family planning or PMTCT services, or from disclosing their status to partners. In many cases, women who test HIV-positive choose not to inform their partners of the results because of fear of blame or abandonment. Women who fear violence are also less able to exert control over their fertility, negotiate safe sex or condom use, or confront infidelity. Furthermore, economic, educational, legal and political discrimination faced by women and girls contribute to their vulnerability.²⁵

FIGURE A: WOMEN'S AND GIRLS' VULNERABILITY AND RISK AND THEIR IMPACT ON HIV TRANSMISSION IN THE CONTEXT OF PMTCT



or age specific. Lastly, services, and relevant underlying determinants of health, such as education, are often of substandard quality.

Community engagement²⁶

The value of community involvement for improving health was recognized over 30 years ago.²⁷ Since then, community involvement has been regarded as a continuum (according to the degree of community members' control and decision-making) that ranges from token representation with no role or power in making decisions to community participation in which local people initiate action, set the agenda and work towards a commonly-defined goal of community engagement. Such engagement brings together people living with HIV, community stakeholders and health providers to develop partnerships, address gaps and challenges, and support

families and individuals, creating a comprehensive community response. While communities are unlikely to question their own assumptions – on gender norms, for example – unless prompted to do so, community-based programmes have succeeded in catalysing change by helping communities reflect on traditions, norms and values that jeopardize their health and survival (see *Section 9 Key Strategies and Actions, Strategy 2*).

Stigma and discrimination

International human rights law proscribes discrimination in access to health care and the underlying determinants of health, and to the means for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV),

sexual orientation, and civil, political, social or other status that has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. Nonetheless, discrimination and stigma continue to pose a serious threat to sexual and reproductive health for many key populations and vulnerable groups, including women, sexual minorities, refugees, people with disabilities, rural communities, indigenous persons, people living with HIV, sex workers, and people held in detention. Some individuals suffer discrimination on several grounds such as gender, race, poverty and health status²⁸ (see *Section 9 Key Strategies and Actions, Strategy 5*).

There is a need for protective laws that ensure non-discrimination, reduce stigma, provide access to justice and change harmful gender norms to address the underlying causes of primary infection of women and the prevention of unintended pregnancies among women living with HIV. Equally important are programmes that promote education and create the conditions for people living with HIV and their partners to be free to make informed choices about their sexual and reproductive health, including regarding whether and how to be sexually active and fulfilled, and whether and how to conceive and enjoy a family.²⁹

Centrality of sexuality³⁰

The principle of recognizing the centrality of sexuality focuses on the 'life-cycle approach' to sexual and reproductive health, which includes helping countries to: respond to adolescents' and young people's SRH needs, including those living with HIV; prevent maternal mortality and morbidity; and provide women and men (including elderly women and men) with the SRH information, goods and services they require. This approach implies that programmes should respond to adolescents' and young people's particular SRH needs; support prevention of maternal mortality and morbidity; and assist governments to provide women and men (including elderly women and men) with the sexual and reproductive health information, commodities and services they require, according to their age needs.

ANNEX 4 PACKAGE OF ESSENTIAL SERVICES FOR HIGH-QUALITY MATERNAL CARE³¹

Package of essential services for high-quality maternal care for all women regardless of HIV status

1. Health education, information on prevention and care for HIV and sexually transmitted infections, including safer sex practices, pregnancy including antenatal care, birth planning and delivery assistance, malaria prevention, optimal infant feeding; family planning counselling and related services
2. Provider-initiated HIV counselling and testing, including HIV counselling and testing for women of unknown status at labour and delivery or postpartum
3. Couple and partner HIV counselling and testing, including support for disclosure
4. Promotion and provision of male and female condoms
5. HIV-related gender-based violence screening
6. Obstetric care, including history taking and physical examination
7. Maternal nutritional support
8. Counselling on infant feeding
9. Psychosocial support
10. Birth planning, birth preparedness (including pregnancy and postpartum danger signs), including skilled birth attendants
11. Tetanus vaccination
12. Iron and folate supplementation
13. Syphilis screening and management of sexually transmitted infections
14. Risk reduction interventions for people who use drugs
15. Hepatitis B screening and infant vaccination³²

Package of services for women living with HIV

1. Additional counselling and support to encourage partner testing, adoption of risk reduction and disclosure
2. Clinical evaluation, including clinical staging of HIV disease
3. Immunological assessment (CD4 cell count) where available
4. Antiretroviral therapy when indicated
5. Counselling and support on infant feeding based on knowledge of HIV status
6. Antiretroviral prophylaxis for PMTCT provided during the antepartum, intrapartum and postpartum period
7. Co-trimoxazole prophylaxis where indicated
8. Additional counselling and provision of services as appropriate to prevent unintended pregnancies
9. Supportive care, including adherence support
10. Additional counselling and provision of services as appropriate to prevent unintended pregnancies
11. Tuberculosis screening and treatment when indicated; preventive therapy (isoniazid prophylaxis) when appropriate
12. Advice and support on other prevention interventions, such as safe drinking water
13. Supportive care, including adherence support and palliative care and symptom management

Additional package of services for all women regardless of HIV status in specific settings

1. Malaria prevention and treatment
2. Counselling, psychosocial support and referral for women who are at risk of or have experienced violence
3. Counselling and referral for women with a history of harmful alcohol or drug use
4. De-worming
5. Consider re-testing late in pregnancy where feasible in generalized epidemics

ANNEX 5 KEY TERMS

Bi-directionality: Refers to both linking SRH with HIV-related policies and programmes, and HIV with SRH-related policies and programmes.³³

Civil society: includes not only community organizations and actors but also other non-governmental, non-commercial organizations, such as those working on public policies, processes and resource mobilization at national, regional or global levels. Civil society organizations (CSOs), whatever level they work at, include community-based organizations (CBOs); non-governmental organizations (NGOs); faith-based organizations (FBOs); and networks or organizations of people living with HIV or key populations.³⁴

Community is a widely used term that has no single or fixed definition. Broadly, communities are formed by people who are connected to each other in distinct and varied ways. Communities are diverse and dynamic, and one person may be part of more than one community. Community members may be connected by living in the same area or by shared experiences, health and other challenges, living situations, culture, religion, identity or values.³⁵

Community-based organizations (CBOs): are generally those organizations that have arisen within a community in response to particular needs or challenges and are locally organized by community members. Non-governmental organizations (NGOs) are generally legal entities, for example registered with local or national authorities; they may be operative only at community level or may also operate or be part of a larger NGO at national, regional and international levels. Some groups that start out as CBOs register as NGOs when their programmes develop and they need to mobilize resources from partners that will only fund organizations that have legal status.³⁶

Community organizations and actors: are all those who act at community level to deliver community-based services and activities and promote improved practice and policies. This includes many civil society organizations, groups and individuals that work with communities, particularly community-based organizations (CBOs), non-governmental organizations (NGOs) and faith-based organizations (FBOs) and networks or organizations of people living with HIV or key populations. It also includes those public or private sector actors that work in partnerships with civil society to support community-based service delivery, for example local government authorities, community entrepreneurs and co-operatives.³⁷

Community systems are community-led structures and mechanisms used by communities through which community members and community-based organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities. Many community systems are small-scale and/or informal. Others are more extensive – they may be networked between several

organisations and involve various sub-systems. For example, a large care and support system may have distinct sub-systems for comprehensive home-based care, providing nutritional support, counselling, advocacy, legal support, and referrals for access to services and follow-up.³⁸

Community systems strengthening (CSS) is an approach that promotes the development of informed, capable and coordinated communities and community-based organisations, groups and structures. CSS involves a broad range of community actors, enabling them to contribute as equal partners alongside other actors to the long-term sustainability of health and other interventions at community level, including an enabling and responsive environment in which these contributions can be effective. The goal of CSS is to achieve improved health outcomes by developing the role of key affected populations and communities and of community-based organizations in the design, delivery, monitoring and evaluation of services and activities related to prevention, treatment, care and support of people affected by HIV, tuberculosis, malaria and other major health challenges.³⁹

Contraception is defined as the intentional prevention of conception using various methods. Contraceptive methods are classified as either modern or traditional. Modern methods of contraception include female and male sterilization, oral hormonal pills, the intra-uterine device (IUD), the male condom, injectables, the implant (including Norplant), vaginal barrier methods, the female condom and emergency contraception. Traditional methods of contraception include rhythm (periodic abstinence), withdrawal, prolonged abstinence, breastfeeding, douching, lactational amenorrhea method (LAM) and folk methods.⁴⁰

Dual protection: Many sexually active people need dual protection: protection against unintended pregnancy and against STIs including HIV. Those contraceptives that offer the best pregnancy prevention do not protect against STIs. Thus, simultaneous condom use for disease prevention is recommended. Condoms used alone can also prevent both STIs and pregnancy if used correctly and consistently, but are associated with higher pregnancy rates than condoms used together with another contraceptive method.⁴¹

Elimination of mother-to-child transmission of HIV

(eMTCT): In addition to the previously used terminology of prevention of mother-to-child transmission, there is a plethora of terms currently in use to describe the intensified commitment with ambitious targets to achieve this outcome, including elimination of:

- mother-to-child transmission of HIV⁴²
- new HIV infections among children by 2015 and keeping their mothers alive⁴³
- new paediatric HIV infections⁴⁴
- new paediatric infections and improving maternal and child health and survival.⁴⁵

People living with HIV have indicated that the term ‘elimination’ of mother-to-child transmission is difficult as it fails to recognize that HIV is not just a virus but is part of people’s lives, affecting how the community relates to them on every level. It is also perceived to be derogatory, as taken out of context, without qualifying terms, it can seem to connote an end to the lives of people living with HIV. The term ‘elimination’ can:

- evoke fear and be disempowering for people living with HIV
- prevent people from accessing necessary services and, subsequently, from being able to prevent transmitting HIV to their child, if they are associated with the term
- be understood to mean eliminating women living with HIV or infants living with HIV in order to eliminate mother-to-child transmission.⁴⁶

The term ‘elimination’ should not be used as a short-hand or as a slogan. Stakeholders must carefully consider their choice of terminology in programming to ensure definitions are clear, not normative, clouded in ambiguity or value laden.

Family planning allows individuals and couples to anticipate and attain their desired number of children, if any, and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman’s ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.⁴⁷

Greater Involvement of People Living with HIV (GIPA)

Principle: GIPA is not a project or programme. It is a principle that aims to realize the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives. In these efforts, GIPA also aims to enhance the quality and effectiveness of the AIDS response.⁴⁸

Harm reduction: Refers to policies, programmes and approaches that seek to reduce the harmful health, social and economic consequences associated with the use of psychoactive substances. It is a comprehensive package of nine elements including: needle and syringe programmes; opioid substitution therapy and other drug dependence treatment; HIV counselling and testing; antiretroviral therapy; prevention and treatment of sexually transmitted infections; condom programmes for people who inject drugs and their sexual partners; targeted information, education and communication for people who inject drugs and their sexual partners; vaccination, diagnosis and treatment of viral hepatitis; and, prevention, diagnosis and treatment of tuberculosis.⁴⁹

Integration: Refers to different kinds of SRH and HIV services or operational programmes that can be joined together to ensure and perhaps maximize collective outcomes. This would include referrals from one service to another, for example. It is based on the need to offer comprehensive and integrated services.⁵⁰ This means,

in terms of service delivery, the organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money.⁵¹

Key populations/key populations at higher risk: Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.⁵²

Linkages: The bi-directional synergies in policies, programmes, services and advocacy between SRH and HIV. It refers to a broader human rights-based approach, of which service integration is a subset.⁵³

Maternal mortality refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.⁵⁴

Positive health, dignity and prevention

- Increasing access to, and understanding of, evidence-informed, human rights-based public health policies and programmes that support individuals living with HIV in making choices that address their needs and allow them to live healthy lives;
- Scaling up and supporting existing HIV testing, care, support, treatment and prevention programmes that are community-owned and led;
- Scaling up and supporting literacy programmes in health, treatment and prevention and ensuring that human rights and legal literacy are promoted and implemented;
- Ensuring that undiagnosed and diagnosed people living with HIV, along with their partners and communities, are included in HIV prevention programmes that highlight shared responsibility, regardless of known or perceived HIV status, and have options rather than restrictions to be empowered to protect themselves and their partner(s);
- Scaling up and supporting social capital programmes that focus on community-drive, sustainable responses to HIV by investing in community development, networking, capacity-building and resources for organization and networks of people living with HIV.⁵⁵

Prevention of mother-to-child transmission of HIV

(PMTCT): Some countries, organizations and individuals prefer to use the term prevention of parent-

to-child transmission of HIV (PPTCT), to avoid placing undue 'blame' on the mother, and to better engage the male partner in HIV prevention. In this document, the term 'prevention of mother-to-child transmission of HIV (PMTCT)' is used and is not intended to attach blame or stigma to the woman who gives birth to an HIV-positive child. It does not suggest deliberate transmission by the mother, who is often unaware of her own HIV status and unfamiliar with the HIV transmission risk to infants. See also discussion of Elimination of mother-to-child transmission of HIV above.

Primary prevention: Primary HIV prevention refers to activities directed to protect a person from acquiring HIV in the first place.⁵⁶

Prong: There are four programme prongs (also known as elements or components) of comprehensive PMTCT programming.

Prong 1: Primary prevention of HIV in women of childbearing age (in this framework with special emphasis on pregnant and breastfeeding women – see *Section 2 Prong 1*).

Prong 2: Prevention of unintended pregnancies in women living with HIV (as part of rights-based sexual and reproductive health of people living with HIV) (see *Section 3 Prong 2*).

Risk is defined as the risk of exposure to HIV or the likelihood that a person may become infected with HIV. Certain behaviours create, increase, or perpetuate risk. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV.⁵⁷

Treatment as prevention refers to the additional prevention dividend resulting from access to HIV treatment by medically eligible people living with HIV.

Treatment for prevention involves people living with HIV choosing to take antiretroviral therapy to reduce sexual transmission of HIV to their sexual partner, even though they do not require treatment for their own health.

Unmet need for family planning is the proportion of women not using contraception among women of childbearing age (15–49 years old), who are either married or in union and who are fecund and sexually active but do not want any more children or would like to delay the birth of their next child for at least two years. This indicator reflects whether women who want to delay or avoid pregnancy have access to and are using family planning services and information at a given moment.⁵⁸

Vertical transmission refers to HIV transmission from mother-to-child during pregnancy, childbearing or breastfeeding.⁵⁹

Violence against women: ... “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. ... Violence against women shall be understood to encompass, but not be limited to, the following: a) Physical, sexual and psychological violence occurring in the family; b) Physical, sexual and psychological violence occurring within the general community; c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs. Types of violence that fall into the above categories include: spousal battery; sexual abuse, including of female children; dowry-related violence; rape, including marital rape; female genital mutilation/cutting and other practices harmful to women; non-spousal violence; sexual violence related to exploitation; sexual harassment and intimidation at work, in school and elsewhere; trafficking in women; and forced prostitution.⁶⁰

Vulnerability refers to unequal opportunities, social exclusion, unemployment, or precarious employment and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk and may be outside the control of individuals. These factors may include: lack of the knowledge and skills required to protect oneself and others; accessibility, quality, and coverage of services; and societal factors such as human rights violations or social and cultural norms. These norms can include practices, beliefs, and laws that stigmatize and disempower certain populations, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.⁶¹

Vulnerable groups: Populations which are subject to societal pressures or social circumstances that may make them more vulnerable to exposure to infections, including HIV, such as, populations of humanitarian concern, refugees, internally displaced persons and migrants, informal-economy workers, people experiencing hunger, poor nutrition and food insecurity, and orphaned and vulnerable children.⁶²

15

ENDNOTES TO ANNEXES

1. www.un.org/millenniumgoals/
2. Global Strategy for Women's and Children's Health. UN Secretary-General, 2010. www.who.int/pmnch/activities/jointactionplan/201009_globalstrategy_6lang/en/index.html
3. 25 Priority countries with commitment to the Global strategy (AFRO:18, EMRO: 2, SEARO: 3, WPRO: 1, AMRO1): Afghanistan, Bangladesh, Benin, Burkina Faso, Cambodia, DRC, Ethiopia, Ghana; Haiti; India; Kenya; Liberia; Malawi; Mali; Mozambique; Nepal; Niger; Nigeria; Pakistan; Rwanda; Sierra Leone; Tanzania; Uganda; Zambia; Zimbabwe.
4. www.who.int/pmnch/about/steering_committee/091207_item1c_h4workplan_rev.pdf
5. Gender Equality Strategy. The Global Fund to fight AIDS, Tuberculosis and Malaria, 2009. www.theglobalfund.org/documents/strategy/TheGenderEqualityStrategy_en.pdf
Annex 2 f. Include programs that empower women and girls so they can protect themselves by having access to sexual and reproductive health care, access to female-controlled prevention measures (female condom, negotiating condom use, etc.), and access to education. In this context the Global Fund will champion activities that strengthen sexual and reproductive health-HIV/AIDS service integration.
6. G8 Muskoka Declaration Recovery And New Beginnings. Muskoka, Canada, 25–26 June 2010. http://canadainternational.gc.ca/g8/assets/pdfs/2010-declaration_eng.pdf
7. www.ghi.gov
8. www.who.int/reproductivehealth/topics/rtis/syphilis/en/index.html
9. www.stoptb.org
10. www.who.int/immunization_monitoring/diseases/MNTE_initiative/en/index.html
11. www.rollbackmalaria.org/gmap/2-1.html
12. Session 4: Reproductive Health. PowerPoint presentation in A Human Rights-Based Approach to Programming: Practical Information and Training Materials. UNFPA and Harvard School of Public Health, Program on International Health and Human Rights. 2010. www.unfpa.org/public/publications/pid/4919
13. These include:
 - low perception of risk of HIV infection by women and their partners;
 - lack of awareness of the possibility of vertical transmission;
 - seroconversion during pregnancy linked to socio-cultural practices, such as abstinence during pregnancy, which might contribute to partners' practicing unsafe sex outside of the relationship and them transmitting HIV to their pregnant or breastfeeding partner;
 - difficulties promoting and/or practicing safer sex, including condom use, for both married and non-married couples, especially during pregnancy;
 - violence or even fear of violence which may prevent women from disclosing their status to partners, accessing voluntary testing and counselling, family planning, and other health, social and legal services; and
 - fear of stigma and discrimination, and more recently criminalization of perinatal transmission, which may affect a person's decision as to whether to undertake HIV testing or not.
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15. According to the ICW/GNP+ e-survey, out of 591 respondents, 41% rated the overall quality of counselling that HIV-positive women receive as average. A significant number (19%) rated the quality of counselling as poor and 9% as very poor. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW, GNP+, 2011. www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf
16. In the ICW/GNP+ e-survey, 58% of respondents felt that HIV-positive women and couples do not have enough support to conceive safely. The majority of respondents mentioned health workers' judgmental attitudes as the major problem affecting safe conception. Vital Voices: Recommendations from consultations with people living with HIV on the IATT's Strategic Framework for PMTCT Components 1 and 2. ICW, GNP+, 2011. www.gnpplus.net/images/stories/Empowerment/consultations/ICW_GNP_Recommendations_PMTCT_Framework_Final.pdf
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21. The national AIDS and SRH programmes should aim to make functioning HIV and sexual and reproductive health and health care facilities, goods and services, as well as programmes, available in sufficient quantity within the country.
22. PMTCT and SRH facilities, goods and services must be non-discriminatory, as well as physically and economically accessible with the right to seek, receive and impart information confidentially.
23. All sexual and reproductive health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned.
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