International HIV/AIDS Alliance

Together to end AIDS

Workshop Guide

Integration works!

A guide to facilitating a workshop on integrating sexual and reproductive health and rights and HIV

About the International HIV/AIDS Alliance

We are an innovative alliance of nationally-based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

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This facilitator's guide is based on the International HIV/AIDS Alliance (Alliance) *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*, and a regional workshop on sexual and reproductive health and rights (SRHR) and HIV integration and linkages held in Nairobi in September 2011. Hosted by the Alliance Technical Support Hub for East and Southern Africa, the workshop was attended by Anglophone Linking Organisations and implementing partners. Additional sessions were included based on a regional workshop on SRHR and HIV integration and linkages in Ouagadougou, Burkina Faso, for Francophone West, North and Central African Linking Organisations and partners in February 2012, and a one-day training on SRHR and HIV in Brighton, UK, for Alliance Secretariat staff in April 2012.

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How was this guide developed?

In September 2011 CAFS facilitated a regional workshop on SRHR and HIV integration in Nairobi, Kenya, for Alliance partners. The three-day workshop was hosted in close collaboration with the Alliance Secretariat in Brighton, UK, and the Alliance East and Southern Africa Technical Support Hub in Nairobi, Kenya. The initiative originated from activities the Alliance has been supporting in the region to provide and scale up technical support to civil society organisations and others responding to HIV. The workshop was developed using technical resources published by the Alliance; specifically the Alliance *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*, published in 2010, and the *HIV update: integrating maternal, newborn and child health into community-based HIV programmes*, published in August 2011.

A key recommendation from this workshop was the need for a facilitator's guide for the Alliance Linking Organisations and other civil society partners. This would demonstrate for partners how to use the Alliance Good Practice Guide and various technical resources on SRHR and HIV integration in their own programming. It would also show in a practical manner how the guide could be used in designing, implementing and evaluating programmes.

This guide has been reviewed by colleagues from the Alliance Secretariat, the East and Southern Technical Support Hub based in Nairobi, Kenya, Marie Stopes International and CAFS.

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Alliance good practice HIV programming standards for sexual and reproductive health and rights and HIV integration

Good practice standard 1	Our organisation promotes the linking and integration of sexual and reproductive health (SRH) and HIV in policies, programmes and services.
Good practice standard 2	In collaboration with others, our organisation promotes the SRH needs and rights of all people.
Good practice standard 3	The people most affected by HIV and SRH problems are meaningfully and consistently involved at all stages of the project cycle.
Good practice standard 4	Our organisation promotes and/or delivers sexuality education that is comprehensive, increases knowledge, self-esteem and skills, and is socially and culturally context-specific and tailored to people's needs.
Good practice standard 5	Our organisation promotes and/or provides information, education and counselling on HIV that is integrated with reproductive concerns and options.
Good practice standard 6	Our organisation promotes and increases uptake of the essential elements of prevention of parent-to-child transmission.
Good practice standard 7	Our organisation promotes and/or provides sexually transmitted infection (STI) education, diagnosis, and treatment, and condoms.
Good practice standard 8	Our organisation promotes and refers users to quality, user-friendly services whenever feasible rather than setting up parallel services. We collaborate with and build the capacity of service providers to better meet the needs of our beneficiaries.
Good practice standard 9	Our organisation works with others to promote and/or implement programmes that address gender and sexuality as an integral component of the SRH and HIV response.
Good practice standard 10	In collaboration with others, our organisation promotes and/or provides interventions to address gender-based and sexual violence and abuse in its HIV and SRH response.
Good practice standard 11	Our organisation has a policy and programme to address stigma and discrimination, which undermine protective behaviours and act as barriers to accessing SRH and HIV services and support.

International HIV/AIDS Alliance (2010), *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*. Available at: www.aidsalliance.org/resources/287-good-practice-guide-hiv-and-sexual-and-reproductive-health

Technical area C: Integration of HIV and sexual and reproductive health and rights

Standard C1	Our organisation promotes the linking and integration of sexual and reproductive health and rights and HIV in policies, programmes and services
Standard C2	Our organisation promotes and/or provides information and services for dual protection (STI/HIV prevention that is integrated with voluntary family planning to protect against unintended pregnancies and STI/HIV)
Standard C3	Our organisation promotes and/or provides comprehensive information and services for prevention of vertical HIV transmission
Standard C4	Our organisation promotes and/or provides education, testing and treatment for sexually transmitted infections, either directly or through referrals
Standard C5	Our organisation ensures client satisfaction and quality of integrated services

International HIV/AIDS Alliance (2014), *Accreditation Standards Guidance Cycle II.* Available at: www.aidsalliance.org/resources/336-alliance-accreditation-system

Introduction to the guide

The goal of this facilitator's guide on HIV and sexual and reproductive health and rights (SRHR) integration is to present a four-day workshop to develop a common understanding on how to integrate HIV and SRHR in order to improve the response of Alliance programmes to HIV. The guide is to be used hand in hand with the Alliance *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*.

Objectives

The workshop is intended to:

- provide a platform for cross-organisational and cross-country exchange and learning on implementing HIV and SRHR integration at programme, policy and organisational levels
- provide practical skills, knowledge and understanding to national and regional partners on integrating HIV and SRHR in programming and advocacy
- provide a forum for learning and sharing of tools, strategies and experiences on SRHR and HIV integration
- familiarise participants with the Alliance's evidence-based resource materials on SRHR
- identify opportunities for advancing HIV and SRHR integration within Linking Organisation programmes in order to meet the good practice programming standards on SRHR and HIV integration.

This training workshop is designed to be implemented in four days, but it could be adapted to a longer or shorter duration according to the needs, background and number of participants.

Training methods

The workshop uses a variety of participatory training methodologies[1] that enhance acquisition of knowledge and practical skills. Group discussions, interactive lectures, buzz groups, brainstorming, group exercises, case studies, questionnaires and visualisation in participatory methods are some of the methods and materials used. These methods stimulate adult learners and enable the participants to be actively engaged in the learning process.

Workshop programme

The 12 sessions included in this facilitator's guide can be used in different ways to design a skills-building workshop. The example on page 4 shows how they can be used for a four-day regional workshop. Alternative sessions are also suggested for workshops of one, two or three days, which you may adapt according to your timeframe, participant profile and objectives. Facilitators should use these as a guide on how best to use the sessions depending on the time available to conduct the workshop.

Session structure

All sessions are between one-and-a-half and two hours long. Contained in each session description is an outline of the session objectives, duration, steps to be followed, content to be covered and handouts that will guide facilitation. In addition, the guide provides notes for the facilitator, additional reading and handouts for the participants where necessary.

Available at: www.aidsalliance.org/resources/287-good-practice-guide-hiv-and-sexual-and-reproductive-health

Abbreviations

ART	Antiretroviral therapy
IEC	Information, education and communication
IUD	Intrauterine device
MDG	Millennium Development Goal
MNCH	Maternal, newborn and child health
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection

1. For example, International HIV/AIDS Alliance (2006). *All together now! Community mobilisation for HIV/AIDS*. Available at: http://www.aidsalliance.org/publicationsdetails.aspx?id=228

Workshop programme

DAY 1	
DURATION	SESSION
2 hours	**Session 1: Welcome and introductions**
30 minutes	Tea break
2 hours	**Session 2: Understanding integration**
1 hours	Lunch
1.5 hours	**Session 3: Linking sexual and reproductive health and rights and HIV**
15 minutes	Tea break
1.5 hours	**Session 4: Gender and sexuality**
15 minutes	Wrap up
DAY 2	
2 hours	**Session 5: Maternal, newborn and child health and HIV integration**
30 minutes	Tea break
2 hours	**Session 6: Family planning and HIV**
1 hours	Lunch
2 hours	**Session 7: Working with key populations**
15 minutes	Tea break
2 hours	**Session 8: Advocacy and community systems strengthening**
15 minutes	Wrap up
DAY 3	
Approx. 4 hours	**Session 9: Field visit**
1 hour	Lunch
2 hours	**Session 10: Using the guide – case study exercises**
15 minutes	Wrap up
DAY 4	
1.5 hours	**Session 11: Assessing organisational capacity**
15 minutes	Tea break
2 hours	**Session 12: Action planning and next steps** **Evaluation and closing**
1 hour	Lunch/departure

Session 1
Welcome and introductions

Time

2 hours

Objectives

- Welcome participants to the training.
- Give the workshop facilitators and participants an opportunity to get to know each other's names and backgrounds.
- Give participants a chance to express their expectations about the training.
- Familiarise participants with the agenda and objectives of the training.

Materials

- Markers, flipcharts, tape
- Copy for each participant of workshop programme, goals, and objectives

Step-by-step instructions

Step 1: Welcome and introductions

45 minutes

1. Welcome the participants to the training. Introduce yourself and the facilitation team. Explain the background, organisations and other relevant details of the facilitation team.

2. To start to get to know each other, ask each participant to share their:
   - name, country and type of work
   - experience in integration, if any
   - expectations for the workshop.

   Write the participants' expectations on a flipchart.

3. Assure participants that expectations will be monitored and evaluated throughout the training. Make sure that any misconceptions about the training are corrected before continuing.

4. Make a presentation on the Alliance and its work in the region as an introduction to the training.

5. **Training goals and objectives**

   Provide an overview of the workshop by presenting:
   - workshop goals, objectives and expected outcomes
   - evaluation methodologies
   - workshop programme.

6. Distribute copies of the workshop programme and briefly explain what will be covered on each day. Invite participants to share their thoughts about the schedule, including on any important issues that may be missing.

7. **Ground rules**

   Explain to the group that for the workshop to be enjoyable and successful for everyone, and for the objectives to be achieved, it is useful to agree on some ground rules. Suggest rules they may like to include, such as:
   - active participation
   - respect for each other's opinions
   - keeping to time
   - having cell phones on silent.

   Explain any logistical issues (for example, daily starting and ending times, where to find bathrooms, time and place for tea and lunch breaks, travel details) and any other concerns related to the training.

Step 2: Setting the scene

60 minutes

Interactive presentation

1. Explain that you will now set the context of the training by making a presentation and guiding a discussion on the global, regional and localised context of HIV and SRHR.
2. Describe the evolution of International Conference on Population and Development (ICPD) goals, Millennium Development Goals (MDGs), Maputo Plan of Action and other international commitments related to SRHR and HIV. Provide an overview of national implementation efforts towards these commitments.
3. Provide an overview/situational analysis of current SRHR and HIV initiatives, government programmes and policies that influence access to services in the region or country.
4. End the session by asking participants to state some of the SRHR and/or HIV challenges they face in their work. Write their responses on a flipchart. Go through the list and explain that the training will address most but not all of these issues. Tape up the flipchart in the room and inform participants that this will be used as a reminder for their group work on Day 4 (Session 12: Action planning and next steps).

Step 3: Wrap up

15 minutes

1. Wrap up by summarising the key messages that have been highlighted during the session (see below for examples).

Key messages

- The International Conference on Population and Development (ICPD) marked a critical shift in the focus of population programmes in order to meet the reproductive health needs of individuals and couples throughout the life cycle. Implicit in this rights-based approach is the idea that every person counts.
- There are no formal MDG outlining targets for SRHR. However:
  - improved SRH directly underpins goals 3–8
  - improved SRH indirectly affects goals 1 and 2.
- In Step 2 it is important to tailor the presentation according to the composition of participants. If several countries are represented, build in time during the discussion to compare and contrast SRHR and HIV concerns.
- Facilitators should discuss the link between SRHR and all the MDGs rather than just goals 4 to 6. To facilitate this, ask participants to reflect on the different components of SRH. Facilitators should emphasise some of the components that are given little focus, such as cancers of the reproductive tract and management of infertility. This also allows participants to examine the components of SRHR throughout the life cycle of an individual, rather than just the child-bearing years that most programmes typically focus on.

- Be sure to discuss the components of SRH, including:
  - family planning
  - safe motherhood and newborn/child survival
  - safe abortion and post-abortion care
  - prevention, testing and treatment of STIs and HIV
  - addressing gender-based violence
  - promoting youth-friendly services
  - protecting and enhancing infertility
  - supporting a satisfying sexual life
  - gender issues and promoting sexual and reproductive rights
  - men's involvement
  - female genital cutting/mutilation
  - cancers of reproductive organs
  - voluntary medical male circumcision.
- The good practice programming standards for SRHR and HIV integration, now part of the Alliance accreditation tool, defines the Alliance's approach to HIV and SRHR programming, and refer to tools that define good practice for specific interventions or ways to assist in implementing these standards.

Additional resources for facilitators

- International Conference on Population and Development (ICPD) Programme of Action, 1994, adopted by the United Nations. Available at: www.unfpa.org/public/icpd
- The United Nations Millennium Development Goals, 2000, adopted by the United Nations. Available at: www.un.org/millenniumgoals/bkgd.shtml
- Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010, 2006, adopted by the African Union. Available at: www.unfpa.org/africa/newdocs/maputo_eng.pdf
- International HIV/AIDS Alliance (2010), *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*. Available at: www.aidsalliance.org/publicationsdetails.aspx?id=507

Session 2
Understanding integration

Time

2 hours

Objectives

- Define the terms 'integration' and 'linkages', and related terms.
- Describe the rationale, evidence and challenges of integrating SRHR and HIV programmes.
- Introduce key principles governing SRHR and HIV linkages.

Materials

- Handout 1: *Sexual and reproductive health and HIV: a framework for priority linkages* (page 45)
- Flipchart, markers, note cards, tape

Good practice standard 1 and accreditation standard C1: Our organisation promotes the linking and integration of SRHR and HIV in policies, programmes and services.

Step-by-step instructions

Step 1: Introduction

5 minutes

1. Introduce the objectives of the session.

Step 2: Buzz group exercise 1

20 minutes

1. Write the word 'integration' on one flipchart and 'linkages' on another. Ask participants to pair up with the person next to them, and in 5 to 10 minutes discuss their understanding of both terms. Ask participants to write down their definitions on two separate coloured note cards and ask them to stick them on the appropriately labelled flipchart.
2. In plenary, discuss some of the common themes that arise from the note card definitions and ask participants if they agree with the definitions.

Step 3: Introduction to integration

60 minutes

1. Explain that in this session, you will start by defining the different terms related to integration to ensure a common understanding by all participants.
2. **Buzz group exercise 2**

   Once participants have a shared understanding of 'integration' and 'linkages', ask participants to go back into their buzz groups and answer the following question:

   - *What common characteristics do SRHR and HIV share?*

   Write their responses on a flipchart.
3. Using these participant responses, continue the session by now discussing **the rationale for integration and linkages of SRHR and HIV services**:
   - SRHR and HIV have similar characteristics, target populations and desired outcomes.
   - Both SRHR and HIV mainly serve reproductive-age populations.

- Sexual and reproductive ill health and HIV share root causes, including poverty, gender norms and inequality, cultural norms and social marginalisation.
- Both SRHR and HIV have common desired outcomes, such as improved quality of life, gender equality and a reduction in maternal, newborn and child mortality.
- Both SRHR and HIV rely on community participation to address sensitive sexuality issues and socio-cultural determinants of behaviour change
- The majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding.
- The risk of HIV transmission and acquisition can be further increased by the presence of certain STIs.
- Both SRHR and HIV are interested in addressing vulnerability, focus on behaviour change and use similar behaviour change communication channels.
- In resource-poor settings, both SRHR and HIV are typically offered through decentralised public health services.

4. Ask participants how integrated services can be offered, and then present the different approaches to integration:

- **One-stop shop** provision of comprehensive and integrated services, such as drop-in centres or clinics that provide HIV services (HIV counselling and testing, prevention, care and treatment) with SRH services (family planning, STI, prevention of vertical transmission of HIV[2], maternal, newborn and child health (MNCH), safe abortion) – for example, the Kenya AIDS NGOs Consortium's (KANCO) sex worker drop-in centre.
- **Referrals** approach, whereby an HIV service (community or clinic based) provides information and referrals for a SRH service. For example, the Network Support Model in Uganda trains people living with HIV to improve access to prevention, care, treatment and support. It offers community-based palliative care, adherence counselling and HIV prevention. Some are selected as network support agents who accompany and empower people living with HIV to use existing government community-based wrap-around health services, including family planning, vertical transmission and STIs.

Use examples to illustrate the difference in these approaches. Also present entry points, and the evidence for and benefits of integration.

- In plenary, ask participants to discuss what they think are some of the key challenges of integration, and record these on a flipchart. The list should include:
  - setting priorities
  - phasing in implementation
  - ensuring referrals to quality service providers
  - staff training and burnout
  - advocacy for SRHR services
  - wrap-around services
  - stigma and discrimination.

  Explain that through group work and looking at case studies, participants will learn how best to address the challenges they have just discussed.

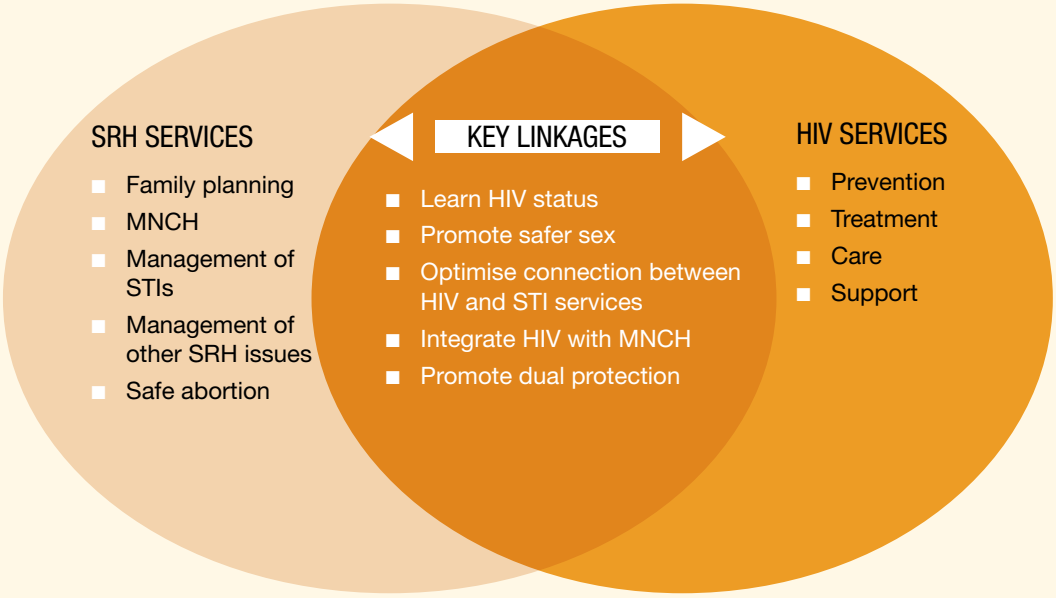
2. Prevention of vertical transmission of HIV, also known as prevention or elimination of mother-to-child transmission (PMTCT or eMTCT), refers to interventions to prevent transmission of HIV to an infant during pregnancy, labor and delivery, and/or during breastfeeding.

Step 4: Framework for priority linkages

30 minutes

1. End the session by distributing Handout 1: *Sexual and reproductive health and HIV: a framework for priority linkages*.

A framework for priority linkages



Source: Adapted from WHO (2005), *Sexual and reproductive health and HIV/AIDS: a framework for priority linkages.*

2. Spend some time discussing the five key linkages:
   - Learn HIV status
   - Promote safer sex
   - Optimise connection between HIV and STI services
   - Integrate HIV with MNCH
   - Promote dual protection from HIV, STIs and unintended pregnancies.

Key messages

- Participants often have some confusion or difficulty understanding that 'integration' and 'linkages' have different meanings.

  Linkages: refers to the policy, programmatic, services and advocacy synergies between SRH and HIV. Linkages also involve addressing the social and structural issues that make people vulnerable to sexual and reproductive ill health and HIV.

  Integration: refers to different kinds of SRH and HIV interventions and services that can be joined together to enhance outcomes.

  Bi-directional integration and linkages mean that SRH components can be linked to HIV programmes, and HIV components can be linked to SRH programmes.

- Facilitators should use the list of challenges to integration that participants developed to ensure that all future examples, case studies and group work will address most, if not all, of their concerns.
- In addition to the four key linkages points, facilitators should also emphasise **dual protection as a key feature of HIV prevention**.

Additional resources for facilitators

- WHO, UNFPA, UNAIDS, IPPF (2005), *Sexual and reproductive health and HIV/AIDS: a framework for priority linkages*. Available at: www.who.int/reproductivehealth/publications/linkages/HIV_05_5/en/index.html
- WHO (2010), *Making the case for interventions linking sexual and reproductive health and HIV in proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria*. Available at: http://whqlibdoc.who.int/hq/2010/WHO_RHR_10.02_eng.pdf

Session 3
Linking sexual and reproductive health and rights and HIV

Time

1 hour 30 minutes

Objectives

- Define 'human rights', 'reproductive rights' and 'sexual rights'.
- Describe SRHR.
- Understand conventions and laws that support SRHR for all people.
- Describe the rights-based approach.

Materials

- Flipchart, markers
- Copies of the IPPF *Charter on Sexual and Reproductive Rights* (page 13)

Good practice standard 2: In collaboration with others, our organisation promotes the SRHR needs and rights of all people.

Accreditation standard 31: Our organisation is committed to a human rights-based approach.

Accreditation standard C5: Our organisation ensures client satisfaction and quality of integrated services.

Accreditation standard A2: Our programmes are designed to build the capacity of both rights holders and duty bearers to claim their rights and to promote, protect and respect the rights of others.

Step-by-step instructions

Step 1: Introduction

1. Introduce the objectives of the session.

Step 2: Overview of human rights and SRHR

20 minutes

1. Begin the session by introducing the four principles of human rights to participants:
   - **Universal** – human rights are applicable everywhere and at all times.
   - **Interdependent and interrelated** – all rights are linked; for example, the right to education is linked to the right to health, and vice versa.
   - **Accountability** – countries and individuals have a responsibility to promote and respect human rights, as well as report violations.
   - **Indivisible** – all rights must be fulfilled, with the exemption of none.
2. Lead a presentation and discussion on SRHR, highlighting the fact that SRHR are part of the vast field of human rights as contained in various national and international rights documents.

Step 3: IPPF Charter on Sexual and Reproductive Rights

60 minutes

1. Group exercise: Ask participants to pair up and distribute copies of the International Planned Parenthood Federation's (IPPF) *Charter on Sexual and Reproductive Rights* (see page 13). Inform participants that this is IPPF's response to the challenge of applying internationally agreed human rights language to SRHR issues. Depending on the size of the group, assign each group at least 2 of the 12 rights, and ask them to discuss the following questions:

IPPF Charter on Sexual and Reproductive Rights

1. The right to life
2. The right to liberty and security of the person
3. The right to equality and to be free from all forms of discrimination
4. The right to privacy
5. The right to freedom of thought
6. The right to information and education
7. The right to choose whether or not to marry and to found and plan a family
8. The right to decide whether or when to have children
9. The right to health care and health protection
10. The right to the benefits of scientific progress
11. The right to freedom of assembly and political participation
12. The right to be free from torture and ill treatment

- *What does this charter/right mean to you?*
- *Is this is in conflict with local tradition and practices?*
- *In what ways can it be used for the integration of SRHR and HIV?*

2. Ask participants to nominate one member to feed back the discussion to the whole group (approx. 5 minutes per group). Facilitate a larger interactive session. You might not have enough time to cover the discussions of all 12 rights, so you might have to select a few key rights as appropriate to the profile of the participants.

Step 4: Wrap up

10 minutes

Key messages

- If people, especially those form key populations and women and girls, are not aware of their human rights, they cannot take appropriate steps to access them, and thereby reduce negative health outcomes such as HIV infections and unsafe abortions.
- Service providers and policymakers play a significant role in ensuring that men and women are aware of their rights and are able to access services.

Additional resources for facilitators

- IPPF Charter on Sexual and Reproductive Rights. Available at: www.ippf.org/resource/IPPF-Charter-Sexual-and-Reproductive-Rights-Guidelines
- International HIV/AIDS Alliance (2010), *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*. Available at: www.aidsalliance.org/resources/287-507-good-practice-guide-hiv-and-shrh

Session 4
Gender and sexuality

Time

1 hour 30 minutes

Objectives

- Understand the concept of gender.
- Describe how gender inequalities influence SRHR programming (accessibility, range, commodities) and HIV prevention, care and treatment.
- Understand the basic concept of sexuality.
- Recognise the centrality of sexuality in HIV.

Materials

- Flipchart, markers, tape
- Handout 2: *Alliance values statement on our work with women and girls* (page 46)

Good practice standard 9: Our organisation works with others to promote and/or implement programmes that address gender and sexuality as an integral component of the SRH and HIV response.

Good practice standard 10: In collaboration with others, our organisation promotes and/or provides interventions to address gender-based and sexual violence and abuse in its HIV and SRH response.

Accreditation standard 33: Our organisation promotes the human rights of women, men, other gender identities and those of all sexual orientations by transforming gender relations and reducing inequality.

Step-by-step instructions

Step 1: Introduction

1. Introduce the objectives of the session.

Step 2: Concept of sexuality

30 minutes

Brainstorming exercise

1. Write the word 'sex' in the middle of the flipchart or whiteboard and make a circle around it. Ask participants to say any words that come to mind when they see the word 'sex'. Write their responses on the flipchart.
2. To encourage responses from the group, ask the following questions:
   - *What do people do before intercourse?*
   - *What body parts are important when it comes to sexuality?*
   - *What are the consequences of sex?*
   - *What are different sexual identities?*

   Ensure that both positive and negative responses are brought out and recorded.
3. Explain that most people focus on sex when we talk about sexuality. However, sex is only a small part of sexuality. Sexuality includes feelings, emotions, experiences and consequences. Sexuality is about the total individual, from a physical, spiritual, emotional, social and intellectual perspective.
4. Now link this exercise to the next by asking, "*Why do people have sex?*" Encourage responses by asking, for example:
   - *Why do young people have sex?*
   - *What are some of the benefits of having sex?*

Start a new flipchart and record participants' responses. To end, point out that it is important that we become aware of how and why we ourselves look at sexuality, so we can avoid judging, stereotyping and discriminating against the target beneficiaries we work with.

5. Finally, draw a large circle on a flipchart and divide it into three equal parts. Write each of the following words in each part: 'physical', 'psychological', 'sociocultural'.
6. Ask the participants to think about which of the three aspects carries more weight in controlling the decisions they themselves make regarding sex.
7. End this session by discussing the different answers that participants give.

Step 2: Concept of gender

30 minutes

1. On a flipchart, draw a line down the middle. On one side write the word 'man' and on the other write 'woman'. Starting with one column (for example, 'man'), ask participants for words that describe physical and personality traits, abilities and roles. Develop a list. When complete, repeat for the other column.
2. Ask participants for some general commonalities and trends that they observe looking at the two lists.
3. Now present information on gender and sexuality, and show the linkages between these and HIV programming. Make this an interactive discussion, and let participants ask questions and contribute.
4. In the discussion make sure you reference responses to gender as outlined in the Alliance *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights* (pages 41–2):
   - **Do not harm** – for example, prevention of mother-to-child transmission versus parent-to-child transmission or vertical transmission. (see box on page 19 for more information).
   - **Gender sensitive** – different needs of women, men and transgender people; for example, condom negotiation and assumptions about orientation.
   - **Gender transformative** – support for gender equity for all people; for example, femininity/masculinity, prejudice against gender and diversity.
   - **Empowering** – equalise the balance of power between the genders; take away guilt and shame around positive sex.

Step 3: Sexual identity and diversity

25 minutes

1. Make a presentation on sexual identity and diversity. Focus on the three key points below:
   - Sexuality is about 'identity' and 'activity'. Identity refers to who we are, how we feel and how we look at ourselves. Activity refers to how we express our sexuality. Both are critical if we are to enjoy good SRH and wellbeing.

Additional resources for facilitators

- RFSU (2010) Range of materials from the Swedish Organisation for Sexual Enlightenment. Available at: www.rfsu.se/en/
- International HIV/AIDS Alliance (2011), *Approaches to gender and sexuality: responding to HIV*. Available at: www.aidsalliance.org/assets/000/000/741/GenderAndSexualityReport_original.pdf?1406302925

- People often see their identities as belonging to different categories: heterosexual, homosexual, bisexual, asexual, transsexual.
- There are also people who do not completely 'identify' with these categories. Some may engage in behaviours such as male-to-male sex while identifying as heterosexual and being married to a woman.

Key messages

- The aim of this session is to create a shared understanding of the concepts of gender, sex roles, gender roles and identities.
- It is important for us as individuals, as well as professionals, to reflect on our own way of looking at sexuality, and at the same time open up and broaden our views on what sexuality can be for others.
- It is important to differentiate between sexual identities and sexual activities.
- The aim in this session is to show the diversity of issues that can be linked to sexuality, and to open up participants' minds to the different aspects of how we look at sexuality.
- Some key terms and concepts for this session:
  - **Sex** – whether we are male, female or intersex, determined by our organs and genes (biology).
  - **Sexuality** – how humans express themselves as sexual beings.
  - **Gender** – socially constructed roles, behaviours, activities and attributes that a society considers appropriate for men and women.
  - **Gender identity** – how a person sees themselves along a continuum from male to female rather than their biological sex.
- It is important to recognise that gender is a complex concept, as it includes other gender identities and roles that transgress the notion of what is traditionally seen as male and female.
- Gender and sexuality have a fundamental bearing on the course, pace and impact of HIV infection and SRH.
- The different attributes, roles and expectations that societies assign to men, women, girls, boys and other gender identities such as transgender people, and the capacity to express oneself sexually, profoundly affect an individual's ability to protect themselves from HIV and cope with its impact.
- Emphasise the concepts of men's involvement and empowerment of women; men and other gender identities; and the fact that gender roles play themselves out in specific contexts, times and cultures.

Session 5
Maternal, newborn and child health and HIV integration

Time

2 hours

Objectives

- Discuss background and global, regional and local trends in maternal, newborn and child health (MNCH).
- Provide an overview of different components of MNCH.
- Understand the importance of linking MNCH and HIV.
- Describe key interventions and opportunities for MNCH and HIV integration (life cycle continuum of care, 4 prongs of prevention of vertical transmission).

Materials

Flipchart, markers

Good practice standard 6: Our organisation promotes and increases uptake of the essential elements of prevention of parent-to-child transmission.

Intervention 8: Preventing HIV transmission to babies during pregnancy, delivery and after birth.
Intervention 9: Improving maternal and newborn health.
Intervention 10: Treatment of HIV-positive children.

Accreditation standard C3: Our organisation promotes and/or provides comprehensive information and services for prevention of vertical HIV transmission.

Accreditation standard G6: Our organisation promotes a holistic approach to treatment and promotes access to treatment and care to all age groups: paediatrics, adolescents, adults and the aged.

Accreditation standard E1: Our organisation promotes the participation of children in processes that are inclusive and age appropriate.

Accreditation standard E2: Our organisation promotes a family-centred approach to reaching HIV-affected children within and through their families and communities.

Step-by-step instructions

Step 1: Introduction

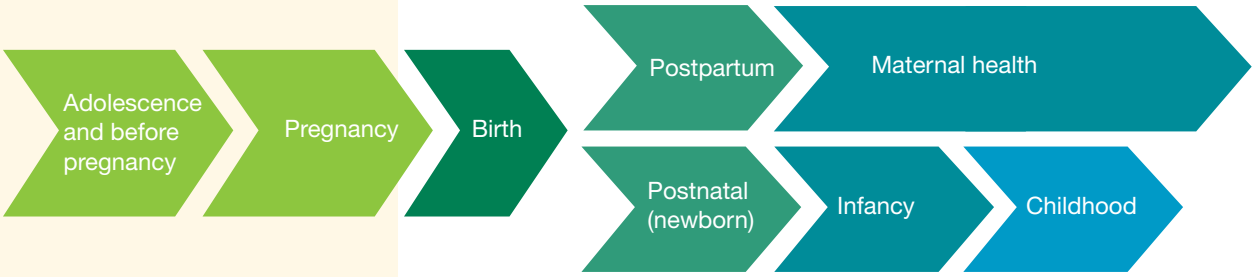
1. Introduce the objectives of the session.

Step 2: An overview of maternal, newborn and child health

30 minutes

2. Explain to participants that you are now going to focus on maternal, newborn and child health (MNCH) by discussing specific interventions, entry points and opportunities for integrating MNCH and HIV. Begin by discussing the impact HIV has on MNCH, women and young girls, and the MDGs (goal 4: reducing child mortality; goal 5: reducing maternal mortality; and goal 6: combating HIV, malaria and other diseases).

3. Follow this with a discussion on the life cycle continuum of care. This refers to integrated service delivery for mothers and children throughout the years from adolescence and before pregnancy, through to pregnancy, birth, postnatal period, infancy and childhood.



The life cycle continuum of care

4. Ask participants to name any opportunities for integration and linkages for MNCH within families, communities and existing health facilities. Write these on the flipchart. The list should include, for example, primary and secondary care, health facilities, antenatal clinics, obstetric care, immunisation clinics, outreach services.

Step 3: Key intervention – comprehensive prevention of vertical transmission of HIV

30 minutes

1. In detail, present the 4 prongs of prevention of vertical transmission as a key intervention for MNCH and HIV integration and relevant services. Discuss the barriers to uptake (for example, community, health services, cultural barriers, policy environment).

4 prongs of prevention of vertical transmission of HIV

1	2	3	4
Primary prevention of HIV among women of reproductive age	The prevention of unintended pregnancies among women and girls living with HIV.	HIV testing and counselling for all pregnant women, with fast referral to antiretroviral therapy (ART), care and support; ART prophylaxis; safer delivery; use of co-trimoxazole for HIV-exposed infants and safer infant feeding. Testing of partners and safer sex promotion, as risk of HIV transmission is very high if partner is recently infected.	Long-term ART for mothers and children living with HIV. Ensure that mothers and children get long-term support with nutrition, prevention of infections, treatment and care.

Step 4: Group work

45 minutes

1. Give participants an example of antenatal care services that also provide HIV and STI counselling, testing and care. Divide the participants into four groups and ask them to identify the specific advantages of integrating these services at the following levels, and how the community can engage:

   - **Individual/peer/household** – for example, individual and couple counselling to improve health-seeking behaviour of pregnant women and sero-discordant couples
   - **Community** – for example, awareness-raising through talks/ theatre on HIV to challenge existing social norms.
   - **Services** – for example, training healthcare workers on integrating antenatal care and HIV/STI services.
   - **Policy/structural** – for example, advocacy on budgetary allocation for integrated services for people living with HIV and other key populations.

Step 5: Wrap up

15 minutes

1. Wrap up by summarising the key messages that have been highlighted during the session.
2. For an alternative activity, look at *Understanding barriers to supply, uptake and retention of prevention of vertical transmission* in Appendix 4.

Key messages

- Most HIV infections occur in regions where there are both high fertility and HIV prevalence rates among women, especially in sub-Saharan Africa (see International HIV/AIDS Alliance (2011), *HIV Update: Integrating maternal, newborn and child health into community-based HIV programmes*, page 2)
- Integrated MNCH/HIV interventions include:
  - comprehensive SRHR services for HIV-positive women, including family planning
  - antenatal care services that provide testing for HIV and STIs
  - direct provision of, or referral for, HIV treatment and care for HIV-positive women from antenatal care services
  - prevention of vertical transmission services.
- Some countries now use the term 'prevention of vertical transmission' instead of 'prevention of mother-to-child transmission' to avoid stigmatising the mother. 'Prevention of parent-to-child transmission' is also used to recognise the role of partners/father in transmitting HIV, and encourages male involvement in HIV prevention, care and support for children.
- Discuss why prong 3 (provision of antiretrovirals during pregnancy, birth and breastfeeding) is often mistaken for prevention of vertical transmission as a whole. Stress the importance of the other prongs, particularly the effect that HIV prevention and voluntary family planning can have in the dual protection of preventing unintended pregnancies and HIV/STI transmission.
- Discuss how the group work highlights the different barriers to an individual's uptake and retention throughout the prevention of vertical transmission journey and that, in order to reach a good health outcome for all 4 prongs of comprehensive prevention of vertical transmission, requires interventions at all levels, namely:
  - **Individual/peer/household** – for example, individual, family or couple counselling on prevention of vertical transmission.
  - **Community** – for example, mobilising community members to educate and inform their communities about vertical transmission, family planning, MNCH and HIV.
  - **Service** – for example, training healthcare workers about the unmet needs and rights of pregnant women living with HIV; understanding and challenging stigma; and the benefits of providing client-friendly services.
  - **Policy/structural** – for example, advocacy for policies and laws that promote access to integrated prevention of vertical transmission services; and helping women living with HIV to realise their rights.
- The issues facing the global success of prevention of vertical transmission go beyond clinical components. They are influenced by issues and people's decisions related to social and cultural practice, gender relations and family life.

Additional resources for facilitators

- International HIV/AIDS Alliance (2010), *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*. Available at: www.aidsalliance.org/resources/287-good-practice-guide-hiv-and-sexual-and-reproductive-health
- International HIV/AIDS Alliance (2011), *HIV Update: integrating maternal, newborn and child health into community-based HIV programmes*.
- UNAIDS (2012), *Promising practices in community engagement for elimination of new HIV infections among children by 2015 and keeping their mothers alive*.

Session 6
Family planning and HIV

Time

2 hours

Objectives

- Discuss background and trends in family planning.
- Provide an overview of different methods of family planning.
- Understand the importance of integrating family planning and HIV.
- Describe key interventions and opportunities for family planning/ HIV integration (dual protection, safer conception/ reproductive choices for people living with HIV).

Materials

Flipchart, markers

Good practice standard 4: Our organisation promotes and/or delivers sexuality education that is comprehensive, increases knowledge, self-esteem and skills, and is socially and culturally context-specific and tailored to people's needs.

Good practice standard 5: Our organisation promotes and/or provides information, education and counselling on HIV that is integrated with reproductive concerns and options.

Intervention 1: Safer sex promotion to prevent STIs, HIV and unintended pregnancy.
Intervention 4: Joining up family planning and HIV services.
Intervention 5: Safe abortion and post-abortion care.

Accreditation standard C2: Our organisation promotes and/or provides information and services for dual protection (STI/ HIV prevention that is integrated with voluntary family planning to protect against unintended pregnancies and STI/HIV).

Accreditation standard C5: Our organisation ensures client satisfaction and quality of integrated services.

Step-by-step instructions

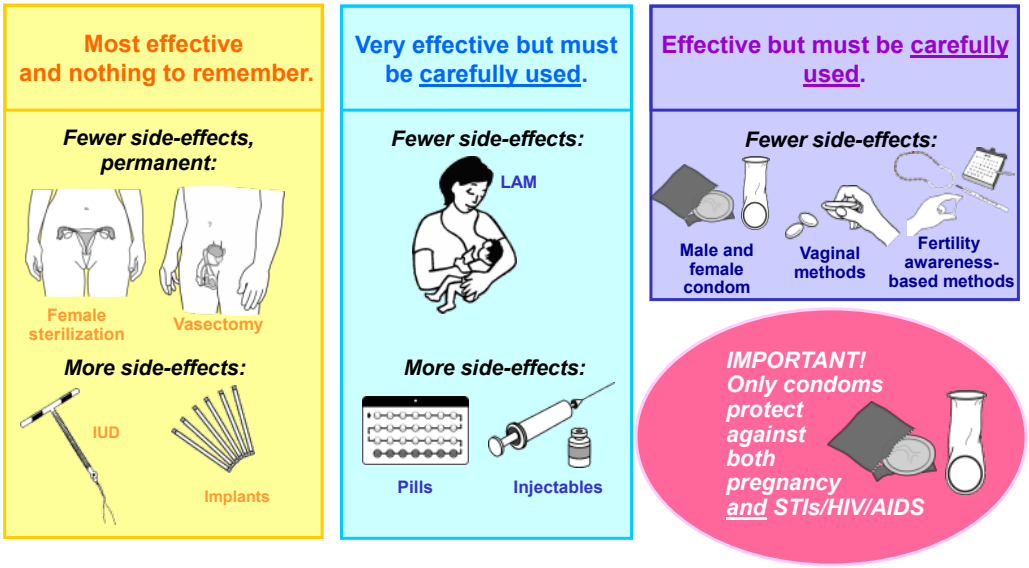
Step 1: Introduction

1. Introduce the objectives of the session.

Step 2: An overview of family planning and links with HIV

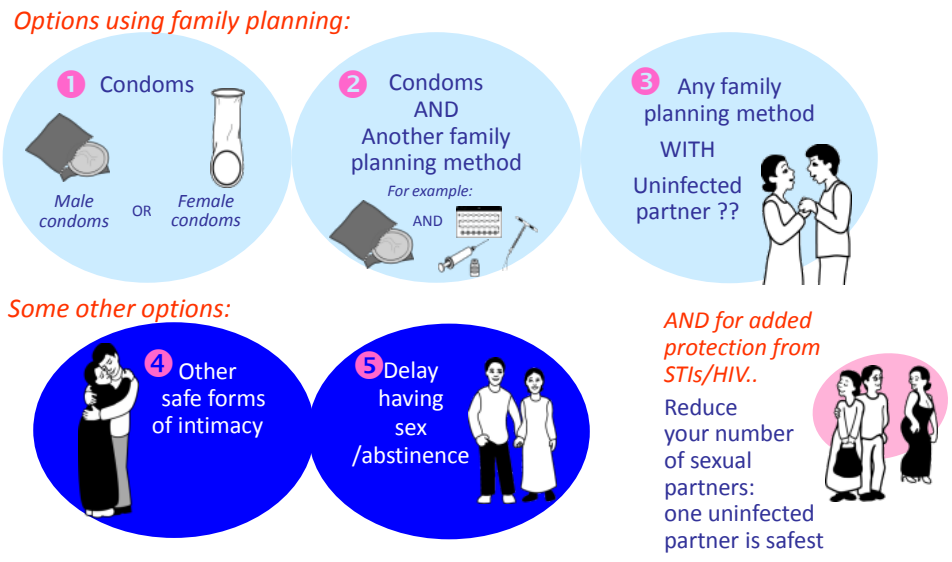
45 minutes

1. Explain to participants that you are going to focus on family planning by discussing specific interventions, entry points and opportunities for integrating voluntary family planning and HIV. Begin by discussing the importance of family planning in:
   - preventing unintended pregnancies
   - avoiding high-risk pregnancies due to maternal age (younger than 15 years or older than 35 years), risky birth spacing (less than two years, or very lengthy) and high parity (too many children)
   - enabling couples to choose how many and when to have children
   - reducing the high unmet need for voluntary family planning
   - reducing the number of maternal and child deaths.
2. Follow this with a discussion on different contraceptive methods, their advantages and disadvantages, and the importance of choosing the right one in terms of the client's:
   - age
   - experiences with family planning
   - knowledge of family planning methods
   - plans for having children



- protection from STIs or HIV
- partner's or family's attitudes
- other needs and concerns.

3. Discuss the diagram above comparing the different methods, and ask participants for their opinions on these. For example:
   - 'Most effective and nothing to remember' – not entirely true for intrauterine devices (IUDs) and implants because they need check-ups, and implants also need to be replaced at some stage. So perhaps better to say, 'Most effective and little or nothing to remember'?
   - 'Very effective but must be carefully used' and 'Effective but must be carefully used'. How about saying instead, 'Must be properly and consistently used'.
4. Continue with a discussion on the importance of **dual protection** and linking voluntary family planning and HIV. For example:
   - Family planning and HIV share many root causes in poverty, gender inequality, stigma and harmful cultural norms.
   - Women of reproductive age represent 40% of people living with HIV.
   - Unmet needs for family planning are often in the same countries where there is higher HIV prevalence; for example, 25% in sub-Saharan Africa.
5. Explain the definition of dual protection, and highlight ways to avoid unintended pregnancies and STI/HIV. Present the slide below and ask for participants' responses.



Pull out key issues related to dual protection. For example:

- It can be difficult it is to know if your partner is uninfected due to a lack of user-friendly HIV counselling and testing services, or their reluctance to take a test or disclose their status due to fear of stigma and discrimination.
- Delay or abstinence can be particularly challenging for young people who wish to explore their sexuality and experience sexual relationships.
- Using condoms as well as an additional contraceptive method in a long-term relationship can be seen as a sign of infidelity or lack of trust in your partner.

Although using condoms and/or using condoms plus another modern contraceptive is the most robust guidance to give, it is important to explore the multiple barriers and risks involved in individual safer sex counselling.

Step 3: Group work

30 minutes

1. Divide participants into small groups. Give them case studies of two women coming into a family planning clinic to get a contraceptive method (this was experienced in a partners' family planning clinic in Tanzania).
   - Married woman, 32 years old, four children, wearing *hijab* in Tanzania.
   - Young women, 20 years old, two small children, regular partner, living in nearby slum in Tanzania.
2. Ask the groups to discuss what contraceptive method they would suggest for these women and why. Give them 10 minutes to discuss and a further 10 minutes to share their answer in plenary.
3. Wrap up the group work discussion by saying that in reality the first woman wanted to use condoms as well as injectables, as her husband is a truck driver and she was not sure that he is faithful. The second woman uses condoms but also wanted to use the pill as an effective contraceptive to avoid pregnancies. Both left only with injectables and no condoms. This highlights the gaps in dual protection counselling and services in family planning, and HIV prevention programming.

Step 4: Discussion on the community role in family planning and HIV

30 minutes

1. Ask participants to identify the role communities and Linking Organisations can play in integrating family planning into HIV services, outreach and policy work. Ask them to think about the role in terms of opportunities within families, communities, existing health facilities and policy work.

   Write down their statements on flipchart paper. Bring out the following roles in discussion:

   - include messages around family planning and dual protection in community awareness-raising and information, education and communication (IEC)

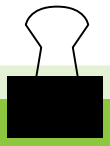
- promote condoms and other non-clinical contraceptives as part of outreach and home visits (community-based distribution)
- make referrals to clinics for clinical contraceptive methods (injectables, implants, IUDs, sterilisation)
- provide information on reduced efficacy of some contraceptives if taking tuberculosis treatment, antiretrovirals, methadone
- advocacy for key population-friendly family planning services, and document cases of denied access or coercive treatment.

Step 5: Wrap up

15 minutes

1. Wrap-up by summarising the key messages that have been highlighted during the session. For more information on family planning and dual protection, suggest that participants look at the Alliance *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*.

For an alternative activity, look at Appendix 4: *Family planning – facts, myths and misconception*.



Key messages

- Family planning is important in preventing unintended pregnancies and enabling couples to choose how many and when to have children. It is prong 2 in comprehensive prevention of vertical transmission.
- People's contraceptive choices and ability to use condoms are influenced by issues related to social and cultural practice, gender relations and family life.
- Most HIV infections occur in regions where there are both high fertility and HIV prevalence rates among women, especially in sub-Saharan Africa (see International HIV/AIDS Alliance (2011), *HIV update: integrating maternal, newborn and child health into community-based HIV programmes*, p.2)
- Dual protection means preventing unintended pregnancy and STIs/HIV. It is prongs 1 and 2 in prevention of vertical transmission. Interventions include:
  - using male or female condoms correctly and consistently in every sexual encounter
  - using male or female condoms and an additional modern contraceptive.
- Communities play a key role in family planning and HIV, as mentioned in Step 4 of the exercise.

Additional resources for facilitators

- International HIV/AIDS Alliance (2010), *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*. Available at: www.aidsalliance.org/resources/287-good-practice-guide-hiv-and-sexual-and-reproductive-health
- International HIV/AIDS Alliance (2011), *HIV update: integrating maternal, newborn and child health into community-based HIV programmes*

Session 7
Working with key populations

Time

2 hours

Objectives

- Clearly define who are key populations in participants' communities and programmes.
- Understand the unmet SRHR needs of key populations, and tailor-make approaches to respond to these through SRHR and HIV integrated interventions and programmes.

Materials

- Flipchart, markers
- Cue cards for the role plays

Good practice standard 11: Our organisation has a policy and programme to address stigma and discrimination, which undermine protective behaviours and act as barriers to accessing SRH and HIV services and support.

Accreditation standard C5: Our organisation ensures client satisfaction and quality of integrated services.

Accreditation standard 33: Our organisation promotes the human rights of women, men, other gender identities and those of all sexual orientations by transforming gender relations and reducing inequality.

Accreditation standard A3: Our organisation holds both state and non-state actors accountable for the enjoyment of all human rights as a core part of all our programmes.

Step-by-step instructions

Step 1: Introduction

1. Introduce the objectives of the session.

Step 2: Group exercise

60 minutes

1. Divide participants into groups of three and ask them to identify who will play client, service provider and observer. In each scenario (see page 25) there is a client from a key population presenting with a SRH problem, and a health worker who has to make the client feel comfortable and respond to their needs. There is also an observer. Allow 10 minutes per discussion.
2. Client and observer read cue cards to themselves, followed by a 10-minute discussion between client and provider. The observer takes note of the interaction and provides constructive feedback at the end of each triad session (five minutes). Swap roles and take the second client/observer cards. Repeat exercise. Swap roles again and take the third client/observer cards.
3. Report back in the plenary on any specific issues that came up, together with reflections on the perspectives of the client, service provider and observer. Highlight any differences that arose due to the clients' age, their risk/vulnerability profile, their SRH needs and the response required from the service provider. This should take 15 minutes.

Step 3: SRHR and HIV with key populations

30 minutes

Presentation on SRHR needs of key populations

1. Key populations have the same SRH needs as the general population, such as family planning, STI, fertility, vertical transmisison. They also have specific issues:

Scenario 1

Client 1: You are a 25-year-old female sex worker who is pregnant. You are attending an antenatal clinic in Quito, Ecuador, for the first time.

Service provider 1: You are an antenatal care nurse based in a clinic on the outskirts of Quito, Ecuador. You have 10 minutes for each consultation.

Observer 1: Did the antenatal care nurse:

- *take a sexual history; for example, number of sexual partners, instances of unprotected sex?*
- *ask if the client had taken an HIV test? If not, did they ask if she wanted to take an HIV test? If client is HIV positive, did they make a referral to prevention of vertical transmission services?*
- *take a moralistic or supportive approach; for example, did they push for abortion or safe motherhood?*
- *ask closed or open-ended questions?*

Scenario 2

Client 2: You are a 20-year-old woman who uses drugs and has just had a baby. You are HIV positive, and are speaking to a social worker before being discharged from hospital or clinic in Kyiv, Ukraine.

Service provider 2: You are a social worker based in a hospital in Kyiv, Ukraine. You are speaking to a mother before she and her baby are discharged. Your records show that your client is HIV positive and uses drugs. You have 10 minutes for each consultation.

Observer 2: Did the social worker explore how the client will:

- *manage the mother and baby's health issues; for example, safe injecting practices, ART, methadone, family planning, HIV prevention, baby's infant feeding and immunisation?*
- *manage social issues for the mother and baby; for example, family/parenting support, housing, financial support?*
- *take a moralistic or supportive approach?*
- *ask closed or open-ended questions?*

Scenario 3

Client 3: You are a 20-year-old woman living with HIV in Tanzania. You and your partner would like to have a child.

Service provider 3: You are an ART adherence counsellor based in a community clinic in Mwanza, Tanzania. You have 10 minutes for each consultation.

Observer 3: Has the counsellor:

- *made a judgement on whether the client should have a child or not?*
- *checked is she is in a sero-discordant couple (where one partner is living with HIV and the other is not)? If so, has the counsellor mentioned prevention of vertical transmission options and safer conception methods?*
- *talked through all the implications, such as the client's physical health, CD4 count and adherence to ART, and invited the partner in for couple counselling to discuss options such as treatment as prevention for sero-discordant couples?**
- *mentioned follow up or referrals to specialist services?*

Scenario 4

Client 4: You are a 35-year-old man who is married with two young children. You also regularly have sex with other men. You are speaking to the provider about anal lesions/warts and getting tested for STIs.

Service provider 4: You are a SRH nurse working in Johannesburg, South Africa. Your records show that your patient has never had an HIV test.

Observer 4: Did the provider:

- *discuss the importance of dual protection and disclosure/sexual history with sexual partners?*
- *mention support services for men who have sex with men, and a possible referral to these services?*
- *discuss the link between STIs and increased HIV transmission?*
- *take a moralistic or supportive approach?*
- *ask closed or open-ended questions?*

* WHO (2012), *Antiretroviral treatment as prevention (TASP) of HIV and TB: programmatic update*. Available at: www.who.int/hiv/pub/mtct/programmatic_update_tasp/en/index.html

Additional resources for facilitators

- UNAIDS, *Know your epidemic and modes of transmission*. Available at: http://www.unaidsrstesa.org/thematic-areas/hiv-prevention/know-your-epidemic-modes-transmission
- *UNAIDS terminology guidelines, revised 2011*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf
- *What works for women and girls: evidence for HIV/AIDS interventions*. Available at: http://www.whatworksforwomen.org
- International HIV/AIDS Alliance and Global Network of People living with HIV (2010), *Good Practice Guide: Greater Involvement of People Living with HIV*. Available at: http://www.aidsalliance.org/publicationsdetails.aspx?id=464

- Sex workers experience menstruation problems, higher levels of sexual and gender-based violence, unintended pregnancies, unsafe abortions, STIs and HIV.
- Men who have sex with men experience higher levels of STIs and HIV, and lack of dual protection if they have female partners.
- People living with HIV experience higher levels of sexual and gender-based violence, unintended pregnancies, unsafe abortions, forced sterilisation and fertility problems.
- Transgender people experience higher levels of sexual and gender-based violence, STIs and HIV, unsafe surgery and silicone injections.

2. Key populations experience a greater vulnerability. For example:
   - stigma, discrimination and criminalisation of same-sex couples, transgender identities, sex work, drug use, and HIV status
   - lack of information and services that integrate SRHR with HIV, STIs or harm reduction.
3. SRHR good practice standards. All are relevant, but especially:
   - Gender and sexuality approach (Standard 9)
   - Upholding the SRHR of those most affected (Standard 2)
   - Meaningful involvement of those most affected, including key populations (Standard 3)
   - Addressing stigma and discrimination (Standard 11)

Step 4: Key populations

30 minutes

1. In small groups, ask participants to spend 15 minutes discussing the following:
   - *What is their understanding of the term 'key populations'?*
   - *Who are the key populations in their communities? Do they work with any of these populations?*
   - *What are their SRHR and/or HIV needs, and are they being addressed?*
   - *What role could you play in promoting work with key populations on SRHR and HIV-related issues?*
2. Ask groups to report back on their discussions.

Step 5: Wrap up

1. Wrap-up by summarising the key messages that have been highlighted during the session.

Key messages

- Key populations are at higher risk of being infected or affected by HIV, and are key to the dynamics of, and responses to, HIV epidemics.
- Key populations primarily include men who have sex with men, sex workers, transgender people, people who use drugs, prisoners and people living with HIV. There are sometimes overlaps between these groups and the associated HIV risks. Pockets of high prevalence exist among key populations in generalised epidemics.
- It is estimated that 5 million people aged 15–24, and 2 million adolescents aged 10–19 were living with HIV in 2009. Globally, young women represent more than 60% of all young people living with HIV, and in sub-Saharan Africa this increases to 72%. However, the SRH needs and rights of young people affected by HIV are not being met. Evidence shows that strong, youth-friendly SRH and HIV interventions can increase uptake; lead to lower rates of early pregnancy, abortion and STIs; and offer greater social protection and parental guidance for vulnerable young people.

Session 8
Advocacy and community systems strengthening

Time

2 hours

Objectives

- Identify gaps and opportunities for integration in the policy environment.
- Map out the different roles and responsibilities among community members, policymakers, programme managers and service providers on integration and linkages.

Materials

Handout 4: *Advocacy and related concepts* (page 50)

Good practice standard 3: The people most affected by HIV and SRH problems are meaningfully and consistently involved at all stages of the project cycle.

Good practice standard 11: Our organisation has a policy and programme to address stigma and discrimination, which undermine protective behaviours and act as barriers to accessing SRH and HIV services and support.

Accreditation standard 36: Our organisation is committed to ensuring the participation of those populations intended to benefit from programmes at all stages of the programme cycle.

Accreditation standard 32: Our organisation is committed to the effective implementation of the Greater Involvement of People Living with HIV (GIPA) principles.

Step-by-step instructions

Step 1: Introduction

1. Introduce the objectives of the session.

Step 2: Introduction to advocacy

20 minutes

1. In pairs, ask participants to quickly brainstorm and answer the following questions:
   - *What is advocacy?*
   - *Why do we advocate?*
   - *How do we advocate?*
2. It is important to have a clear understanding of the differences between advocacy and other related concepts (IEC and behaviour change communication (BCC), community mobilisation, networking). Discuss these with participants using Handout 4: *Advocacy and related concepts*.

Example definitions of advocacy

"Advocacy is a process to bring about change in the policies, laws and practices of influential individuals, groups and institutions that hamper an effective integrated HIV/SRHR response."
(adapted from an advocacy skills-building workshop, Alliance, Zimbabwe, July 2001)

"Advocacy is an ongoing process aiming at change of attitudes, actions, policies and laws by influencing people and organisations with power, systems and structures at different levels for the betterment of people affected by the issue." (adapted from an advocacy skills-building workshop, India HIV/AIDS Alliance, India, November 2002)

Example definitions of advocacy (cont.)

"Advocacy is an action directed at changing the policies, positions and programmes of any type of institution."
(*An introduction to advocacy: training guide*, SARA Project)

"Advocacy is pleading for, defending or recommending an idea before other people."
(*An introduction to advocacy: training guide*, SARA Project)

Source: International HIV/AIDS Alliance, (2003), *Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS.*

Step 3: Group exercise

60 minutes

1. Give participants an example of the mobilisation of married couples to prevent and treat HIV in parents and babies.
2. In small groups, ask them to discuss the following questions:
   - *What is the problem?*
   - *Who should advocate to address the problem?* (For example, give brief details of the non-governmental organisations or community groups involved, including any people directly affected by the issue.)
   - *What should be the advocacy objective at national or local level?* (For example, improving the policy environment that supports and promotes male involvement in prevention of vertical transmission and SRH services.)
   - *Who should they advocate to?*
   - *Who could be their potential allies?*
   - *What advocacy platforms could they use or need to create?*
   - *What methods can be used?*
   - *Is there a need for building capacity in advocacy, and among whom?*
   - *What potential difficulties and barriers might be faced?*
   - *How can these be overcome?*
   - *What are the intended results of the advocacy effort?*
   - *What sources of assistance/support would be most helpful?*
   - *What can be learned from doing this advocacy?*
3. Report back to plenary and hold a larger discussion with the whole group on these questions.

Step 3: Community systems strengthening

45 minutes

1. Ask participants the following questions:
   - *What is the role of the community in integrated programmes?*

   Make sure they think about the individual/peer/household, community, service and policy/structural levels.

   Now lead the participants in an interactive discussion on these questions, noting any points that may be used to inform Session 12: Action planning and next steps on Day four.

2. Briefly make a presentation on the community systems strengthening framework, highlighting the six core components of community systems:
   - Enabling environments and advocacy
   - Community networks, linkages, partnerships and coordination
   - Resources and capacity-building
   - Community activities and service delivery
   - Organisational and leadership strengthening
   - Monitoring and evaluation, and planning.

Now lead an interactive discussion using the example of the 'mobilisation of couples to prevent and treat HIV in parents and babies' from page 46 of the *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights* to emphasise these six core areas.

Step 4: Wrap up

1. Wrap up by summarising the key messages that have been highlighted during the session.

- As most participants are likely to work primarily in programme and advocacy interventions, it is important to stress the difference between programme and advocacy objectives:
  - The **primary audience** includes decision-makers with the authority to directly affect the outcome of your advocacy objective. These are the individuals who must actively approve the policy change. These decision-makers are the primary 'targets' of an advocacy strategy.
  - The **secondary audience** includes individuals and groups that can influence the decision-makers (or primary audience).
- Make sure the group understands that advocacy can be achieved at different levels: local, national and international. These are levels where the power or influence lies, rather than necessarily where the advocates are working.
- Encourage participants to discuss their own advocacy work. Be aware that they may have different understandings of what advocacy is. Note these differences and explore them during the workshop.
- **Strengthening community systems**, including community organisations and networks, leads to improved outcomes for interventions dealing with major health challenges such as HIV and SRHR, including MNCH. It is an approach that promotes the development and sustainability of communities and community organisations and actors, and enables them to contribute to the long-term sustainability of health and other interventions at community level.
- **Links between health systems strengthening and community systems strengthening**

  In order for integrated services to be effective and access people who are not currently reached, there needs to be better links between community providers of SRHR and HIV care and professionals within health institutions. These linkages should be strengthened through:
  - wider community participation in design and implementation of HIV programmes

- better institutional structures that enable transfer of knowledge from highly educated health workers to community health workers
- better referral systems between community-based organisations and formal health institutions
- formalised partnerships between civil society and the public and private health sector.

Integration of informal (community) and formal health systems can increase efficiency, reduce staff overload, increase awareness and uptake of services, and enhance community mobilisation and participation – a critical enabler in the HIV response.

- **Community mobilisation**

  The process should ensure that those most affected, such as people living with HIV and key populations, are actively involved in the community responses. This is because:

  - they have expert knowledge of the problem
  - they can suggest solutions based on their experience and perspective
  - they are often highly motivated
  - it reduces stigma towards those most affected.

Additional resources for facilitators

- International HIV/AIDS Alliance (2003), *Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS*. Available at: www.aidsalliance.org/resources/252-advocacy-in-action-a-toolkit-to-support-ngos-and-cbos
- International HIV/AIDS Alliance and ICASO (2010), *Measuring up: a guide for facilitators. HIV-related advocacy evaluation training for civil society organisations*. Available at: www.aidsalliance.org/resources/340-measuring-up-hivrelated-advocacy-evaluation-training-pack

Session 9
Field visit

Time

4 hours

Objective

Identify good practices for integration, any gaps and barriers, and entry points and opportunities for integration in specific settings.

Examples of possible sites

- Sex worker programme/clinic or referrals
- Network of people living with HIV
- Community-based organisation or network, and referrals for services for men who have sex with men
- Comprehensive youth-friendly clinic
- MNCH unit with prevention of vertical transmission services.

Good practice standard 11: Our organisation has a policy and programme to address stigma and discrimination, which undermine protective behaviours and act as barriers to accessing SRH and HIV services and support.

Accreditation standard 31: Our organisation is committed to a human rights-based approach

Accreditation standard 38: Our organisation prioritises communities most affected by HIV and its HIV programmes are tailored to meet their needs.

Step-by-step instructions

Step 1

Introduce the objectives of the visit, including logistics and background information on the site(s).

Step 2: Field visit

1. Selection of an appropriate site visit is dependent on factors such as prevailing SRHR and HIV environment (key populations, people living with HIV, young people, general population and so on). Selection also depends on the make-up of the group. Are participants primarily working in HIV? In that case, it may be useful to visit a site whose primary focus is HIV but has included SRHR and other health components.

2. Participants should have guiding questions to inform discussion, Q&A and observations during the visit. For example:
   - *What SRHR interventions/services are implemented?*
   - *What HIV interventions/services are provided?*
   - *What SRHR and HIV interventions are integrated?*
   - *What gaps/barriers exist as challenges?*
   - *What are the opportunities and entry points for integration?*
   - *How are they ensuring sustainability (financial and human resources, commodities and so on)?*
   - *What is the level of community involvement, and in which activities?*
   - *How is the programme addressing stigma and discrimination in the community and among service providers?*
   - *How do they measure and assure the quality of the services they provide and refer their clients to?*

3. It may be useful to divide the participants into groups and suggest that each group focuses on certain questions.

4. Ensure you build in time for a field visit debrief as a larger group to discuss observations. It might also be possible to come up with recommendations that participants can share with the site managers.

Session 10
Using the guide – case study exercises

Time

2 hours

Objectives

- Become familiar with the Alliance's evidence-based resource materials on SRHR.
- Provide an overview of the Alliance approach to SRHR and HIV linkages and integration.
- Demonstrate in a practical manner how the guide may be used in designing, implementing and evaluating participants' own programmes.

Materials

- International HIV/AIDS Alliance (2010), *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*
- Handout 5: *Case studies* (page 51)

Step-by-step instructions

Step 1: Introduction

1. Introduce the objectives of the session

Step 2: Working practically with Alliance resources

30 minutes

2. Introduce the *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights* and an overview of the Alliance approach to SRHR and HIV linkages and integration. Explain to participants that they will now work with the guide and other resources in a practical manner to demonstrate its potential in designing, implementing and evaluating their own programmes and services.

3. Begin by making a presentation on the Change Framework (Ottawa Charter) that guides the work of the Alliance. This introduces the concept of working at multiple levels in order to provide positive change for good SRHR.

   Working at multiple levels
   - Individuals, peers, relationships and households
   - Community norms, social attitudes, values and beliefs
   - Services
   - Policies and structures

4. Ask participants to brainstorm on what specific interventions make up each of the four different levels. Make a note of the interventions that participants themselves are currently engaged in.

5. Conclude this session by briefing participants on how and why the guide was developed.

Step 3: Case study exercise

90 minutes

1. In this session, participants will become familiar with the *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights* and how it may be used practically.

2. Divide the participants into three groups, and provide each group with an case study of integrated services (see Handout 5: *Case studies*). Ask them to answer the following questions about their case study:

   - *What standard(s) is clearly demonstrated in your case study?*
   - *How are the objectives of the case study operationalised (activities/interventions)?*

- *Based on the good practice standards and information in the key interventions section in Chapter 4 of the Good Practice Guide, what are the gaps and opportunities within the case study?*

3. Ask participants to present to the larger group.

Step 4: Wrap up

1. Wrap up by summarising the key messages that have been highlighted during the session.

Case study 1

- **Good practice standard 6:** Our organisation promotes and increases uptake of the essential elements of prevention of parent-to-child transmission.
- **Intervention 8:** Preventing HIV transmission to babies during pregnancy, delivery and after birth.
- **Intervention 9:** Improving maternal and newborn health.

Case study 2

- **Good practice standard 10:** In collaboration with others, our organisation promotes and/or provides interventions to address gender-based and sexual violence and abuse in its HIV and SRH response.
- **Intervention 11:** Optimising integration between STI and HIV services.
- **Intervention 14:** Addressing gender-based violence.

Case study 3

- **Good practice standard 6:** Our organisation promotes and increases uptake of the essential elements of prevention of parent-to-child transmission.
- **Intervention 8:** Preventing HIV transmission to babies during pregnancy, delivery and after birth
- **Intervention 11:** Optimising integration between STI and HIV services.

What are the good practice programming standards?

- Standards define the Alliance's approach to HIV programming.
- They set out what our beneficiaries can expect from our programmes.
- Standards define good practice in various technical areas.
- They are based on evidence, and on Alliance experience and values.
- They refer to tools that define good practice for specific interventions, or ways to assist in implementing the standard.
- Standards are aspirational.

Why develop programming standards?

- To define and promote good practice in community-based HIV programming, based on evidence, programme learning and the Alliance's values.
- To support assessment/evaluation of programme quality.
- To influence programme design.

- To build an evidence base for quality programming.
- To shape the provision of technical support.

Alliance Good Practice Guides:

- provide a fuller description of the value and meaning of each standard
- provide practical case examples
- allow contextualisation of standards.

Alliance good practice HIV programming standards for sexual and reproductive health and rights and HIV integration

Good practice standard 1	Our organisation promotes the linking and integration of SRH and HIV in policies, programmes and services.
Good practice standard 2	In collaboration with others, our organisation promotes the SRH needs and rights of all people.
Good practice standard 3	The people most affected by HIV and SRH problems are meaningfully and consistently involved at all stages of the project cycle.
Good practice standard 4	Our organisation promotes and/or delivers sexuality education that is comprehensive, increases knowledge, self-esteem and skills, and is socially and culturally context-specific and tailored to people's needs.
Good practice standard 5	Our organisation promotes and/or provides information, education and counselling on HIV that is integrated with reproductive concerns and options.
Good practice standard 6	Our organisation promotes and increases uptake of the essential elements of prevention of parent-to-child transmission.
Good practice standard 7	Our organisation promotes and/or provides sexually transmitted infection education, diagnosis, and treatment, and condoms.
Good practice standard 8	Our organisation promotes and refers users to quality, user-friendly services whenever feasible rather than setting up parallel services. We collaborate with and build the capacity of service providers to better meet the needs of our beneficiaries.
Good practice standard 9	Our organisation works with others to promote and/or implement programmes that address gender and sexuality as an integral component of the SRH and HIV response.
Good practice standard 10	In collaboration with others, our organisation promotes and/or provides interventions to address gender-based and sexual violence and abuse in its HIV and SRH response.
Good practice standard 11	Our organisation has a policy and programme to address stigma and discrimination, which undermine protective behaviours and act as barriers to accessing SRH and HIV services and support.

International HIV/AIDS Alliance (2010), *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*. Available at: www.aidsalliance.org/resources/287-good-practice-guide-hiv-and-sexual-and-reproductive-health

Session 11
Assessing organisational capacity

Time

1.5 hours

Objectives

- Assess institutional capacity for the integration of SRHR in HIV programming.
- Prioritise areas for institutional strengthening for integration.

Materials

Flipcharts, markers and note cards

Good practice standard 1 and accreditation standard C1: Our organisation promotes the linking and integration of SRH and HIV in policies, programmes and services.

Accreditation Standard C5: Our organisation ensures client satisfaction and quality of integrated services.

Step-by-step instructions

Step 1

Introduce the objectives of this session, which will be the building blocks Session 12: Action planning and next steps.

Step 2

90 minutes

1. Divide participants for this session and Session 12 according to, for example, organisation, thematic focus (such as service provision, target groups), geographic location and so on.
2. Ask the groups to conduct a SWOT (strengths, weaknesses, opportunities, threats) analysis of their organisations or programme (30 minutes) based on Good Practice Standard 1.
3. In plenary, ask groups to present the results of their SWOT analysis, with feedback and contributions from facilitators and the other participants. Ask groups to spend no more than 10 minutes presenting their group work, with five minutes for feedback and comments.

STRENGTHS (INTERNAL)	WEAKNESSES (INTERNAL)
1.	1.
2.	2.
3.	3.
4.	4.
OPPORTUNITIES (EXTERNAL)	**THREATS (EXTERNAL)**
1.	1.
2.	2.
3.	3.
4.	4.

Session 12
Action planning and next steps

Time

2 hours

Objectives

- Prioritise areas for institutional strengthening for integration.
- Allow participants to reflect on specific actions they will take after the workshop to integrate SRHR and HIV.

Materials

Flipcharts, markers and note cards

Step-by-step instructions

Step 1

Introduce the objectives of this session.

Step 2: Next steps

60 minutes

1. After the group presentation of the SWOT analysis, ask participants to return to their groups and select three priority areas from their SWOT exercise to focus on for the following year. Ask them:
   - *What actions/activities can you implement in the next year?*
   - *Who will be responsible?*
   - *What support will be required and from where?*
   - *What timeframe will you need to complete the actions?*

PRIORITY AREA	PROPOSED ACTION	RESPONSIBILITY	SUPPORT REQUIRED	TIMEFRAME
1.				
2.				
3.				

2. Participants will then present their final group work discussions as their next steps or actions moving forward. Encourage constructive feedback from participants in order to finalise and strengthen the action proposed.
3. Make a final presentation on the Alliance approach to HIV/SRHR programming and the standards on SRHR and HIV integration to wrap up the training and reinforce the work and content covered during the workshop.

Step 4: Evaluation and closing

30/60 minutes

1. Explain to the participants the purpose of the end-of-course evaluation. Tell them that it is to get feedback on their perceptions of the relevance of the training, facilitators, duration and the information gained. Tell the participants that the information will be used to improve future training.

Appendix 1: Alternative timetables

One-day workshop

DURATION	SESSION
2 hours	**Session 1: Welcome and introductions**
30 minutes	Tea break
2 hours	**Session 2: Understanding integration**
1 hour	Lunch
1.5 hours	**Session 10: Using the guide – case study exercises**
15 minutes	Tea break
1.5 hours	**Session 12: Action planning and next steps**
15 minutes	Wrap up

Two-day workshop

DAY 1	
DURATION	SESSION
2 hours	**Session 1: Welcome and introductions**
30 minutes	Tea break
2 hours	**Session 2: Understanding integration**
1 hour	Lunch
1.5 hours	**Choose one from the following sessions:** Session 5: Maternal, newborn and child health and HIV integration Session 6: Family planning and HIV Session 7: Working with key populations Session 8: Advocacy and community systems strengthening
15 minutes	Tea break
1.5 hours	**Choose one from the following sessions:** Session 5: Maternal, newborn and child health and HIV integration Session 6: Family planning and HIV Session 7: Working with key populations Session 8: Advocacy and community systems strengthening
15 minutes	Tea break
DAY 2	
4 hours	**Session 9: Field visit**
1 hour	Lunch
1.5 hours	**Session 10: Using the guide – case study exercises**
1.5 hours	**Session 11: Assessing organisational capacity**
15 minutes	Tea break
1.5 hours	**Session 12: Action planning and next steps**
15 minutes	Wrap up

Three-day workshop

DAY 1	
DURATION	SESSION
2 hours	**Session 1: Welcome and introductions**
30 minutes	Tea break
2 hours	**Session 2: Understanding integration**
1 hour	Lunch
1.5 hours	**Session 3: Linking sexual and reproductive health and rights and HIV**
15 minutes	Tea break
1.5 hours	**Session 4: Concepts of gender and sexuality**
15 minutes	Wrap up
DAY 2	
2 hours	**Choose one from the following sessions:** Session 5: Maternal, newborn and child health and HIV integration Session 6: Family planning and HIV Session 7: Working with key populations
30 minutes	Tea break
2 hours	**Session 8: Advocacy and community systems strengthening**
1 hour	Lunch
4 hours	**Session 9: Field visit**
DAY 3	
2 hours	**Session 10: Using the guide – case study exercises**
15 minutes	Tea break
1.5 hours	**Session 11: Assessing organisational capacity**
15 minutes	Tea break
2 hours	**Session 12: Action planning and next steps**
15 minutes	Wrap up

Appendix 2: Workshop evaluation

A. You

1. **Please rate yourself in terms of experience in areas of integration of SRHR and HIV** at the four levels: individual, peer, relationships; community; services; policies and structures)

   a. A lot of experience ☐
   b. Some experience ☐
   c. Relevant experience but not in this specific area ☐
   d. Very little experience ☐

2. **Prior to the training workshop, please rate your skill with or knowledge of**: (circle)

   Please rate on a scale of 1 to 5, where 1 is the minimum (poor) and 5 is the maximum (excellent)

a.	Linkages	1	2	3	4	5
b.	Integration	1	2	3	4	5
c.	Alliance Good Practice Guide	1	2	3	4	5
d.	Sexual reproductive health and rights	1	2	3	4	5
e.	Gender and sexuality	1	2	3	4	5
f.	Maternal, newborn, child health	1	2	3	4	5
g.	Assessing capacity for integration	1	2	3	4	5

B. This workshop

3. **Please rate this workshop in the following areas:**

   Please rate on a scale of 1 to 5, where 1 is the minimum (poor) and 5 is the maximum (excellent)

a.	Structure of the workshop	1	2	3	4	5
b.	Usefulness of materials	1	2	3	4	5
c.	Extent to which you acquired new skills	1	2	3	4	5
d.	Session methodologies (presentation, case studies, etc.)	1	2	3	4	5
e.	Balance of theory vs. practice (1 = too much theory; 5 = too little)	1	2	3	4	5
f.	Extent to which workshop contributed to networking	1	2	3	4	5

4. **What did you like best about the workshop?**

5. **How would you improve this workshop?**

6. **What would you eliminate from the curriculum?**

7. **What other subjects or activities should have been included in this workshop?**

8. **What workshop/training methods could be changed?**

9. **How well did the workshop facilitate the exchange of experiences among participants?**

   Not at all ☐ Somewhat ☐ Quite a lot ☐

10. **How will you apply the knowledge and/or skills acquired in the course?** Please give specific examples

11. Logistics

Please rate on a scale of 1 to 5, where 1 is the minimum (poor) and 5 is the maximum (excellent)

a.	Overall workshop organisation	1	2	3	4	5
b.	Logistics	1	2	3	4	5
c.	Accommodation and meals	1	2	3	4	5

12. Do you have any other comments or concerns about the workshop?

Name (optional) _____

This may help us to follow up on any ideas and suggestions you have made.

Please use the space overleaf for any additional comments where there is not enough room here (include the question number).

Appendix 3: Resources

- International Conference on Population and Development (ICPD) Programme of action, 1994, adopted by the United Nations.
  Available at: www.unfpa.org/public/icpd
- International HIV/AIDS Alliance (2010), *Good Practice Guide: Integration of HIV and sexual and reproductive health and rights*.
  Available at: www.aidsalliance.org/resources/287-good-practice-guide-hiv-and-sexual-and-reproductive-health
- International HIV/AIDS Alliance and ICASO (2010), *Measuring up: a guide for facilitators. HIV-related advocacy evaluation training for civil society organisations.*
  Available at: www.aidsalliance.org/publicationsdetails.aspx?id=477
- International HIV/AIDS Alliance (2003), *Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS*.
  Available at: www.aidsalliance.org/resources/252-advocacy-in-action-a-toolkit-to-support-ngos-and-cbos
- IPPF (1996), *IPPF Charter on Sexual and Reproductive Rights*.
  Available at: www.ippf.org/resource/IPPF-Charter-Sexual-and-Reproductive-Rights-Guidelines
- Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010, 2006, adopted by the African Union.
  Available at: www.unfpa.org/africa/newdocs/maputo_eng.pdf
- RFSU, Range of materials from the Swedish Organization for Sexual Enlightenment.
  Available at: www.rfsu.se/en/
- UNAIDS, *Know your epidemic and modes of transmission*.
  Available at: www.unaidsrstesa.org/thematic-areas/hiv-prevention/know-your-epidemic-modes-transmission
- UNAIDS terminology guidelines, revised 2011.
  Available at:www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf
- United Nations Millennium Development Goals, 2000, adopted by the United Nations.
  Available at: www.un.org/millenniumgoals/bkgd.shtml
- What works for women and girls: evidence for HIV/AIDS interventions.
  Available at: www.whatworksforwomen.org
- WHO (2010), *Making the case for interventions linking sexual and reproductive health and HIV in proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria*.
  Available at: www.who.int/reproductivehealth/publications/linkages/rhr_10_02/en/
- WHO (2005), *Sexual and reproductive health and HIV/AIDS: a framework for priority linkages*.
  Available at: www.who.int/reproductivehealth/publications/linkages/HIV_05_5/en/index.html

Appendix 4: Alternative activities

Session 5: Maternal, newborn and child health and HIV integration

Understanding barriers to supply, uptake and retention of prevention of vertical transmission

Objective

To understand the barriers that different individuals face at various stages along the prevention of vertical transmission of HIV cascade.

Materials

Role cards

Time

30 minutes

Step-by-step instructions

1. Walking towards a successful prevention of vertical transmission outcome. Who can get there?

   Each person is given a role card. For example:

   - pregnant woman whose husband has other partners and is violent
   - schoolgirl who thinks she might be pregnant
   - unregistered migrant man with a wife and three children
   - woman from an isolated village on her fifth pregnancy
   - sex worker with a two-year-old child.

2. Ask the participants to stand at one end of the room. Read out the following questions. Each time they can answer 'yes' in their roles, they move one step forward.

   - *Can you get a confidential HIV test?*
   - *Can you get and use a condom every time you have sex?*
   - *Can you get prevention services that meet your specific needs?*
   - *Can you get and use a contraceptive method every time you have sex?*
   - *Can you get family planning services that meet your specific needs?*
   - *Can you talk to your family about HIV?*
   - *Can you travel easily to access different services?*
   - *Can you get non-discriminatory services at a government clinic?*
   - *Can you ask your partner to come to the clinic with you?*
   - *Can you or your partner follow infant feeding advice without interference?*

3. Key points to draw out for each role:

   Pregnant woman whose husband has other partners and is violent

   She would be at risk of HIV due to her husband's multiple sexual partners. It would be very difficult for her to go for an HIV test, and get and use HIV prevention, family planning and MNCH services. It would also be difficult to negotiate condom or contraceptive use, or ask her partner to accompany her to clinic because of fear of him reacting violently.

   Schoolgirl who thinks she might be pregnant

   Her age would restrict her ability to access testing and HIV, family planning and MNCH services due to legal restrictions, as well as socio-cultural disapproval of a young woman being sexually active. She also would be unable to afford any travel expenses, and would be ashamed to speak to her family or sexual partner about her situation for fear of being rejected and thrown out of the house.

   Unregistered migrant man with a wife and three children

   His lack of legal right to stay in the country could prevent him or his family from accessing health services for fear of them being discovered and deported back to their country of origin. He may not be able to afford to pay for condoms or transport to clinics, and as a man he may not be comfortable talking to his wife about their SRH issues.

   Woman from an isolated village on her fifth pregnancy

   She would perhaps want to limit her number of children but lacks information, accessible services or the means to access family planning or prevention of vertical transmission services.

   Sex worker with a two-year-old child

   Stigma, discrimination and fear of arrest would keep her away from health services. If she did go, she would need to feel she could trust the service provider before she disclosed her occupation and sexual risk history in order for them to provide the appropriate service for her.

Session 6: Family planning and HIV

Family planning – facts, myths and misconceptions

Objective

To discuss trends in family planning and dispel common myths and misconceptions about the different methods.

Materials

Flipcharts, tape and markers, Handout 3: *Contraceptive methods*

Time

90 minutes

Step-by-step instructions

1. Divide participants into groups of two to four people. Randomly assign each group a family planning method. Ask participants to write on a flipchart everything they know about the assigned method. This should include how it is used, contra-indications and its effectiveness. The point of this exercise is to clarify facts about the different methods.

2. Also ask participants to write down common myths/misconceptions about the assigned method. Give participants about 10 minutes to do this.

   Family planning methods

   - Male and female condoms
   - Contraceptive pill
   - Emergency pill/Plan B
   - Intrauterine device (IUD)
   - Male and female sterilisation
   - Implants
   - Injectables
   - Lactation amenorrhea method (LAM)
   - Withdrawal
   - Fertility awareness

3. When the participants are finished, tape the flipcharts on the different methods to the walls around the room. With the whole group, go through each flipchart, crossing off any information that may be incorrect and including any important information that may be missing. Use this session to clear up any myths/misconceptions and provide appropriate responses for participants who might be faced with these issues on a daily basis. Ensure that the whole group contributes to this session, as the aim is for participants to help each other and provide information.

4. End the session by distributing Handout 3: *Contraceptive methods*, and highlight the key points of each method with participants. Invite participants to review the handout and ask any further questions they might have on the following day.

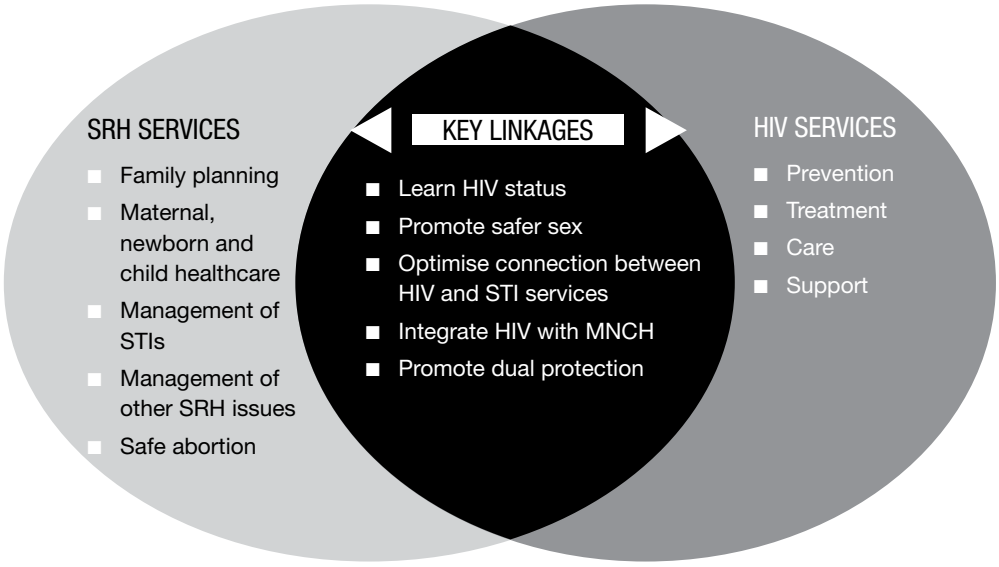
Handout 1: Sexual and reproductive health and HIV: a framework for priority linkages

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

Linkages are the policy, programmatic, services and advocacy synergies between SRH and HIV. It refers to a broader human rights approach, of which integrated services are one component. Linkages can happen between core HIV interventions and core SRH interventions. Linkages also involve addressing the social and structural issues that make people vulnerable to sexual and reproductive ill health and HIV.

Bi-directional integration and linkages mean that SRH components can be linked to HIV programmes and HIV components can be linked to SRH programmes.

A framework for priority linkages



Source: Adapted from WHO (2005), *Sexual and reproductive health and HIV/AIDS: a framework for priority linkages.*

Handout 2: Alliance values statement on our work with women and girls

The goal of the International HIV/AIDS Alliance (Alliance) is to contribute to a world in which communities have brought an end to HIV transmission, and secured their health and human rights. Gender and sexuality have a fundamental bearing on the course, pace and impact of HIV infection. The different attributes, roles and expectations that societies assign to men, women, girls and boys, and the capacity to express oneself sexually, profoundly affect an individual's ability to protect themselves from HIV and cope with its impact. It is important to recognise that gender is a complex concept as it includes other gender identities and roles that transgress the notion of what is traditionally seen as male and female (see Alliance key population policy).

This values statement is addressing our work with women and girls based on the Alliance's commitment to gender equality in its organisational, programming and policy work. It outlines the Alliance's 'gender transformative' approach whereby we try to change the conditions that create inequity, to give women and girls as well as men and boys the same entitlements to human rights and the same level of power, influence and resources to shape their own lives and participate in society. This in turn enables women and girls to make their own decisions regarding their bodies, and helps reduce their vulnerability to HIV and increase access to HIV prevention, care and treatment.

Priority issues faced by women and girls

Despite many successes in the HIV response over the past two years, the number of women and girls living with HIV has increased in every region of the world. Biologically, women are twice as likely to contract HIV from a man than a man is to contract HIV from a woman.[1] In sub-Saharan Africa, 60% of adults living with HIV are women and girls. Whilst many programmes are gender sensitive, the social, political and economic factors that shape vulnerability are not adequately addressed.[2]

Social, political and economic factors determine what behaviour and roles are culturally accepted in different societies, how resources and knowledge are distributed and the rights that can be claimed. The legal protections provided and the legal rights available for women and girls to own property and land are often limited. Importantly, women and girls are a heterogeneous group and have diverse realities and needs. In many societies women are seen as the primary care givers, which undermines their income-raising opportunities and job security. Young women and girls with older male sexual partners are at greater risk of being forced into early marriage and experiencing violence due to the unequal intergenerational power relations. Social norms also influence men, women and girls and boys' attitudes on sex, risk-taking and access to information and services.[3]

The specific needs of women in generalised and concentrated epidemics can be diverse and difficult to address depending on vulnerability and risk factors, such as the ability to realise their human rights and access information and services. Women and girls who use drugs, female sex workers and partners of men who use drugs experience stigma and discrimination. Whilst men who use drugs or male sex workers are subject to stigma and discrimination, female drug users and sex workers are at greater risk of further marginalisation through violence, rape and harassment. They often lack legal protection, and have poor access to health, social and legal services. Criminalisation of drug use and sex work, and stigmatising attitudes of health care providers prevents many women and girls from disclosing their health and development needs and seeking health care.

Many women and girls living with HIV suffer blame and violence upon disclosure of their HIV status, particularly as they are often first diagnosed at antenatal clinics. The ensuing stigma and discrimination can lead to separation from their partner and loss of their children and home; poor access to services and treatment; isolation; and lack of employment.[4]

While women and girls often bear the largest burden of gender inequalities, gender norms and stereotypes also have a negative impact on men and boys' vulnerability to HIV. Male involvement is essential in challenging gender inequities and for an effective HIV and AIDS response by identifying and valuing positive aspects of masculinity, while at the same time developing leadership skills to challenge and change

1. UNFPA (July 2010), *Media Fact Sheet. HIV and women and girls: promoting gender equality and rights*.
2. UNAIDS (2009), *Briefing note. Agenda for accelerated country action for women and girls, gender equality and HIV.*
3. World Bank (September 2011), *Engendering development through gender equality in rights, resources, and voice.*
4. UNIFEM and ActionAid (2009), *Together we must! End violence against women and girls and HIV & AIDS*.

aspects of masculinity that perpetuate inequalities and violate the rights of women, children and other men.[5]

Alliance approach to working with women and girls

Recognising and responding to gender and sexuality issues is central to the Alliance's approach. Alliance values state that, "the lives of all human beings are of equal value and that everyone has the right to access the information and services they need". Through supporting community action, the Alliance's gender work is underpinned by a range of fundamental values, such as:

- Right to informed choice, belief and free speech
- Freedom of movement and self-determination
- Freedom from violence, abuse and slavery-like practices
- Right to meet and organise to further common interests or beliefs
- Non-discrimination, whether by race, religion, nationality, gender or sexual orientation
- Value of diversity and non-judgmental cross-cultural understanding
- Protection of children and upholding the rights of girls and boys
- Protection and assistance to the poor and marginalised

The Alliance adopts a gender transformative approach to its work with women and girls by aiming to change gender norms that legitimise unequal relationships between men, women, girls and boys'; perpetuate gender-based violence; and lead to sexual risk-taking behaviours. It also addresses the quality of relations between men and women and with people who have other gender identities (please see Alliance key populations policy).

Our approach promotes change through:

- empowerment programmes that help women and girls have more control over sexual decision-making and risk reduction
- creating a family environment that encourages more equitable gender and social norms
- mobilising communities, and appropriately involving men and boys, to challenge harmful socio-cultural norms, violence, stigma and discrimination against women and girls
- improving access for women and girls by training and sensitising health care workers, police and other service providers to provide services that are non-discriminatory and sensitive to the needs of women and girls
- advocating for:
  - equitable access to HIV and integrated services for women and girls
  - protection against gender-based violence, coercion and abuse
  - change to policies, laws or customs that limit the power and autonomy of women; that prescribe traditional or limiting definitions of masculinity, femininity and other gender identities; and that affect property and inheritance rights and access to education.

To reduce vulnerability to HIV and AIDS in a sustainable and long-term manner, the Alliance prioritises the meaningful involvement of women and girls living with HIV in all aspects of global and national responses to HIV; and the strengthening of community capacity to respond to AIDS and other health, development and human rights priorities.

5. WHO (2009), *Integrating gender into HIV/AIDS programmes in the health sector: tools to improve responsiveness to women's needs*.

Handout 3: Contraceptive methods

METHOD	DESCRIPTION	HOW IT WORKS	EFFECTIVENESS TO PREVENT PREGNANCY	COMMENTS
Combined oral contraceptives (COCs) or 'the pill'	Contains two hormones (estrogen and progestogen)	Prevents the release of eggs from the ovaries (ovulation)	■ >99% with correct and consistent use ■ 92% as commonly used	Reduces risk of endometrial and ovarian cancer; should not be taken while breastfeeding
Progestogen-only pills (POPs) or 'the mini-pill'	Contains only progestogen hormone, not estrogen	Thickens cervical mucous to block sperm and egg from meeting, and prevents ovulation	■ 99% with correct and consistent use ■ 90–97% as commonly used	Can be used while breastfeeding; must be taken at the same time each day
Implants	Small, flexible rods or capsules placed under the skin of the upper arm; contains progestogen hormone only	Same mechanism as POPs	>99%	Healthcare provider must insert and remove; can be used for three to five years depending on implant; irregular vaginal bleeding common but not harmful
Combined contraceptive skin patches*	Patch placed on skin contains two hormones (estrogen and progestogen) that are released through the skin and into the bloodstream. One patch per week for 3 consecutive weeks	Prevents the release of eggs from the ovaries (ovulation) and thickens cervical mucous to block sperm and egg from meeting	99%	As a new contraceptive method there is relatively limited information on the safety of the combined contraceptive patch among healthy women or those with specific medical conditions
Progestogen-only injectables	Injected into the muscle every two or three months, depending on product	Same mechanism as POPs	■ >99% with correct and consistent use ■ 97% as commonly used	Delayed return to fertility (one to four months) after use; irregular vaginal bleeding common, but not harmful
Monthly injectables or combined injectable contraceptives (CIC)	Injected monthly into the muscle, contains estrogen and progestogen	Same mechanism as COCs	■ >99% with correct and consistent use ■ 97% as commonly used	Irregular vaginal bleeding common, but not harmful
Intrauterine device (IUD): copper containing	Small flexible plastic device containing copper sleeves or wire that is inserted into the uterus	Copper component damages sperm and prevents it from meeting the egg	>99%	Longer and heavier periods during first months of use are common but not harmful; can also be used as emergency contraception
Intrauterine device (IUD) levonorgestrel	A T-shaped plastic device inserted into the uterus that steadily releases small amounts of levonorgestrel each day	Suppresses the growth of the lining of uterus (endometrium)	■ >99% ■ 85% as commonly used	■ Reduces menstrual cramps and symptoms of endometriosis; amenorrhea (no vaginal bleeding) in 20% of users ■ Also protects against STIs, including HIV

METHOD	DESCRIPTION	HOW IT WORKS	EFFECTIVENESS TO PREVENT PREGNANCY	COMMENTS
Female condoms	Sheaths or linings that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film	Forms a barrier to prevent sperm and egg from meeting	90% with correct and consistent use; 79% as commonly used	Also protects against STIs, including HIV
Vaginal rings*	The vaginal ring (NuvaRing) is a flexible ring about 2 inches wide that is placed into the vagina for 21 days at a time. It releases the hormones progestin and estrogen	Prevents the release of eggs from the ovaries (ovulation)	>99%	As a new contraceptive method there is relatively limited information on the safety of the combined contraceptive patch among healthy women or those with specific medical conditions
Male sterilisation (vasectomy)	Permanent contraception to block or cut the vas deferens tubes that carry sperm from the testicles	Keeps sperm out of ejaculated semen	>99% after three months' semen evaluation; 97–98% with no semen evaluation	Three month delay in taking effect while stored sperm is still present; does not affect male sexual performance; voluntary and informed choice is essential
Female sterilisation (tubal ligation)	Permanent contraception to block or cut the fallopian tubes	Eggs are blocked from meeting sperm	>99%	Voluntary and informed choice is essential
Withdrawal (coitus interruptus)	Man withdraws his penis from his partner's vagina and ejaculates outside the vagina, keeping semen away from her external genitalia	Keeps sperm out of the woman's body, preventing fertilisation	■ 96% with correct and consistent use ■ 73% as commonly used	One of the least effective methods, because proper timing of withdrawal is often difficult to determine
Fertility awareness methods (natural family planning or periodic abstinence)	Calendar-based methods: monitoring fertile days in menstrual cycle; symptom-based methods: monitoring cervical mucous and body temperature	The couple prevents pregnancy by avoiding unprotected vaginal sex during these fertile days, usually by abstaining or by using condoms	75%	Can be used to identify fertile days by women who want to become pregnant and women who want to avoid pregnancy
Lactational amenorrhea method (LAM)	Temporary contraception for new mothers whose monthly bleeding has not returned; requires exclusive breastfeeding day and night of an infant less than six months old	Prevents the release of eggs from the ovaries (ovulation)	99% with correct and consistent use; 98% as commonly used	A temporary family planning method based on the natural effect of breastfeeding on fertility
Emergency contraception (levonorgestrel 1.5 mg)	Progestogen-only pills taken to prevent pregnancy up to five days after unprotected sex	Prevents ovulation	Reduces risk of pregnancy by 60–90%	Does not disrupt an already existing pregnancy

Source: WHO (May 2013), Family planning: fact sheet 351.

Handout 4: Advocacy and related concepts

	ADVOCACY	IEC AND BCC	COMMUNITY MOBILISATION	NETWORKING AND PARTNERSHIPS	FUNDRAISING AND RESOURCE MOBILISATION	OVERCOMING STIGMA AND DISCRIMINATION, AND ADDRESSING HUMAN RIGHTS VIOLATIONS
What can it change?	**In the short term:** awareness and attitudes. **In the medium to long term:** policies and laws, and implementation of policies, laws and practices	Awareness, knowledge, skills and behaviour	Capacity of communities to identify and address issues affecting them	Isolation and duplication. Create and strengthen linkages between services and across sectors	Level of resources available for HIV and AIDS work	Level of stigma and discrimination against people living with HIV and incidences of human rights violations
Target group	Decision-makers, leaders, policymakers, people in positions of influence	Particular groups of the population by age group and gender, local communities, an entire society	Members of a community*	Individuals, groups, organisations and sectors who have a similar agenda	Communities, local councils, government, donors, private sector	People who stigmatise or discriminate Government agencies and services (human rights violations)
Does it mainly target people who have influence over others?	Yes	No	No	No	No	No
Typical indicators of success	Increased awareness and understanding of the gaps and structural barriers to the response among policymakers Policies and laws, as well as implementing practices, that enable effective HIV prevention and care	Percentage of sex workers reporting condom use clients at last sex Changes in attitude to people living with HIV	A community problem is solved More people engage in community-based activities Increased capacity of community-based organisations to deliver services and advocate for desired changes	Members of the network or partnership achieve more than they could if they worked alone Increased access to a continuum of care and reduced loss to follow up	Farmer gives use of building for meetings Members of mosque give alms Donor gives grant Private company sponsors a community-based event	Fewer workers dismissed because of HIV status Fewer cases of depression among people living with HIV Positive changes in policing practices

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

Handout 5: Case studies

Case study 1: Repositioning postnatal care in a high HIV prevalence environment – operations research in Swaziland[1]

Population Council operations research tested whether a change in the Swaziland national guidelines for postnatal care strengthened postnatal care attendance and follow-up of mothers and infants.

Since June 2004 comprehensive prevention of vertical transmission services have been integrated into a MNCH care package at selected sites in Swaziland. While antenatal attendance is high, which allows many women to access prevention of vertical transmission services during the antenatal period, one of the main challenges identified for prevention of vertical transmission programmes is follow-up of mothers and infants after delivery. The postnatal period from birth to six weeks is critical for ensuring the health of the mother and infant, and better follow-up will help ensure that mothers and their infants are healthy and thriving.

The Ministry of Health and Social Welfare wanted to explore changing their policy on when postnatal visits should occur. Horizons, the Elizabeth Glaser Pediatric AIDS Foundation, Basic Support for Institutionalizing Child Survival, and the Central Statistical Office assisted the ministry in conducting operations research. This entailed collecting the data needed to re-orient the postnatal visit, document the implementation of a revitalised postnatal service, assess the impact of these changes, and inform reproductive health programming with regard to HIV.

The study objectives were to:

- determine why postnatal care is under utilised within MCH services
- document the types of service delivery modifications required to improve care, follow-up and referrals
- measure the effect of changing the postnatal care policy guidelines on the quality of postnatal care and the use of postnatal services by all women
- increase the use of HIV care and support services by HIV-positive women and their infants.

The research comprised a pre-/post-test design to evaluate the effectiveness of the new postnatal service guidelines in four facilities providing delivery and/or MCH services.

The key findings of this study were that facilities are prepared to provide a new postnatal care package. Health provider knowledge increased in several areas, and consequently more information was provided to pregnant women during late pregnancy about the postnatal period. As a result, women and their babies received better postnatal care. One indicator of this was that a higher proportion of postpartum women were breastfeeding during the post-intervention period.

The strong prevention of vertical transmission programme maintained a high proportion of women testing for HIV and receiving ART. In addition, there was an increase in HIV testing among women's partners and subsequent sharing of test results, as well as increased use of care and support services by HIV-positive postpartum women and their infants.

Overall, the new postnatal package was well received by clients and providers. To address the barriers to sustaining the new care package, these findings suggest strengthening policy guidelines; developing and implementing a plan to strengthen health systems; emphasising capacity-building through community-based interventions; further developing effective communication techniques; and using monitoring and evaluation tools to document all activities.

Case study 2: Thohoyandou Victim Empowerment Programme, South Africa[2]

The Population Council partnered with Thohoyandou Victim Empowerment Programme (TVEP), a community-based organisation established in 1997 to document their innovative 'one-stop centre' model for post-rape care. TVEP employs a multi-sectoral, comprehensive model to reduce and address sexual and gender-based violence in the Vhembe District of Limpopo Province.

Using trauma centres, TVEP provides medical, legal, and social services and support to survivors of sexual and gender-based violence. While other non-profit organisations in the area address domestic violence cases, TVEP manages the only trauma centres in Thohoyandou. It is therefore one of the few places that survivors of sexual assault can turn to for services.

Each trauma centre is staffed by a manager, professional trauma counsellor, victim advocate and volunteer general assistant. Once a survivor arrives at a trauma centre, they are debriefed and counselled by the victim advocate. The survivor is informed of their medical, social and legal options, as well as the advantages and disadvantages of each. The victim advocate then calls a doctor to examine the survivor, and if they arrived without a police officer, the victim advocate calls the police. The survivor is offered voluntary counselling and testing services (including

1. Accessed from Warren, C. et al (2008), Repositioning postnatal care in a high HIV environment: Swaziland: Population Council. Available at: www.popcouncil.org/uploads/pdfs/horizons/Swaziland_PostnatalCare.pdf

2. Keesbury, J. and Askew, I. (2010), *Comprehensive responses to gender based violence in low-resource settings: lessons learned from implementation*, Population Council. Available at: www.popcouncil.org/pdfs/2010RH_CompRespGBV.pdf

pre- and post-test counselling), pregnancy testing, post-exposure prophylaxis, medication for STIs and emergency contraception. They are also given the option to join a support group for survivors of domestic violence and sexual assault, and/or one of two support groups for HIV-positive people.

In addition to these services, each survivor is given a care package, including a comfort plush toy (for children and adults), one month's supply of nutritional supplements, bus tickets for follow-up care (including HIV re-testing and trauma counselling), and an information booklet. Depending on the survivor's situation, they may also stay at the on-site safe house and, when indicated, be referred to professional counselling.

TVEP's victim advocates play an important role in providing support to survivors and liaising between clients and medical professionals, the legal team, and the investigating officer. TVEP employs 10 victim advocates at the trauma centres, and at any one time there are four victim advocates on duty (two at each centre). Each victim advocate has a 12-hour shift.

Post-exposure prophylaxis provision at TVEP trauma centres was started in 2002. As part of support services, victim advocates assist HIV-negative clients who start post-exposure prophylaxis to complete the full 28-day course. Clients who present at TVEP within 72 hours and agree to take post-exposure prophylaxis are given all 28 days of pills at the initial visit. If clients agree, victim advocates conduct home visits at day 3 and day 28 to provide continued social, medical and legal support. One objective of the home visits is to increase the likelihood that clients complete the full course of prophylaxis. Home visits are also conducted to follow up on other issues, including food security and concurrent or continued violence. Clients who present after 72 hours, or those who decline post-exposure prophylaxis or home visits, are not visited at the home by victim advocates. However, they do continue to support clients through phone calls, and clients can also call victim advocates.

In addition to providing health and medical support to survivors, victim advocates also provide psychosocial and legal support. They prepare survivors for court and keep them updated on their cases, as well as attend court hearings when possible. The victim advocates are also responsible for documenting information on the survivor, the home visits, and other support provided to survivors. Victim advocates document health and legal information at the first trauma centre visit, during or immediately after each phone call, and during or immediately after each home visit.

To assess programme outcomes, in late 2009 a consultant was contracted to review a total of 5,204 client records collected over a 20-month period between January 2007 and October 2009. Data quality emerged as an important constraint in analysing the data, and consequently some service delivery questions could not be answered with the available information.

Case study 3: Action for rights, relief and development, South Sudan[3]

Action for Rights, Relief and Development (ARRD), supported by the Alliance Linking Organisation in South Sudan, ACHI, in the Pageri Payam district of Eastern Equatoria State in South Sudan. It works in an area of around 23,000 inhabitants with a radius of over 100 miles.

There are around eight clinics in the area, but only one provides prevention of vertical transmission services. The closest hospital, in Nimule, is around 40 miles away. As a sub-grantee of the UK Department for International Development-supported MNCH project, ARRD responds to two main issues that affect the provision of safe maternal health care in the area: uptake of health services by women, and referrals and transportation.

1. Uptake of health services by women

Many women in the area were unaware of the risks of delivering at home. Most relied on traditional birth attendants; others who wanted to deliver in a clinic or hospital could not afford to pay for the maternity kit (which includes gloves, containers, medication, razors and other utensils). As it is obligatory for pregnant women to undergo an HIV test in hospital and for their husband to accompany them, many men and women do not attend clinics. Through peer educators and community dialogues every month, ARRD sensitises families about the importance of the uptake of maternal health services, including HIV testing for women and men, and the need to prioritise it.

2. Referrals and transportation

Unless pregnant women go to the clinic of their own volition, without ARRD pregnant women and their families would not be able to access essential services capable of assessing their situation and referring them to the clinic or hospital if necessary. Once at the clinic, women are asked to return for checkups (especially for prevention of vertical transmission, in the case of HIV-positive women) but without ARRD there would be no follow-up to ensure they return for ongoing services and adhere to the protocol. The same applies for referrals from the clinic to the hospital. The transportation provided for pregnant women by ARRD is also essential. Since most women lack financial means or would be unable to find vehicles, they would not deliver in the clinic or hospital otherwise.

3. International HIV/AIDS Alliance (2011), *HIV update: integrating maternal, newborn and child health into community-based HIV programmes*.

Notes

Good Practice Guide series

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

- Greater involvement of people living with HIV (GIPA)
- Community guide to HIV treatment as prevention
- Integration of HIV and sexual and reproductive health and rights
- Community-based TB and HIV integration
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