

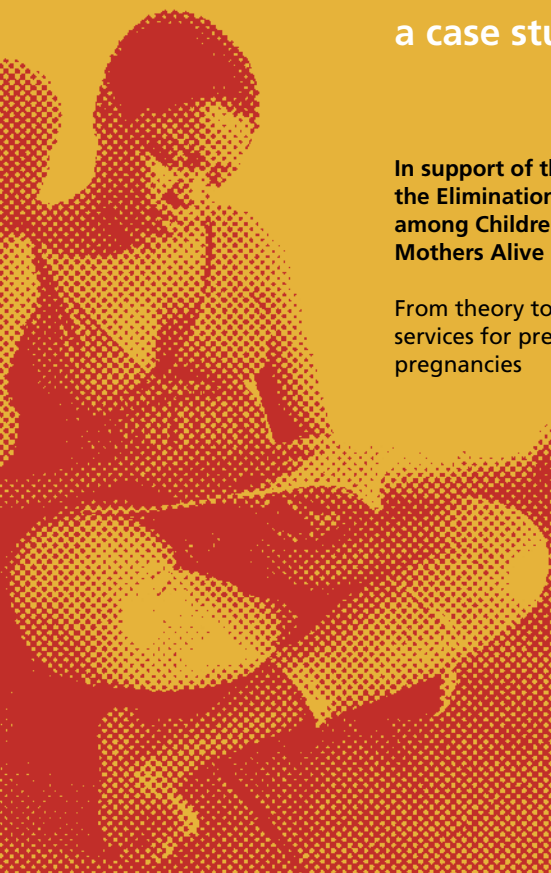
Linking Sexual and Reproductive Health and HIV/AIDS

Gateways to integration

a case study from Swaziland

**In support of the Global Plan towards
the Elimination of New HIV Infections
among Children by 2015 and Keeping their
Mothers Alive**

From theory to practice: Implementing
services for preventing HIV and unintended
pregnancies



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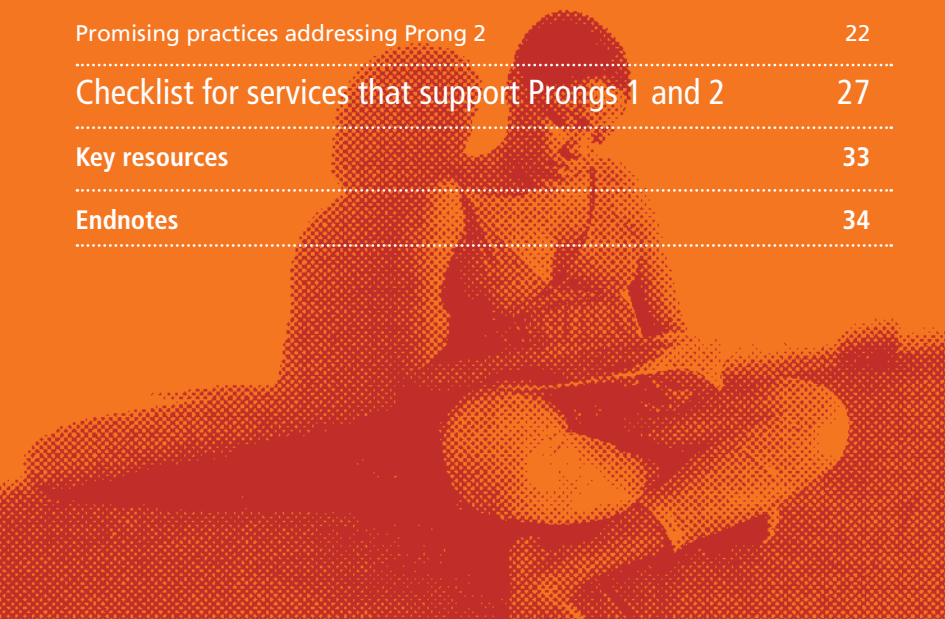
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SafeHands for Mothers 2011

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Abbreviations

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
DHS	Demographic and Health Survey
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
eMTCT	eliminating mother-to-child transmission (of HIV)
EPI	Expanded Programme on Immunizations
FLAS	Family Life Association of Swaziland
GBV	gender-based violence
GNP+	Global Network of People Living with HIV
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
IATT	Inter-Agency Task Team (on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and their Children)
ICW	International Community of Women Living with HIV/AIDS
IEC	information, education and communication
IPPF	International Planned Parenthood Federation
MCH	maternal and child health
MDGs	UN Millennium Development Goals
MNCH	maternal, newborn and child health
MTCT	mother-to-child transmission
NERCHA	National Emergency Response Council on HIV and AIDS
PEP	post-exposure prophylaxis
PITC	provider-initiated HIV testing and counselling
PMTCT	prevention of mother-to-child transmission
SDHS	Swaziland Demographic and Health Survey
SRH	sexual and reproductive health
STI	sexually transmitted infection
SWANNEPHA	Swaziland National Network of People Living with HIV and AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	voluntary counselling and testing
WHO	World Health Organization
YAM	Youth Action Movement, FLAS peer-education programme

Making the case for implementing services that support Prongs 1 and 2 – programming of elimination of mother-to-child transmission

Key definitions

In delineating the full scope of a linked SRH and HIV response, the following distinction has been made between linkages and integration:²

Linkages

Bi-directional (two-way) synergies in policy, programmes, services and advocacy between SRH and HIV. This is a broad, human rights-based approach, of which service integration is a sub-set.

Integration

Joining together different kinds of SRH and HIV services to ensure and maximize collective outcomes. This includes referrals from one service to another, aiming to offer comprehensive support.³

Global attention has for some time focused on prevention of mother-to-child transmission (PMTCT) of HIV as an essential means of making progress towards reducing child mortality (UN Millennium Development Goal 4). Recently, there has been a shift to recognising that improving maternal health (MDG 5) and preventing and treating HIV (MDG 6) are interlinked and also impact on child survival (MDG 4).

The commitment towards elimination of new HIV infections among children by 2015 and keeping their mothers alive

Building on the past progress and success of country-led national PMTCT programmes, there is renewed global consensus that

the world must now strive towards the elimination of new HIV infections among children by 2015 and keeping mothers alive. These joint goals can be achieved at a country level through implementation of the four prongs (see Table 1) for comprehensive programming of elimination of mother-to-child transmission (eMTCT), integrated with sexual and reproductive health (SRH).

Increasingly the first two prongs – preventing new HIV infections (Prong 1) and preventing unintended pregnancies in women living with HIV (Prong 2) – are receiving the recognition, commitment and programming support required to have an impact. These two prongs form the basis of this case study,

Table 1: The four prongs for comprehensive programming

Prong 1	Prong 2	Prong 3	Prong 4
Prevention of HIV among women of reproductive age within services related to reproductive health, such as antenatal care, post-partum and post-natal care and other health and HIV service delivery points, including working with community structures.	Providing appropriate counselling and support, and contraceptives, to women living with HIV, to meet their unmet needs for family planning and spacing of births, and to optimize health outcomes for these women and their children.	For pregnant women living with HIV, ensuring HIV testing and counselling, and access to the antiretroviral (ARV) drugs needed to prevent HIV infection from being passed on to their babies during pregnancy, delivery and breastfeeding.	HIV care, treatment and support for women and children living with HIV, and for their families.

which should be used in conjunction with *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015: In support of the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*.⁴

Global targets have been established for attainment by 2015, with related targets and indicators for each prong. The targets are to:

- reduce the number of new childhood HIV infections by 90%
- reduce the number of AIDS-related maternal deaths by 50%.

A modelling exercise⁵ has demonstrated that if countries implement the WHO PMTCT 2010 antiretroviral therapy (ART) recommendations⁶ to provide more effective regimens, a 60% reduction in new paediatric HIV infections can be obtained.

Reducing HIV incidence in reproductive age women (Prong 1) and eliminating unmet need for family planning (Prong 2) can result in an *additional* 13% reduction. Family planning and HIV prevention also have other intrinsic benefits to women⁷ which were not fully captured in the modelling exercise. Benefits include reducing maternal mortality, improving child survival, decreasing poverty, fostering economic empowerment, and advancing education. A further 6% reduction in mother-to-child transmission (MTCT) can be achieved

by limiting the duration of exclusive breastfeeding to 12 months (with antiretroviral prophylaxis).

The *Global Plan towards elimination of new HIV infections in children and keeping their mothers alive* has given renewed impetus to strengthen programme interventions for Prongs 1 and 2.

As the *Countdown to Zero* Global Plan highlights, the impact of keeping children alive will be lost if their mothers are not also kept alive. Thus, the target of a 50% reduction in HIV-related maternal deaths is in line with the goals set in both the *Countdown to 2015 Initiative* for maternal, newborn and child survival and the UNAIDS *Getting to zero: 2011–2015 strategy*.⁸ This indicator therefore captures a broader package of integrated HIV and maternal, newborn and child health services, which is critical for achieving the goal of this Global Plan.

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

- Remaining HIV-negative, particularly throughout pregnancy and breastfeeding (period of higher risk), protects infants and children from becoming HIV-positive by eliminating the possibility of HIV transmission from the mother.

- Primary prevention of HIV improves survival and well-being. HIV is the leading cause of death among women of childbearing age, contributing significantly to maternal mortality.
- The benefits of family planning are far reaching, ranging from fewer maternal and newborn deaths and healthier mothers and children to increased family savings and productivity, better prospects for education and employment, and ultimately improvement in the status of women.
- Unintended pregnancies contribute to maternal morbidity and mortality; 27% of maternal deaths can be prevented by meeting unmet need for family planning.
- HIV-related morbidity and mortality in a mother living with HIV impacts critically upon her child's survival.
- Fewer unintended pregnancies mean fewer infants born to mothers living with HIV, thus resulting in a smaller number of potentially HIV-positive infants.

Key interventions and strategies related to Prongs 1 and 2

Table 2 lists the *essential* services required for primary prevention in the context of PMTCT (Prong 1) and for preventing unintended pregnancies in women living with HIV (Prong 2).

Importantly, the package of essential services listed in Table 2 should be modified according to the key features of HIV and sexual and reproductive health in each country. In addition, these preventative interventions must be linked to other HIV prevention efforts at the community level, such as: sexuality education and skills-building for young people to prevent HIV and unintended pregnancies; male circumcision; and the distribution of appropriate information and commodities to support dual protection.

In order to effectively implement the delivery of the above package of essential services related to Prongs 1 and 2, five key strategies will contribute to overcoming barriers



HIV infections in infants have been virtually eliminated in many high-income countries ... Now we must apply the tools at our disposal ... in Africa.

The lives of mothers and their babies can be saved through a combination of HIV testing and counselling, access to effective antiretroviral prophylaxis and treatment, safer delivery practices, family planning, and counselling and support for optimal infant feeding practices."

Michel Sidibe, UNAIDS, addressing the Ambassadors to the African Union, 31 May 2010⁹

to women accessing comprehensive eMTCT services, namely:

- **Strategy 1:** Link SRH and HIV at the policy, systems and service delivery levels
- **Strategy 2:** Strengthen community engagement
- **Strategy 3:** Promote greater involvement of men
- **Strategy 4:** Engage organizations of people living with HIV
- **Strategy 5:** Ensure non-discriminatory service provision in stigma-free setting.¹⁰

Table 2: Essential package of services for Prongs 1 and 2¹¹

	Prong 1: Primary prevention of HIV infection among women of childbearing age	Prong 2: Preventing unintended pregnancies in women living with HIV
1	Information and counselling to reduce the risk of sexual HIV transmission	Information and counselling to support reproductive rights, including preventing unintended pregnancies
2	HIV counselling and testing (particularly for pregnant, post-partum, and breastfeeding women and their male partners) and referral or on-site treatment	Clinical management of HIV
3	Treatment for prevention	Rights-based family planning and services
4	STI screening and management	STI screening and management
5	Condoms (female and male): promotion, provision, and building negotiation skills	(see Rights-based family planning and services)
6	Blood safety and anaemia prevention to reduce blood-related transmission	Stigma and discrimination eradication
7	Gender-based violence prevention and impact mitigation	Gender-based violence prevention and impact mitigation

From theory to practice: Implementing services that support Prongs 1 and 2: A case study from Swaziland

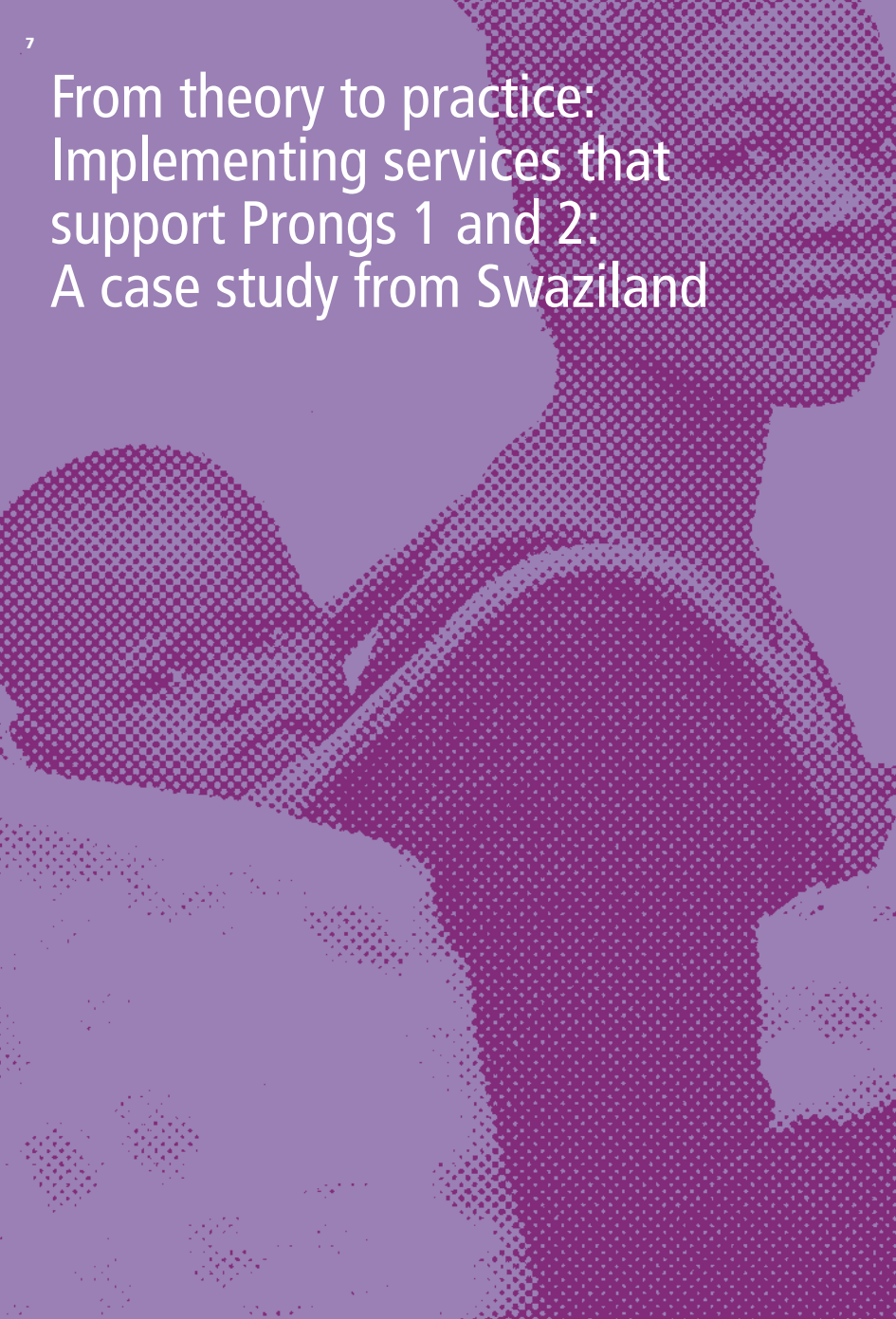


Table 3: Swaziland – vital statistics at a glance¹²

Estimated population (2007)	1,018,444		
Adult population aged 15–49 years (2007)	418,093		
Life expectancy at birth (2009)	Male 47 Female 50		
Crude birth rate (2009) – births per 1000 population	30/1,000 population		
Total fertility rate (2006–07)	3.8%		
HIV prevalence rate in adults aged 15–49 years (2009)	25.9 %		
Estimated number of HIV-positive people (2011)	197,112		
Estimated number of HIV-positive adults aged 15–49 years (2011)	182,792	Male 76,892 Female 105,900	
Estimated deaths due to AIDS (2011)	6,524		
Estimated number of adults in need of ART, according to CD4 cell count (2011)	CD4 <350: 81,324 CD4 <200: 60,716		
Estimated number of people receiving ART (2009)	35,345		
Estimated number of HIV-positive pregnant women (2011)	10,728		
Estimated number of HIV-positive pregnant women in need of PMTCT (2011)	9,118		
Percentage of young people aged 15–24 years who used a condom last time they had sex with a casual partner (2007)		15–19 years	20–24 years
	Male	68.8%	71.1%
	Female	51.9%	55.8%
Percentage of young people aged 15–24 years who had sex before age 15 years (2007)	Male 5% Female 7%		
Contraceptive prevalence rate among currently married and unmarried women aged 15–49 years (2007)	Married 50.6% Sexually active unmarried 64.5%		
Births attended by skilled health personnel (2005–2009)	74%		
PMTCT coverage (2009) ¹³	69%		

Background

Swaziland is known for having the highest rate of adult HIV infection in the world, with a recent figure at 25.9%.¹⁴ Swaziland is also one of 22 low- and middle-income priority countries¹⁵ with the highest estimated numbers of pregnant women living with HIV.

The generalized HIV epidemic has had a devastating effect on this small country: its present life expectancy (49 years for the total population) is one of the lowest in the world,¹⁶ with women and children being particularly affected.

The 2006–07 Demographic and Health Survey (DHS) estimated that 39% of pregnant women are HIV-positive, giving birth to 17,000 HIV-exposed infants each year (Swaziland DHS 2007).¹⁷ Orphans and vulnerable children account for an estimated 15% of the total population.¹⁸

In 2003 the Ministry of Health and Social Welfare, in partnership with the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), launched Swaziland's PMTCT programme. Since then the country has made good progress on increasing access to treatment, including through PMTCT programmes. Importantly, it has achieved more than 80% coverage of ARV prophylaxis to prevent PMTCT,¹⁹ one of the four prongs for PMTCT programming. PMTCT services are now available at 87.7% of the country's 171 public health facilities offering antenatal care (ANC).²⁰ As a result of the country's concerted

efforts to provide ART in maternal and child health settings, the number of women beginning ART has increased from 259 in 2007 to 1,844 in 2009.²¹ This case study, however, is concentrating on the complementary PMTCT services related to preventing HIV among women of childbearing age, particularly pregnant women, and preventing unintended pregnancies among women living with HIV.

In Swaziland, PMTCT services are located within the Ministry of Health's Reproductive Health Department (rather than in the HIV Department) and are thus recognized as an integral part of maternal, newborn and child health (MNCH) services so as 'to provide a platform for comprehensive services to keep women, children and families healthy.'²²

The Ministry of Health's current *Guidelines for Prevention of Mother-to-Child HIV Transmission* (2010)²³ clearly articulates how this integration occurs within a MNCH setting across five stages: HIV counselling and testing, antenatal care, intrapartum care, post-natal care services and follow-up of the HIV-exposed infants.

Political commitment to PMTCT

The Government of Swaziland, recognizing that MTCT will reverse the progress made to improve child survival through the Expanded Programme on Immunizations (EPI) and safe motherhood initiatives, has placed PMTCT as its top priority.²⁴

With the publication of the country's most recent revision of its national PMTCT guidelines in October 2010, the Ministry of Health noted that eMTCT is now considered a realistic public health goal in Swaziland and pledged its commitment to providing equitable access to quality PMTCT services within MNCH settings within the country.²⁵ This political commitment to PMTCT was reiterated at the United Nations General Assembly High-Level Meeting on AIDS in mid-2011 by the country's prime minister.

Implemented within the framework of the 'Three Ones' principle – namely, that stakeholders harmonize their operations by having one

national strategic HIV framework, one national coordinating authority and one country-level monitoring and evaluation system.²⁶ The country's National Multisectoral Strategic Framework on HIV and AIDS 2009–2014 clearly acknowledges combining the comparative advantages of a variety of stakeholders to achieve the framework's results.

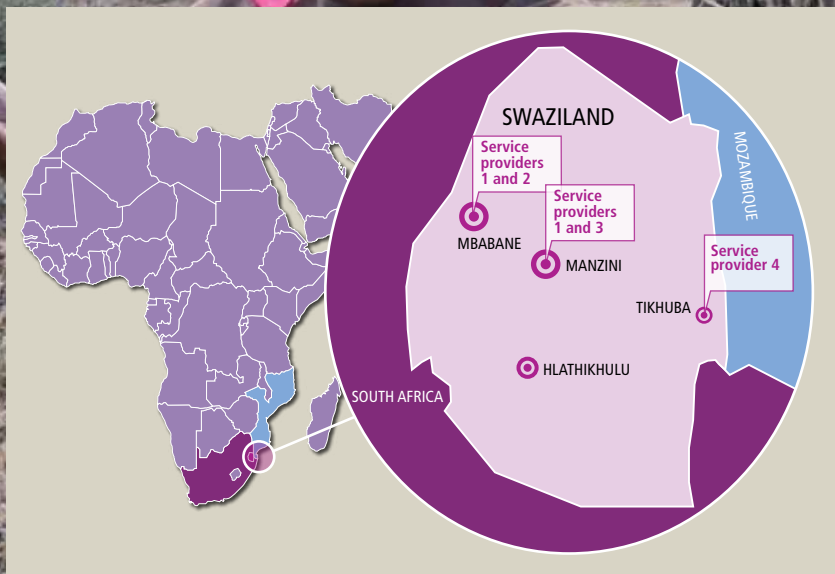
The various approaches taken by the following four service providers illustrate firsthand how such stakeholders are attempting to collectively contribute to the implementation of the four components of comprehensive PMTCT programming.

“ With a National Strategic Framework that includes a concerted focus on prevention, over the past seven years we have increased the number of sites providing PMTCT services from 3 to 142, and, in the process, have reduced mother-to-child transmission of HIV to 10% and we aim to get that down to zero by 2015. ”

Statement by His Excellency the Right Honourable Dr Barnabas Sibusiso Dlamini, Prime Minister of the Kingdom of Swaziland, at the United Nations General Assembly High-Level Meeting on AIDS, New York, 8 June 2011.



Case study sites



Service provider 1

Family Life Association of Swaziland

Established in 1979, the Family Life Association of Swaziland (FLAS), an affiliate of the International Planned Parenthood Association (IPPF), focuses on providing SRH services and information to young people in Swaziland.

A range of HIV-related services, including ART, is comprehensively integrated into the health service package offered at its two clinics in Manzini and Mbabane – each of which has a youth-friendly service for clients under 24 years of age. A sexual health clinic for men is also available in Mbabane where men can access voluntary counselling and testing (VCT), treatment for sexual transmitted infections (STIs), condoms, infertility counselling and circumcision. Unlike the public health clinics where clients pay 5 lilangeni (US\$0.70) for a consultation, the rates for services at FLAS are higher, with for example, a general consultation costing 12.50 lilangeni (US\$1.75) and a 45-minute ANC consultation costing 62.50 lilangeni (US\$8.75). Despite the higher costs there are a considerable number of clients that are able to pay the higher fees and elect to use the FLAS clinics for, among other things, the reduced waiting times and the sense of privacy that is offered in the consultation rooms.

FLAS services are also available for free to under-served populations in a number of urban and rural locations via its two mobile clinics. At present FLAS conducts approximately 58,000 consultations a year.

FLAS offers a full range of PMTCT services, addressing all four prongs and including activities to encourage the involvement of men in the service. In 2010, at the Manzini clinic, of the 152 clients who were pregnant women living with HIV, only seven had a child who was born HIV-positive, a 4.6% infection rate.

“ At FLAS we put the rights of women living with HIV at the centre. This starts with ensuring confidentiality and making sure that each PMTCT client only has to see one specially trained service provider for all the services they receive whilst they are with us, such as counselling, HIV testing, ANC services and prophylaxis or ART.”

Service provider, FLAS, 2011

Service provider 2

Baylor College of Medicine Children's Foundation – Swaziland

The Baylor College of Medicine Children's Foundation – Swaziland (commonly referred to as Baylor) is a partnership between Baylor College of Medicine International Pediatric AIDS Initiative and the Government of the Kingdom of Swaziland. Its primary focus is on the provision of care and treatment to HIV-positive children and adolescents and their HIV-positive family members. It is also a site for paediatric HIV- and AIDS-related clinical and operations research and health professional training.

The Baylor clinic in Mbabane, the capital of Swaziland, opened in 2006, and an outpatient PMTCT programme was incorporated into its services in 2008. During 2009–2010, satellite clinics at Raleigh Fitkin Memorial Hospital in Manzini and Hlathikhulu Hospital in Hlathikhulu opened and became fully functional. Overall, in 2010 Baylor had 4,284 active patients and at any given time supports approximately 90 pregnant women who are living with HIV, taking care of their prenatal and comprehensive health care needs.

The majority of Baylor's PMTCT clients are pregnant and have tested HIV-positive at another facility that does not offer PMTCT services – and so have been referred to Baylor.

Baylor also runs a teen club which provides emotional and educational support to 350 adolescents living with HIV from across Swaziland, encouraging and enabling them to live positively, build confidence and successfully transition into adulthood.



Our entry point is the child. We are known as a place that cares for HIV-positive children. But we are also known as a PMTCT clinic. The majority of clients we see here know their HIV status, are pregnant and come specifically for PMTCT. Sometimes they are being referred from other clinics as well – those clinics that don't do PMTCT but just provide HIV testing."

Service provider, Baylor, 2011

Service provider 3

King Sobhuza II clinic

King Sobhuza II clinic, a busy urban facility in Manzini, started their PMTCT programme in 2003 in one small room. Here, they did HIV counselling and testing and follow-up consultations, and sent patients to Raleigh Fitkin Memorial Hospital for ART initiation. Given the limited physical space and the fact that only one nurse had undergone training, the PMTCT programme was separate from the clinic's ANC services.

Currently, infrastructural and technical support is provided by EGPAF and the clinic is able to offer a PMTCT service that is fully integrated into its MCH services (and ANC programme) – and all their staff have undergone the necessary training.

The consultation rooms are not labelled as offering a specific service, and the staff rotate on a six-monthly basis between the different consultation rooms so that they are comfortable with offering all aspects of MCH care. The facility sees about 60,000 women and children each year.

“ A supermarket approach exists here! So whilst you have found me in the family planning consultation room this time, next time you will find me in an ANC consultation room.”

Service provider,
King Sobhuza II, 2011



Service provider 4

Tikhuba clinic

The Tikhuba clinic is situated in a small rural town just a few kilometres from Swaziland's eastern border with Mozambique.

The Tikhuba clinic started its PMTCT programme in 2005. The facility sees about 250 clients a year from the surrounding community at their first antenatal care visit. The majority of the clients are women, as many men are working and living away from home during the week and others are reluctant to seek medical assistance. Aware of the lack of male involvement, the Tikhuba clinic employs both male and female counsellors so as to try to encourage the male partners of their clients to come in for HIV counselling and testing.

“ Many of our clients are poor and have a minimal educational background so we have to work hard to help them to understand the importance of certain issues with regards to their health such as using condoms and encouraging men to accompany their partner to the health facility either antenatally or postnatally.”

Service provider, Tikhuba, 2011



Promising practices addressing Prong 1

1. Community-based, preventative health education activities (including about PMTCT)

In an attempt to increase the community's awareness of SRH-related issues, including awareness of PMTCT, FLAS – together with one of the Mentor Mothers based at FLAS's clinic in Manzini – brought together a team of community volunteers. Each of the 30 registered community volunteers conducts educational activities in their local neighbourhood: from community dialogues on SRH and HIV issues, distributing information, education and communication (IEC) materials and condoms to individuals to embarking on a door-to-door campaign to educate households about HIV and other key SRH-related issues – part of which includes information about the availability of the PMTCT programme and ART. One of the important objectives of this outreach work is to try to reduce the level of HIV-related stigma among local community members. Another objective is to encourage those who require treatment – such as ARVs – or SRH counselling to attend the FLAS clinic in Manzini.

Similarly, FLAS's Youth Action Movement (YAM), a peer-education programme based in four sites in Swaziland, trains youth educators to facilitate weekly sessions with their peers on life skills, rights, and SRH- and HIV-related matters. Opportunities are created within the

curriculum to discuss family planning, dual protection, reproductive health decision-making and the availability of PMTCT.

The Ministry of Health has established community-based structures that provide education at community level and these include rural health motivators whose activities include door-to-door education activities.

2. Provider-initiated HIV testing and counselling linked to SRH services

In 2006, in response to the unmet need in relation to HIV counselling and testing (HCT), with only 22% of women and 9% of men having tested for HIV and received their results (SDHS, 2006–7), Swaziland adopted provider-initiated HIV testing and counselling (PITC) with a strong human rights perspective.²⁷ In line with this approach, and given that they are offering integrated SRH and HIV services, FLAS strongly encourages all their female clients coming to access contraceptives or for any SRH consultation to receive counselling and get tested for HIV. In addition, in accordance with the national PMTCT guidelines, FLAS encourages all their clients who test for HIV early in pregnancy to re-test every two months.

3. Encouraging male partner involvement, including HIV testing

Great emphasis is placed on encouraging male involvement in the maternal and child health facility at King Sobhuza II clinic in Manzini. The

clinic has integrated its HIV-related services (such as testing, treatment and PMTCT) into its MCH services.

When a woman attends the clinic one of the critical things that a service provider will discuss with her is the health of her partner, and specifically her knowledge of her partner's HIV status. As a way of encouraging greater male involvement in sexual health matters, and specifically in the health of their partner and child, the clinic has developed a standard 'notification' (or love letter as it is sometimes referred to) for the client's partner.

Addressed to the partner, it "*kindly invites*" them to visit the clinic and, based on the nature of the consultation with the client, invites them to discuss one or more of the following health issues: their "*health as a father*", the "*health of the person you are in love with*", the "*health of your child*", "*safe pregnancy*" or "*other issues*".

As a way of further encouraging the partner to attend the clinic the letter then informs the partner that "*when you arrive at the clinic you do not have to wait in the line, but you will be attended promptly if you bring this letter with you*".

One of the potential benefits of a partner learning his HIV status is that he would have the opportunity to start taking ARVs, which would not only benefit him but reduce the risk of transmission to his partner.

The challenge

The lack of male involvement in all aspects of the PMTCT programme is a concern for many service providers. Women frequently attend their first ANC consultation alone without their partner.

Offering incentives, such as a prompt consultation with a health professional (King Sohbuza II clinic); providing treatment and support to the *whole* family in a single visit rather than exclusively focusing on the referred client (Baylor); employing a male HCT counsellor (Tikhuba clinic); or establishing a health clinic specifically for men (FLAS) are some of the ways that service providers in Swaziland have tried to increase their male client base and engagement with the issue of PMTCT.

In Tikhuba clinic a community-based awareness-raising activity on PMTCT, aimed specifically at men, was conducted where local men congregate to dip their cattle: information was disseminated about PMTCT – and specifically about the importance of accompanying their pregnant partner to the clinic. Male-friendly HCT facilities were also made available at the agricultural site.

Just as the mothers2mothers programmes are functioning effectively,²⁸ creative ways of considering how equivalent 'father to father' programmes could be instituted should continue to be discussed, along with other means of men interacting and discussing

their concerns, becoming aware of PMTCT, and changing behaviours to support the health and well-being of themselves, their partner(s) and children.

Another important arena for promoting male involvement is through the workplace. The 2006 *Tripartite Declaration to Combat HIV/AIDS at Workplaces in Swaziland* states that “HIV requires ongoing and innovative human resource management strategies”.²⁹ Employers need to find creative solutions during times of pregnancy so men can accompany their partners to ANC appointments and be available to support them during and after the pregnancy. HIV workplace programmes should also actively encourage men to support their partners during pregnancy as part of a workplace programme.

4. The promotion of HIV counselling and testing as part of the ANC routine

As part of their routine ANC consultations, FLAS service providers talk to the client about the importance of her knowing her HIV status and encourage her to get counselled and tested at their first visit. In order to try to support their HIV-negative pregnant clients to remain HIV-negative throughout their pregnancy, FLAS requests that such clients return every eight weeks to get tested for HIV, until they deliver.

The challenge

Reducing HIV sexual transmission risk within sero-discordant couples and managing safer conception is a challenge that health service providers in Swaziland frequently face.

Couples HCT is an important and feasible intervention that can be effectively integrated into existing MNCH and other SRH services. Not only does it provide an opportunity for the challenging issue of disclosure to be addressed, but working with couples, rather than just the individual partner, has been shown to be an effective intervention for reducing the risk of HIV transmission among sero-discordant couples (Allen et al. 2003; DeZoysa et al. 2000. Cited in Spino, Clark and Stash 2010).³⁰

Encouraging and ensuring that couples are counselled jointly would also require that both professional and lay health workers are sufficiently skilled to facilitate quality couples counselling and convey appropriate behaviour change messages in the joint counselling sessions.

5. Safer sex information and counselling during ANC consultations (including intensified post-test counselling)

Part of the post-test counselling sessions conducted during such visits focus on encouraging the client to introduce and/or use a condom in their sexual relationship.

Such discussions are initiated by first exploring how much the client knows about condoms and what they perceive their benefits to be – specifically in terms of ‘dual protection’. This is then followed by a demonstration of how to use a condom, the provision of such commodities to the client and guidance on how to negotiate condom use with their partner.

The challenge

New evidence shows an increased risk of HIV infection for women and their male partners during pregnancy.³¹ A recent study conducted by EGPAF, the Swaziland Ministry of Health, the Swaziland National AIDS Programme and George Washington University in six maternity sites in Swaziland, found that 5.6% of the study sample seroconverted during pregnancy.³²

Further research would be helpful to determine the circumstances behind the nearly 6% sero-conversion rate during pregnancy, and the key factors enabling some couples to use condoms (including during the pregnancy and breastfeeding periods) to help tailor behaviour change and communication interventions and prevention programmes.

6. STI screening and management at ANC consultations

Given the increased risk of HIV transmission in the presence of ulcerative and inflammatory STIs, pregnant clients are screened for

STIs at each one of their four routine ANC visits. In accordance with the national PMTCT guidelines, screening for syphilis is routinely conducted at a woman’s first ANC visit.

7. Discussions about family planning incorporated into ANC visits (see also the next section on Prong 2: Preventing unintended pregnancies among women living with HIV)

Conversations about family planning are initiated at the first ANC visit at all the facilities. After ascertaining a woman’s fertility desires, as appropriate, counselling on the selection of a suitable family planning method continues throughout the pregnancy with the aim of equipping the client with the necessary information and confidence to initiate their preferred method six weeks after delivery.

The introduction and finalization of decision-making around family planning early on in the ANC consultations is seen as an essential part of the client’s planning for the post-delivery period. The aim of such conversations is to ensure that by the time the woman delivers her baby she has already chosen her contraceptive method, if she intends to space her next pregnancy.

The promotion of dual protection³³ from unintended pregnancies and STIs/HIV is also emphasized across all facilities. Condoms alone or with another method reduce HIV transmission. And since there is higher risk of HIV transmission

during pregnancy, family planning, by ensuring that pregnancies are intended, may also contribute indirectly to preventing HIV.

No matter what the client's choice is in terms of a family planning method, the use of a dual method with condoms (or condoms alone for dual protection) is reinforced in every consultation. One example of this (Baylor) is a reminder to staff to emphasize dual protection printed at the top of the facilities' patient record forms.

The challenge

Despite overall high ANC attendance, with 97% of Swazi women receiving some antenatal care from a medical professional, Swaziland's DHS 2006–07 survey found that only 26% of women had had an antenatal care visit by their fourth month of pregnancy as recommended.³⁴ Although most women receive some antenatal care, their late attendance might mean that they are not receiving all the recommended components of antenatal (and PMTCT-related) care, thus necessitating a greater understanding among health workers of how to encourage earlier attendance.

8. The provision of family planning commodities at the second post-partum visit

Following delivery the client and newborn return to the facility for their post-partum visits: the first within 7–14 days and the second

within six weeks of the date of delivery. At the first visit the client who has requested contraception is reminded that she is due to receive her family planning method at the next visit. Although the practice might change in the future, to date, unless a specific request is made, the facilities do not ordinarily give their clients their family planning methods prior to the six-week visit.

9. Identification and referral for services to prevent and manage gender-based violence

Gender-based violence is one of the issues that service providers at FLAS are trained to be alert to as part of their SRH counselling routine, and is listed as one of the potential issues that might be discussed under 'SRH counselling' on their daily register.

HIV and STI post-exposure prophylaxis (PEP) is available at FLAS for clients who have experienced sexual assault or violence, and a formal memorandum of understanding has been established between FLAS and a local organization specialized in gender-based violence, Swaziland Action Group Against Abuse. Clients requiring legal assistance, for example, are referred to this partner organization and the organization in turn refers their clients who need clinical assistance, including PEP, to FLAS.

The challenge

Although not often raised or presented as a problem by the client,

many health workers interviewed did acknowledge that the subtle signs of gender-based violence are an issue that they have to pay special attention to in their consultations.

This vigilance is appropriate given that a 2007 study in Swaziland showed that 33% of females in the age range 13–24 years reported experiencing some form of sexual violence before reaching 18 years of age.³⁵ However, due to the limited space in many of Swaziland's public health facilities, where a consultation room might be shared with another client, the disclosure of experiences of physical or emotional abuse is likely to be more difficult. And even if such a disclosure is made, many rural clients are likely to find it a challenge to attend the more urban-based specialist organizations offering counselling and legal advice about gender-based violence.

Violence against women – including both intimate partner violence and sexual violence against women – is a violation of women's human rights and a significant public health problem.³⁶ Gender-based violence may have a negative effect on women's access to services, which contributes to adverse health outcomes. For example, a woman who cannot negotiate the use of a condom for fear of violence is at increased risk of HIV and other STIs, and a woman may be subjected to violence after she discloses her HIV status to her partner.³⁷

Internationally it is increasingly realized that pregnant women are particularly vulnerable to gender-based violence. In addition, women living with HIV might face violations of their sexual and reproductive health rights by, for example, being actively encouraged or coerced to undergo sterilization³⁸ or to terminate their pregnancy.³⁹

A programme to address gaps in the health sector capacity to support survivors of sexual violence was implemented between 2007 and 2010.⁴⁰ Technical guidelines on case management for survivors of sexual violence were developed as well as a training manual for health workers. To date 29 trainers have been trained who in turn have trained 57 health workers from 48 health facilities in Swaziland. To ensure that the trained staff can put their skills to good use, job aids now need to be developed along with the provision of emergency kits and equipment to support the implementation of the programme in all health facilities.

Promising practices addressing Prong 2

1. Providing non-judgmental rights-based health services

Ensuring that health workers understand the importance of creating a non-judgmental and supportive environment from which clients, especially those living with HIV, are able to exercise their reproductive rights and access quality health care is considered an important part of the staff induction process for all the service providers. New staff members in FLAS, for example, are introduced to the principles of providing a youth-friendly SRH service, and the rights of clients are displayed in a poster in SiSwati in the reception room. Along with other quality of care assessment tools, such as a suggestions box in the reception area, both FLAS and King Sobhuza II clinic have community-based user committees that represent the interests of clients in the facility's planning meetings. The encouragement of a greater sense of community ownership and confidence in being able to provide the health team with feedback about the quality of their services creates an enabling environment in which key health rights are then discussed and honoured.

2. Increasing awareness about the reproductive rights of women living with HIV

Service providers from all sites reinforced the Ministry of Health's commitment to support the rights

“ Being HIV-positive does not mean I cannot have children. I can have children. Depending on how I feel – it will depend on me whether I want to have a child or children as someone living with HIV. Here at FLAS the women are provided with family planning – they say we can still have children if we want to like any other women.”

Mothers2mothers counsellor, FLAS, 2011

of people living with HIV to have children. This principle is clearly stated in the country's national ART registration form which records the 'child wish' of those on ART. Further discussions are held with HIV-positive clients at the clinic about how important it is to inform the health care provider about their intention to get pregnant. King Sobhuza II works in partnership with the Swaziland Network of People Living with HIV/AIDS (SWANNEPHA) and asks their representatives to provide additional input to the clinic's HIV-positive clients about reproductive rights, fertility intentions and related decision-making.

The presence of Mentor Mothers from the mothers2mothers programme in three of the four service providers was seen as a definite advantage by health professionals in each facility. Mentor Mothers are HIV-positive mothers who provide peer education and counselling to HIV-positive pregnant

women, and accompany clients from one service area to the next in the large clinics. Not only do they perform these crucial functions, but their very presence is perceived to reduce HIV-related stigma and discrimination.



By having the Mentor Mothers in the clinic it has shown our clients that living with HIV is not such a big thing: they are with us in our tea room and in our meetings. It seems that the stigma is getting a bit lower. Also they are empowered to speak about their own experience as an HIV-positive mother and this provides additional support for our clients.”

Service provider, KING SOBHUZA II clinic, 2011

Another successful peer education initiative led by people living with HIV that is used in Swaziland is that of the paid expert client.⁴¹ Working as part of a multidisciplinary care team at a health facility, the expert clients – who themselves are HIV-positive – act as a link between clients living with HIV and the other members of the health care team. They conduct group education sessions, conduct individual counselling sessions (particularly on ART adherence) and help patients negotiate referrals from one service point or provider to another.

A recent national survey conducted by SWANNEPHA identified that there was still some room for improvement in terms of how health care providers engaged with HIV-positive women about their reproductive health options. This finding points to the need for continued pre- and in-service health provider capacity-building to address rights and stigma and discrimination, as well as continued engagement of people living with HIV in programme monitoring and evaluation, and community engagement.

3. Encouraging male partner involvement

While recognizing the difficulties of trying to obtain greater male involvement in maternal and child health, another approach adopted by the Baylor clinic is to encourage its HIV-positive clients to come as a family to the clinic. The team feels that being able to support the family as a unit (as opposed to referring the father to another site and on another day from his partner and child) is not only practical, but opens up the possibilities of facilitating couple counselling around other SRH issues.

The challenge

Health workers have an important role to play in assisting their clients to consider the potential benefits of disclosing their HIV-positive status to their sexual partner (such as, for example, increased psychosocial support, the opportunity to discuss and implement HIV risk reduction

People Living with HIV Stigma Index

The People Living with HIV Stigma Index was rolled out in Swaziland in 2010. The purpose of the index is to increase local capacity to assess and measure change related to stigma and discrimination in the context of the HIV epidemic.

The in-country partnership included the SWANNEPHA, FLAS, UNAIDS, UNFPA, the Global Network of People Living with HIV (GNP+), International Community of Women Living with HIV (ICW) and the Ministry of Health. People living with HIV were at the centre of the process as interviewers, interviewees and data collectors as well as in the analysis of the data and compilation of the final report.

Using a questionnaire adapted for use across Swaziland, 1,233 people living with HIV were interviewed across the country, made up of 74.3% (916) females, 25.3% (312) males and 0.4% (5) who identified themselves as transgender.

The highest percentage was the 44.5% who had lived 1–4 years with HIV, followed by 33.2% who had lived 5–9 years with HIV. A majority (75.8%) of interviewees lived in rural areas, 22.5% lived in small towns and 1.7% lived in cities. The interviews took place in the second half of 2010.

Results from the interviews, specifically pertaining to rights, showed the following:

- Only 52.2% of the respondents had received counselling about their reproductive options since being diagnosed as HIV-positive.
- About 12.2% were advised by a health care professional not to have a child since they were diagnosed as HIV-positive. 3% of those interviewed were coerced into being sterilized.
- 5.8% of interviewees stated that their ability to obtain ART was conditional on the use of certain forms of contraception.
- 1% of the respondents had an experience of being coerced by a health care professional to terminate a pregnancy because of their HIV status.
- 10.2% experienced being coerced by a health care professional in relation to a method of giving birth because of their HIV status.
- 17.3% felt that they were coerced with regard to infant feeding practices.

More information about *The People Living with HIV Stigma Index* project can be found at: www.stigmaindex.org

strategies for serodiscordant couples, and to carefully plan for a pregnancy in the future), and weighing these against the potential risks they might face – such as a separation or divorce from their partner, violence, and the potential loss, even if meagre, of economic support from the partner.

Given their workloads and the limited consultation time that health professionals often have with their clients in a facility, establishing a seamless referral mechanism from the health worker to a resident lay counsellor (for example, Expert Clients and Mentor Mothers) and/or a women's support group is important. Clients that have as yet not disclosed their status to their partner can then explore their concerns about disclosure with a counsellor, consider the support they might require in the disclosure process, and identify the critical SRH issues that would be important for them to discuss with their partner.

4. Negotiating condom use

While the full range of contraceptive options is and should always be made available, considerable guidance about how to negotiate condom use for women living with HIV is provided by a Social Worker at Baylor Clinic. The HIV-positive client, especially if the HIV status of her male partner is unknown, will be provided with suggestions about how she can creatively introduce the use of condoms into their relationship – for example, by raising

their aspirations and dreams as a family, including whether they want to have more children.

In addition, family planning counselling is repeated from the first ANC visit throughout the pregnancy and post-partum period, including during child immunization visits.

5. Identifying and eliminating gender-based violence

In the smaller facilities (such as FLAS and Baylor), where clients are attended to in a private consultation room and are able to request to see a particular service provider, the possibilities of discussing gender-based violence with the service provider are a lot easier.

A dropping CD4 cell count or a suggestion by a client that she is experiencing 'social problems' often alerts service providers to screen for gender-based violence. At FLAS the issue of gender is mainstreamed into all of their in-service training courses, and service providers are thus alert to the further vulnerability that women living with HIV might face in relation to sexual harassment, abuse and violence. If women are experiencing or fear gender-based violence, they are helped on site or referred, depending on what is required. A local initiative to strengthen the capacity of service providers to identify and manage gender-based violence in health care settings is described on page 20.

6. Discussing safer sex in ANC visits

At the Tikhuba clinic, service providers encourage their HIV-positive pregnant clients to practise safer sex with partners during their pregnancy. The potential for re-infection and STI transmission to occur during pregnancy, and transmitting HIV to sero-negative partners, are explained to clients during their ANC visits.



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



The purpose and benefit of completing this checklist

The questions in this checklist will help an organization assess whether it is providing the package of essential services that support Prongs 1 and 2 of PMTCT. As such the checklist is a mechanism by which programme managers and health providers can assess the extent to which they are offering their clients (and, where appropriate, the broader community) a limited or comprehensive range of services – both in terms of educational input and counselling support, the provision of SRH commodities and clinical practice.

Some simple instructions to consider before checklist completion

1. Consider all questions for each prong

All organizations using this self-assessment guide should consider all the questions for each prong. Remember, this is a learning process, so the more questions considered, the more will be revealed about a programme and how responsive it is in its support of Prongs 1 and 2 of PMTCT.

2. Work as a team rather than as an individual

It would be beneficial to have a group of three to five staff members, particularly those who are involved in HIV and SRH programming, to work together in completing the checklist. Having a group, rather than an individual, respond to all the questions will allow for a more collective reflection process. It will

also assist the team to brainstorm a variety of ways in which current practice could be improved and transformed in the future.

3. Rate the programme accurately so as to support future improvement

For each question, three responses are possible:

Y = Yes, we undertake this work and/or activity

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

I = Our work in this area is insufficient, in preparation, or being considered

There is no formalized scoring process for this assessment. Instead, examining the questions that were marked as 'no' or 'insufficient' will help to determine priority areas that are most relevant for improvement.

Table 4: Checklist for services that support Prong 1

Question	Y	N	I	
<p>1. Consider your community- and facility-based health education activities, aimed at both young and adult women, and their partners. Are these activities conducted to increase awareness about (a) the advantages and (b) the availability of the following services to:</p>	support informed decision-making about sexual debut, the risks of HIV transmission and the use of contraception, including condoms?			
	support consistent use of male or female condoms to prevent HIV transmission, other STIs, and unintended pregnancy?			
	encourage uptake of voluntary counselling and testing in order to determine their HIV status?			
	encourage the early treatment of sexually transmitted infections?			
<p>2. Are these activities and services provided in an adolescent- or youth-friendly manner? Do they attempt to address – even in a partial way – the structural factors that increase women’s vulnerability to HIV, such as:</p>	gender inequality?			
	multiple concurrent partnerships?			
	violence against women?			
	HIV-related stigma and discrimination?			
<p>3. Are women who have experienced gender-based violence routinely provided with:</p>	counselling support and related SRH services?			
	psychosocial and legal support?			
	emergency contraception in the event of a sexual assault?			
	post-exposure prophylaxis in the event of a sexual assault?			
<p>4. For those women who are pregnant, have tested HIV-negative and are attending antenatal, or post-partum care services, are they routinely:</p>	provided with information and counselling on safer sex, risk reduction and condom use during the course of their pregnancy and the post-partum period?			
	provided with information and counselling on STI prevention (including information on the recognition of symptoms) and, where necessary, the treatment of STIs?			
	encouraged and supported to involve their male partner in their antenatal and post-natal care consultations?			
	provided with the contraceptives of choice in preparation for post-partum sexual activity and, importantly, provided with condoms during their antenatal care consultations?			

Question	Y	N	I	
	provided with an opportunity to discuss the issue of post-partum sexual activity and contraception early after delivery or even late in the last trimester to provide women with the appropriate knowledge to allow them to make informed decisions regarding their reproductive futures?			
	encouraged to re-test for HIV on a regular basis throughout and after their pregnancy – ideally with their partner in the context of a couple counselling session?			
5. Are contraceptive commodities and, importantly, male and female condoms, readily available to women at every consultation they have with a health service provider?				
6. Are creative strategies used by health care providers to encourage greater male involvement in antenatal, maternity and post-partum care such as:	educational talks?			
	an invitation to attend a medical consultation without waiting in line?			
	couple counselling?			
7. Are health care providers, with a woman's consent, able to skilfully address male partners in such a way as to raise awareness of their responsibility for practising safer sex and facilitate the associated behaviour change?				
8. To ensure the components of Prong 1 are integrated into routine practice within the facility and organization:	are all members of the health team sufficiently trained to provide the above interventions with their clients?			
	has the team agreed at which points in the PMTCT process (i.e. provider-initiated HIV testing and counselling, antenatal care, intrapartum care, post-natal care, and follow-up of HIV-exposed infants) the above information and counselling will be provided to clients?			
	has the health team identified which members of the health team will provide clients with the above information and services?			
	are the above elements incorporated into standard operating procedures or guidelines of the facility or organization, so that all (and specifically new) members of the health team are aware of this practice?			

Table 5: Checklist for services that support Prong 2

Question	Y	N	I	
<p>1. Do women living with HIV also receive, as part of their routine HIV services, SRH counselling which:</p>	affirms the right of women living with HIV, and couples, to make an informed decision about whether and when they want children?			
	provides women with information on the healthy timing and spacing of pregnancies?			
	focuses, on a regular basis, on fertility intentions – and if a pregnancy is desired, is a client provided with the necessary pre-conception counselling and care so as to plan for conception in a way that optimizes her health, that of her partner (particularly in the case of a sero-discordant couple) and prevents MTCT?			
	provides information, in a non-judgmental manner, on the full range of contraceptive options available to women, their use and side effects, and how a client can access the commodity of their choice at the service delivery site – including the availability of and access to emergency contraception?			
	discusses the value of dual protection and provides the client with skills-building support to reduce unprotected sex (and, for example, introduce the use of condoms into her existing and future sexual relationships)?			
	discusses the involvement and joint responsibility of the client's male partner in practising safer sex, contraception and planning for conception – and considers ways the client can encourage his involvement in these issues in the future?			
	provides information and counselling on STI prevention (including information on the recognition of symptoms) and, where necessary, the treatment of STIs?			
	provides support for HIV disclosure, particularly in sero-discordant couples?			
<p>2. If a support group for people living with HIV is convened, are the above sexual and reproductive health and rights issues similarly raised and discussed as part of the content of this group?</p>				

Question	Y	N	I	
3. Are members of the health team equipped to provide counselling and support for perinatally infected adolescents who, increasingly, will require similar information and services related to family planning and dual protection, pre-conception care and PMTCT?				
4. Are contraceptive commodities and, importantly, male and female condoms readily available to women living with HIV at every consultation they have with a health service provider?				
5. Are women living with HIV, who have experienced gender-based violence, routinely provided with:	counselling, psychosocial and legal support?			
	emergency contraception and other related services in the event of a sexual assault?			
6. To ensure the components of Prong 2 are integrated into routine practice within the facility and organization:	are all members of the health team sufficiently trained to provide the above interventions with their clients?			
	has the team agreed at which points in the PMTCT process (i.e. provider-initiated HIV testing and counselling, antenatal care, intrapartum care, post-natal care, and follow-up of exposed infants) the above information and counselling will be provided to clients?			
	has the health team identified which members of the health team will provide clients with the above information and services?			
	are the above elements incorporated into standard operating procedures or guidelines of the facility or organization so that all (and specifically new) members of the health team are aware of this practice?			

Key resources

www.srhivlinkages.org

This resource pack aims to build a common understanding of SRH and HIV linkages and provide an overview of the current status of these linkages among key partners. It contains a wide variety of useful resources for organizations working in the SRH and HIV field and advocating on this issue.

Preventing HIV and Unintended Pregnancies: Strategic Framework 2011-2015. In Support of the Global Plan towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive

This framework offers guidance for preventing HIV infections and unintended pregnancies – both essential strategies for improving maternal and child health, and eliminating new paediatric HIV infections. The framework should be used in conjunction with other related guidance that together addresses all four prongs of PMTCT. This document focuses on strengthening rights-based policies and programming within health services and the community for:

- **Prong 1:** Primary prevention of HIV in women of childbearing age (with special emphasis on pregnant and breastfeeding women); and

- **Prong 2:** Prevention of unintended pregnancies in women living with HIV (as part of rights-based SRH of people living with HIV).

It offers guidance to:

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

IATT on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers, and their Children and IATT Working Group on Primary Prevention of HIV and the Prevention of Unintended Pregnancies in Women Living with HIV.

Endnotes

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