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**Guidelines for Integrating
Sexual and Reproductive Health
into the HIV/AIDS Component
of Country Coordinated Proposals
to be submitted to the
Global Fund to Fight AIDS, Tuberculosis and Malaria
Round 7 and Beyond**

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INTRODUCTION

Sexual and reproductive health (SRH) is intricately connected with the AIDS epidemic that continues to ravage individuals and communities around the world. With over 40 million people living with HIV, innovative measures must urgently be added to the prevention and treatment efforts already underway. Women and girls continue to acquire HIV at disproportionately higher rates due to greater physiological vulnerability, socio-economic disempowerment, gender-based violence and other factors. Efforts to curb the rate of HIV infection must also focus on boys' and men's behaviours, as well as respond to their sexual and reproductive health needs. In addition, the sexual and reproductive health needs of vulnerable populations such as young people, men who have sex with men, injecting drug users and sex workers, as well as those of people living with HIV, must be addressed in a holistic manner. Only with such an approach can HIV prevention targets be met and the human rights of these people protected. SRH services targeting these populations provide an entry point for HIV services, and vice versa.

Over the past year, there has been a broad, growing recognition of the need to intensify and accelerate actions towards universal access to comprehensive prevention, treatment, care and support and, despite exceptionally poor performance in the scale-up of PMTCT, global recognition of the need to address the impact of HIV on maternal and neonatal health outcomes has increased. Commitment to achieving universal access goals, which include important SRH services, by 2010 was affirmed by Heads of State and Government and their representatives participating in the 2006 High-Level Meeting on AIDS held at the United Nations in New York, 31 May–2 June 2006.¹

Many countries are already working to scale up HIV interventions to achieve the universal access targets. However, scaling up is hindered by weak integration of services and health systems, as well as suboptimal health system management, procurement of supplies, etc. Increased integration of services will help governments and the international community reach their targets of comprehensive prevention, treatment, care and support.

It is for these reasons that five partners (Global AIDS Alliance (GAA), the International HIV/AIDS Alliance, International Planned Parenthood Federation (IPPF), Interact Worldwide, and Population Action International (PAI)) and other nongovernmental organizations, service providers, and international agencies are advocating for a commitment to health programming that operationalizes the delivery of integrated SRH and HIV/AIDS programmes.

The Global Fund to Fight AIDS, Tuberculosis and Malaria, a unique multilateral partnership that has proven itself to be a successful mechanism for fighting these diseases, has recently launched Round 7 of its grant-making activities.² In preparation for this and future rounds, *Guidelines for Integrating Sexual and Reproductive Health into the HIV/AIDS Component of Country Coordinated Proposals to be submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria* is designed to support Country Coordinated Mechanisms to develop Country Coordinated Proposals for the Global Fund that integrate sexual and reproductive health into the HIV/AIDS component.

The Global Fund supports integration efforts. At the *Advocacy Summit on Global Fund Round 7: Integrating of Sexual and Reproductive Health within the HIV and malaria Components of Country Coordinated Proposals*, Geneva, Switzerland, 4-6 December 2006, the Global Fund indicated that SRH integration would be supported if the impact on HIV can be clearly demonstrated. As such SRH commodities could be funded and proposals that include planned and costed technical support and capacity building could be considered. Furthermore, if CCMs do not have the capacity to undertake integration, they can request funds through their proposals to the Global Fund to strengthen their capacity in this regard.

These *Guidelines* are a response to the low number of SRH-related proposals included in Country Coordinated Proposals in previous Global Fund funding rounds, as well as to the expressed request of SRH and HIV/AIDS providers to maximize the impact of the Global Fund on their work. Annex 1

¹ The United Nations General Assembly (2005). World Summit Outcome. General Assembly fifty-ninth session, 20 September 2005.

www.who.int/hiv/universalaccess2010/worldsummit.pdf

² The Round 7 Call for Proposals is available at <http://www.theglobalfund.org/en/apply/call7/>.

Integrating SRH into the HIV/AIDS Component of a Country Coordinated Proposal provides background information.

Prioritized services and/or programmes that could receive financial support from the Global Fund include:

1. Integrate STI treatment services at the point of service delivery, for example where VCT, prenatal and antenatal care, antiretroviral therapy or prevention of mother-to-child HIV transmission services are provided. Support could be provided to those who currently run or manage stand-alone centres to increase the range of interventions and services to include STI screening and treatment, and to discuss dual protection and PMTCT+ so that women who choose to do so can have safe and healthy pregnancies and deliveries;
2. Integrate voluntary testing and counselling at the point of service delivery, for example, in family planning, adolescent, antenatal and STI management settings;
3. Prevention of parent-/mother-to-child HIV transmission (PMCTC+);
4. Provision of antiretroviral therapy and comprehensive care for PLHIV;
5. Scaling-up of adolescent STI and HIV prevention programmes, including greater support for age-appropriate comprehensive sexual health education and services, and provision of information and services to achieve dual protection against unintended pregnancy and STIs, including HIV, for those in need, including orphans and other vulnerable children;
6. Integrate sexual and reproductive health services for vulnerable populations, including sex workers and their clients and regular partners, men who have sex with men and injecting drug users and their sexual partners, as well as positive prevention and comprehensive SRH for people living with HIV, including dual protection for serodiscordant couples and maternal health services for HIV-positive women; and
7. Combating gender-based violence by strengthening the ability of health care providers to recognize signs and symptoms of sexual, physical or emotional assault in women and girls, as well as in boys (such programs may be especially relevant regarding orphans and other vulnerable children programming, which the Global Fund consistently supports), and to provide treatment and referral to services for people in need.

These seven areas are briefly described below, indicating what types of services are included under each heading. However, no attempt has been made to analyze services, describe them in detail or identify gaps. Furthermore, no advice is offered on which services should be included in individual proposals.

1. INTEGRATE STI TREATMENT SERVICES AT THE POINT OF SERVICE DELIVERY

Infection with sexually transmitted infections other than HIV, such as syphilis, chancroid, gonorrhoea, chlamydia, trichomoniasis and genital herpes, increases the chance of HIV transmission during unprotected sex. Research from South Africa suggests that infection with bacterial vaginosis could double a woman's susceptibility to HIV infection.³ As a result, the control of STIs has received renewed attention as one of the interventions that are feasible and cost-effective to contribute to attaining Millennium Development Goal (MDG) 6, halting and reversing the spread of HIV and other diseases.⁴ However, people in general, particularly young people, tend to be ill-informed about STIs. In countries severely affected by HIV, controlling and managing STIs as a strategy for preventing HIV transmission should be a high priority in primary health care facilities, sexual and reproductive health services, private clinics and other health care settings.

Appropriate and prompt comprehensive case management (syndromic management in low-resource settings) of STIs reduces the risk of HIV transmission to sexual partners, and of the reproductive-tract and obstetric complications associated with STIs. Systematic assessment for STIs, consisting of history-taking, clinical examination and laboratory screening, where feasible, should be part of the initial clinical evaluation of all clients, and in particular of HIV-positive people and pregnant women.

In general, men access STI services more than other sexual and reproductive health services; thus, STI services present a vital opportunity for increasing their involvement in the sexual and reproductive health of both sexes. STI services can offer them HIV voluntary counselling and testing and contraceptive advice, including dual protection, either on site or through service linkages. A negative HIV test result is a key opportunity to reinforce behaviours for avoiding infection with STIs, including HIV. For women, the first point of contact is often family planning or antenatal clinics, which should also provide VCT, STI management, contraception and PMTCT+, or referral to services that provide these. Integrating STI management at the point of service delivery is a crucial step in making a comprehensive range of services available to both HIV-positive and HIV-negative people.

A number of factors have contributed to the current and projected shortage of SRH supplies, including greater knowledge and demand due to decades of successful family planning and SRH programmes. Yet, the AIDS epidemic continues to leave billions of people in need of protection. Furthermore, weak logistics systems compounded by a lack of commitment in many developing countries have had an impact on supplies. For example, shipments of condoms might reach capital cities in global South countries, but not necessarily the rural areas, where they are also urgently needed. Condoms also need careful storage and safeguarding from sunlight and heat to preserve their integrity and thus the protection they can provide.

In order to ensure the long-term stability of SRH supplies, funding should be directed not simply to increase purchases of SRH supplies, but also to build in-country capacity to more effectively manage the increasingly complex financing of SRH supplies, as well as forecasting, procurement and delivery systems. The adequate provision of SRH supplies can be prioritized by ensuring their inclusion in national essential drug lists.

Scale up what works:

Training

- Train services providers on STI diagnosis and treatment, including HIV.
- Educate SRH staff to overcome prejudice or ignorance regarding HIV-positive people, particularly in relation to their sexual and reproductive health choices.

Services

- Provide primary point-of-care comprehensive diagnosis and treatment of STIs (syndromic management where diagnostic resources are limited), with an emphasis on HIV-positive people and pregnant women, including screening and treatment for syphilis.

³ Myer L et al. (2005). Bacterial Vaginosis and susceptibility to HIV infection in South African women: a nested case-control study. *Journal of Infectious Diseases* 192: 000-000, 2005.

⁴ Millennium Development Goals. Goal 6
<http://www.millenniumcampaign.org/site/pp.asp?c=grKVL2NLE&b=186386>

- Provide VCT or refer to VCT services so that people know their HIV status to be able to prevent HIV transmission and to enable people to access treatment, care and support programmes.
- Provide information on dual protection, counselling and access to condoms.
- Support safer-sex campaigns and provide information about HIV transmission modes, reducing the number of partners, condom use and alternatives to penetrative sex, as well as providing information on other STIs.
- Increase the access of young people and members of vulnerable groups to SRH-related information, commodities and services.
- Increase access to prevention information and counselling for HIV-positive and HIV-negative individuals.
- Provide male and female condoms.
- Ensure access for people living with HIV (or referral to) antiretroviral therapy, PMTCT+, the management of opportunistic infections when indicated, and comprehensive SRH care services.
- Provide (or refer to services) treatment of tuberculosis, malaria and hepatitis C, when indicated.

Supplies

- Develop a reliable supply and effective delivery system for SRH commodities.
- Advocate for SRH-related supplies to be included in the country's essential drugs list.

Box 1 The Ethiopian Experience⁵

The Family Guidance Association of Ethiopia (FGAE) is a member of a technical working group on VCT linked to the CCM, although it is not a CCM member. The technical working group is chaired by the MoH. The CCM is composed of the government as well as bilateral, multilateral and community-based organizations, including the Relief and Development Association (CRDA), PLHIV and professional associations.

FGAE developed a funding proposal, which was included in the Country Coordinated Proposal, in part due to its close working relationships with other partners and its significant contribution to VCT (FGAE has 33 VCT sites) in Ethiopia. FGAE is the recipient of **US \$350,000** through the Global Fund and provides **US \$50,000 in matching funding**.

The programme provides:

- IEC/BCC on stigma and discrimination
- VCT
- Condom promotion and distribution
- Diagnosis and treatment of STI
- Increased access to care, support and treatment for people living with HIV/AIDS
- Training of community members and religious leaders to provide support
- Monitoring and evaluation

2. INTEGRATE VOLUNTARY TESTING AND COUNSELLING (VCT) AT THE POINT OF SERVICE DELIVERY

The vast majority of people living with HIV do not know that they are HIV positive. It is in their interest to know that they are HIV positive so that they can protect themselves and others. VCT is also the primary entry point to HIV-related care and support, including access to antiretroviral therapy. Therefore, scaling-up of testing is of the utmost necessity and there is an ongoing debate as to how to achieve this.⁶ Testing and counselling can be made available in a broad range of public health settings, including tuberculosis services, STI treatment services, services for vulnerable populations, etc. In this way, people presenting with other health concerns may be reached. Furthermore, VCT should be integrated into family planning, antenatal care, SRH interventions for young people, and all sexual and reproductive health services.

⁵ IPPF (2005). *Models of Care Country Coordinating Mechanisms Research*. <http://content.ippf.org/output/ORG/files/13139.pdf>

⁶ WHO/UNAIDS (2006). *Guidance on Provider-initiated HIV Testing and Counselling in Health Facilities Draft For Public Comment - November 27, 2006*.

In the days before antiretroviral therapy, pre-test counselling prepared a person not only for the test but also for the consequence of coping with a HIV positive result without any treatment. As the treatment situation has changed both in terms of antiretroviral therapy being found effective and the drugs becoming affordable and accessible, protocols for counselling—both pre-test and post-test—need to be overhauled to reflect issues around the benefits of treatment, adherence and side effects.

Counselling needs to have positive effects. In response to the stigma and discrimination surrounding HIV and people living with HIV; there is a need for a massive investment in programmes to destigmatize HIV and make people living with HIV acceptable in society. Along with such general awareness, the content of pre-test counselling has to change, making taking a HIV test a positive step with benefits, rather than one that frightens people.

Counselling is essential not only because it is often the only entry point for information for persons who may test negative, but also for those who test positive so that messages of prevention, safety, treatment availability and adherence are imparted. Knowledge of one's HIV status is essential for tailoring sexual and reproductive health care, counselling and access to treatment services. In particular, VCT also offers the opportunity of reaching men and boys not just on HIV prevention but also STI management, family planning and combating gender-based violence, something that needs to be consistently supported due to their general lack of health service access. As antiretroviral therapy becomes the norm, there is a need for more money and resources for counselling. In effect, there is a growing need for more, targeted and up-to-date counselling, not less.

It is in this context that family planning, antenatal, and all sexual and reproductive health services have an opportunity to support increased VCT for women, men, adolescents and vulnerable populations, while at the same time providing both pre-test and post-test counselling, which reflects current challenges and opportunities.

Scale up what works:

Training

- Train SRH, family planning, antenatal, maternal health workers and STI health care workers to explain the benefits of voluntary HIV testing and counselling.
- Train SRH, family planning, antenatal, maternal health workers and STI health care workers to provide VCT.
- Train SRH, family planning, antenatal, maternal health workers and STI health care workers to counsel HIV-negative people and those in serodiscordant relationships.
- Train SRH, family planning, antenatal, maternal health workers and STI health care workers to counsel HIV-positive people on dual protection and positive prevention.
- Train SRH, family planning, antenatal, maternal health workers and STI health care workers to provide information and counselling on adherence to and the side effects of antiretroviral therapies.
- Train peer providers on the above, as appropriate.

Services

- Promote and provide voluntary counselling and testing in SRH, family planning, antenatal, maternal health and STI services so that people know their HIV status to be able to prevent HIV transmission and to enable people to access treatment, care and support programmes.
- Provide counselling to people who test HIV negative on safer sex so that they can remain HIV negative.
- Offer VCT to all pregnant women.
- Encourage couples who have lost a child in the first year of infancy to undergo VCT.
- Provide information on dual protection, counselling and access to condoms.
- Ensure access for men and women to VCT within family planning settings.
- Promote couples VCT and the attendance of male partners for family planning discussions and STI management.
- Provide antiretroviral therapy in SRH settings or effective referrals to antiretroviral therapy programmes.
- Promote voluntary counselling and testing with adolescents so that they know their HIV status to be able to prevent HIV transmission and to enable them to access treatment, care and support programmes, as needed.

- Ensure that sexual and reproductive health services for young people are confidential, accessible and free from judgment, and offer a complete range of services, including VCT.
- Ensure that VCT is available and offered to injecting drug users, sex workers and men who have sex with men in SRH, family planning, antenatal, maternal health and STI services.
- Ensure that survivors of rape have access to VCT. If available, provide HIV post-exposure prophylaxis, which should be given within 72 hours of sexual assault, together with counselling.
- Support programmes to de-stigmatize HIV and make people living with HIV acceptable in society.

Advocacy

- Advocate for revised pre-test and post-test counselling guidelines, which reflect the current challenges and opportunities in the country.

Capacity Building

- Build the capacity of SRH diagnostic services to include VCT.

3. PREVENTION OF PARENT-/MOTHER-TO-CHILD HIV TRANSMISSION

Children born to HIV-positive mothers may be infected during pregnancy, delivery or breastfeeding. Most infections can be prevented through antiretroviral therapy treatment during pregnancy and childbirth, and through counselling on infant feeding risks and options. Although PMTCT is often restricted to the provision of antiretroviral therapy to HIV-positive pregnant women before and during labour, safe delivery practices and infant feeding counselling and support; a broader approach has been defined and includes the following four elements:

1. Preventing primary HIV infection in women;
2. Preventing unintended pregnancies in HIV-positive women;
3. Preventing HIV transmission from HIV-positive pregnant women to their infants; and
4. Providing care, treatment and support for HIV-positive women identified through PMTCT or VCT programmes and their families.⁷

All four elements are essential if the United Nations General Assembly Special Session on HIV/AIDS goal for reducing the proportion of HIV-positive children by 50% by 2010 is to be attained.⁸ Current estimates indicate that, because of limitations in coverage, use of services and drug efficacy, using the third element of preventing mother-to-child HIV transmission alone will only reduce HIV in infants by between 2% and 12% in many countries. The most effective way to reduce the proportion of HIV-positive infants is by preventing primary HIV infection in women (element 1), and by preventing unintended pregnancy among women infected by HIV (element 2). These two measures have intrinsic benefits for women and can decrease the proportion of HIV-positive infants by 35% to 45% in some countries, with a significant contribution coming through providing VCT, family planning information, services and counselling.

Preventing primary infection

The vast majority of women of all ages in sub-Saharan Africa and elsewhere are HIV negative. Their biggest need is to remain so. Family planning services have great potential for leading the way in promoting sexual and reproductive health and in efforts to prevent HIV transmission. Transmission of HIV and other STIs warrants special consideration during family planning counselling. The correct and consistent use of condoms continues to be the most effective contraceptive method to protect against acquiring and transmitting HIV and other STIs. Family planning services need to be comprehensive and address HIV prevention including, where appropriate, the benefits of abstinence, the risk associated with unprotected sex with multiple partners, the role played by gender-based violence—or the fear of violence—in transmission of STIs, including HIV, and the promotion and provision of dual protection.

⁷ The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children 3-5 May 2004.

http://www.who.int/reproductive-health/stis/docs/glion_cal_to_action.pdf

⁸ United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (2001). Declaration of Commitment on HIV and AIDS. Paragraph 54.

<http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>

Substantial progress has been made in understanding the dynamics of condom use outside of marriage, both with sex workers and with short-term partners. What is less well documented are the dynamics within marriage or stable relationships that prevent condom use and what are the opportunities for introducing condoms as a form of family planning or as STI prevention, or both. Married women in many resource-poor states are among the most vulnerable to HIV and STI infection, yet they are often unable to negotiate condom use with their husbands.

Preventing primary infection requires strengthening and supporting initiatives that engage men. For many women in developing countries, the ABC prevention approach (abstinence, being faithful or reducing their number of sexual partners, and condom use) is challenging. For example, among young women surveyed in Harare (Zimbabwe), Durban and Soweto (South Africa), 66% reported having one lifetime partner, and 79% had abstained from sex at least until the age of 17 (roughly the average age of first sexual encounter in most countries). Yet, 40% of these young women were HIV positive. Many had been infected despite staying faithful to one partner⁹. In Rakai, Uganda, an ongoing study has found that more than 85% of women (and 90% of men) living with HIV are currently or were previously married. Meanwhile, 45% of married men said they had multiple sexual partners compared with just 5% of women.¹⁰

Pregnancy

Programming interventions must recognize that, in many cultures and communities, the high level of pressure to demonstrate reproductive well-being by having a baby is not often diminished by high HIV prevalence. Programmes should focus on increasing follow-up care during and after pregnancy and providing VCT for couples who have lost a child in the first year of infancy.

STI and HIV prevention must occur early enough to make a difference. There is a heightened risk of violence against women during pregnancy and an increased risk of STIs and HIV infection, as well as a common lack of adequate care. Services to prevent mother-to-child HIV transmission include VCT; antenatal care; diagnosis and treatment of STIs, including syphilis; the provision of antiretroviral therapy and treatment of opportunistic infections; safe delivery practices; and replacement feeding and advice on feeding options. Services must also include prevention of unintended pregnancies among HIV-positive women by promoting dual protection in tandem with other contraceptive methods. Through VCT, women can learn their HIV status in time to benefit from such services.

Prevention of mother-to-child-transmission (PMTCT) efforts may fail if they focus narrowly on women and their biological role in transmitting HIV. Many men effectively control both family finances and their wives' ability to use health care. Failure to engage men may leave women unable to participate in PMTCT programmes even if the women are convinced of the benefits.

Women living with HIV need to know the risks of pregnancy to their own health as well as the risks of HIV transmission to their infants. They must also be aware of the effectiveness, availability and cost of antiretroviral drugs for treating HIV and preventing HIV transmission to their infants, as well as the potential toxicity of such drugs.¹¹ Although pregnancy does not have a major effect on the progression of HIV, women living with HIV have a greater risk of certain adverse pregnancy outcomes, such as intrauterine growth restriction and preterm delivery.

A HIV diagnosis may have a significant impact on a woman's decision whether or not to carry a pregnancy to term. Women need to know where safe abortion is available in those countries in which abortion is legal and what restrictions may apply to them, about the abortion procedures being provided and the expected side effects. Women everywhere need to know the risks of undergoing unsafe abortions (those performed by unskilled providers and/or in unhygienic conditions) and, where available, how to access post-abortive care. Access to emergency contraception should also be provided.

⁹ Meehan A et al. (2004). Prevalence and risk factors for HIV in Zimbabwean and South African women. XV International AIDS Conference. Abstract MoPeC3468 Bangkok. 11–16 July in UNAIDS (2005). AIDS Epidemic Update. December 2005.

data.unaids.org/Publications/IRC-pub06/epi_update2005_en.pdf

¹⁰ Wawer M et al. (2005). *Declines in HIV prevalence in Uganda: Not as simple as ABC*. Abstract 27 LB, 12th Conference on Retroviruses and Opportunistic Infections, February 22-25, 2005. Boston U.S.A. in UNAIDS (2005). AIDS Epidemic Update. December 2005.

data.unaids.org/Publications/IRC-pub06/epi_update2005_en.pdf

¹¹ UNFPA and WHO (Forthcoming). Reproductive and sexual health of women with HIV -Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings.

HIV-positive women tend to be more affected by certain pregnancy-related complications than their sero-negative counterparts, including miscarriage, unsafe abortions, post-partum hemorrhage, puerperal sepsis, and complications of caesarean-section and should receive information and treatment regarding these conditions. Skilled care during pregnancy, childbirth and the postpartum period includes considering the possibility of STIs and HIV-related complications during these events, paying attention to HIV-related treatment and care needs, and intervening to reduce STIs (e.g., congenital syphilis) and HIV transmission to infants.¹²

HIV-positive women who are bearing children must be provided with adequate information to make an informed decision on which mode of delivery is most appropriate for them. Before the widespread use of antiretroviral therapy, elective Caesarean sections were relatively common among HIV-positive women in developed countries. However, for women who are on antiretroviral therapy for whom the probability of mother-to-child transmission is much reduced, the risks involved in a Caesarean section (such as obstetric complications and morbidity) may well outweigh the benefits.¹³ Services must be explicit in their communications with HIV-positive women as to the potential risks and benefits of the different modes of delivery available.

Pregnant women living with HIV have an increased risk of developing malaria and its consequences, and therefore require additional care. HIV impairs the ability of pregnant women to deal with infection, making them more vulnerable to clinical and placental malaria and severe malarial anaemia. This results in the deaths of more pregnant women who have dual HIV and malaria infections than those who have either HIV or malaria. In 2003, it was estimated that about 440 000 pregnant women with malaria in Sub-Saharan Africa were also HIV positive.¹⁴

Note that malaria chemoprophylaxis for pregnant women can be requested as part of the antenatal care package that could be funded through the Malaria Component of the Global Fund. See Section 4 of the *Draft Proposal Form: Seventh Call for Proposals*. Proposals would need to clearly state how malaria chemoprophylaxis for pregnant women is linked to HIV treatment and care.¹⁵

Birth and postpartum services

Comprehensive postpartum follow-up and care for women living with HIV and their infants extends beyond the six-week postpartum period and includes assessment of maternal healing after delivery, evaluation for postpartum infections, ongoing infant-feeding counselling and support for the woman's choice of how to feed her baby, and information on dual protection, other contraceptive choices and birth spacing. PMTCT+ programmes must provide care and treatment for mothers living with HIV, including ensuring their continued access to antiretroviral therapy. Maternal medical services during the post-partum period should coordinate between obstetric care providers and HIV specialists to ensure continuity of antiretroviral therapy for the woman's HIV infection, including increased support around adherence.

¹² This and the following two paragraphs are taken from UNFPA and WHO (2006). Reproductive and sexual health of women with HIV -Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings. <http://www.who.int/hiv/en>

¹³ Berer M (2004). HIV/AIDS, sexual and reproductive health: intersections and implications for national programmes. *Health Policy Plan*. 2004 Oct; 19 Supplement 1:i62-i70.

¹⁴ The 2005 Malaria Report <http://www.rbm.who.int/wmr2005/>

¹⁵ Paula E Brentlinger, Christopher B Behrens and Mark A Micek (2006). *Challenges in the concurrent management of malaria and HIV in pregnancy in sub-Saharan Africa*. The Lancet Infectious Diseases 2006; 6:100-111 (February 2006).

<http://download.thelancet.com/pdfs/journals/1473-3099/PIIS1473309906703838.pdf>

Approximately one million pregnancies are complicated by both malaria and HIV infection in sub-Saharan Africa annually. No published studies have shown whether standard intermittent malaria preventive treatment and antiretroviral regimens are medically and operationally compatible in pregnancy. Further research is urgently needed to define safe and effective protocols for concurrent management of HIV and malaria in pregnancy, and to define appropriate interventions for different populations subject to differing levels of malaria transmission and anti-malarial drug resistance.

Scale up what works:

Training

- Include PMTCT+ as part of training for SRH workers.
- Increase the training and use of skilled birth attendants to reduce trauma during birth. Such trauma can increase the risk of HIV infection due to conditions such as fistula that arise from obstructed labour, often occurring in adolescents and malnourished or ill mothers.
- Train SRH workers to provide clear information to HIV-positive women on the potential risks and benefits of the different modes of delivery.
- Train non-health professionals (such as trained and traditional birth assistants and village health workers, who still attend to more than half the total births in many countries) on providing antiretroviral drugs during labour.
- Train maternal health workers to provide infant feeding counselling, family planning information, STI management and antiretroviral therapy adherence support.

Services

- Provide information about HIV transmission modes, reducing the number of partners, condom use and alternatives to penetrative sex, as well as providing information on other STIs.
- Ensure access for all clients to the management of STIs and other infections such as tuberculosis, hepatitis and malaria within family planning, VCT, antenatal and maternal health services, or by referral.
- Promote dual protection against HIV transmission and unintended pregnancy through condom use alone or in combination with other contraceptive methods.
- Ensure access for men and women to family planning information and services within PMTCT+ and VCT services.
- Improve antenatal VCT programmes to ensure greater uptake of testing, returns for results and sustained engagement with PMTCT+ service for follow-up, care, treatment, safe delivery and postpartum management.
- Promote couples VCT and the attendance of male partners for family planning discussions and STI management.
- Ensure that male and female condoms are available and distributed in family planning, PMTCT+, maternal health and VCT settings, together with information and counselling on their correct and consistent use.
- Include PMTCT+ in all maternal, child and reproductive health services.
- Link PMTCT+ services to other services such as drug dependency treatment; harm reduction and peer counselling; tuberculosis, malaria, hepatitis C and STI diagnosis and treatment; and other public health initiatives, such as the Baby-Friendly Hospital Initiative and youth-friendly services.¹⁶
- Integrate antenatal syphilis screening and treatment within PMTCT+ services.
- Support community engagement that builds awareness around HIV transmission from parents- and mother-to-baby, and corrects myths and misperceptions around HIV transmission. Scale up to cover all pregnant women, sexually active women of reproductive age and men.
- Provide women living with HIV with information on emergency contraception and terminating or continuing pregnancies and referral to services that provide safe abortion in circumstances allowed by the law.
- Provide women living with HIV with ongoing infant feeding counselling, family planning, STI management and access to antiretroviral therapy and support through maternal health services.

Supplies

- Ensure the supply of antiretroviral drugs and contraceptives, including male and female condoms, as well as HIV, STIs and pregnancy testing kits.
- Establish tracking mechanisms to ensure quality services and to prevent shortfalls of supplies.

¹⁶ The Baby-Friendly Hospital Initiative (BFHI), launched in 1991, is an effort by UNICEF and the World Health Organization to ensure that all maternal centers, whether free standing or in a hospital, become centers of breastfeeding support. <http://www.unicef.org/programme/breastfeeding/baby.htm>.

Capacity Building

- Strengthen the human, institutional and technical resources to carry out prevention programmes.

Monitoring and Evaluation

- Build on existing data to develop and improve the monitoring and evaluation of programmes linking VCT and family planning to PMTCT+ services.

4. PROVISION OF ANTIRETROVIRAL THERAPY

As the costs of antiretroviral drugs have fallen and access is being expanded, ensuring people who are living with HIV continue to have access is an ongoing challenge. Innovative ways of distributing drugs and providing the psycho-social support needed for the ever growing number of people who know their HIV status and who may be taking antiretroviral therapy are urgently needed. This is particularly the case in countries with insufficient health infrastructure and supply mechanisms. At the same time, the needs for food, clean water and palliative care, as well as treatment of opportunistic infections cannot be ignored. Currently, millions of people living with HIV have no employment, lack community support, face stigma and discrimination, and live in societies with no or minimal social security.

Even without antiretroviral therapy people living with HIV can maintain good health, including a healthy sex life, for a decade or longer. As increasing numbers of HIV-positive people have access to antiretroviral therapy, this time span is increasing, extending the period over which people can engage in sexual relations and have children. A HIV-positive person may have one or multiple partners; their partner or partners may also be positive (“concordant couple”), may be negative (“discordant couple”) or may be untested. The needs and concerns of HIV-positive people and their partners vary according to these circumstances, which themselves vary over time. As such, it is critical that health services address the wide range of sexual and reproductive health needs arising over the course of a HIV-positive person’s life.

SRH providers will generally not be prescribing antiretroviral therapy, though this may change in response to increased testing driven by demand for services. However, SRH services already have a large role to play in antiretroviral therapy roll-out, particularly in countries where the health system infrastructure is deteriorating or the health system is already overburdened. HIV testing and counselling is the primary entry point to access HIV-related care and support, including access to antiretroviral therapy as well as information and support. VCT programmes in SRH settings can provide effective referrals for antiretroviral therapy.

Antiretroviral therapy has often not been accompanied by clear, accessible information about its benefits, issues around adherence and treatment side effects. This is compounded by the limited knowledge of people living with HIV and their families about treatment options and preventive prophylaxis for opportunistic infections. Vast numbers of people living with HIV lack basic treatment literacy, particularly as antiretroviral drugs are available over the counter at pharmacies in some countries. SRH services are well placed not only to provide guidance on treatment, side effects and adherence—contributing to the support mechanisms available to people and decreasing the burden on antiretroviral therapy programmes. However, this must be in addition to and not at the expense of SRH settings providing their primary services.

SRH services could become a primary point of antiretroviral therapy distribution and monitoring. Such a strategy may be particularly useful in high prevalence countries or where there are few health care facilities. SRH organizations should assess their technical and human resources capacity to provide antiretroviral therapy. Men currently have greater access to antiretroviral therapy than women. However, women access SRH services more often than men. If SRH organizations were to provide access to antiretroviral therapy more equitable distribution of antiretroviral therapy may be achieved. Many SRH organizations already supply clinical services such as STI management. Building on existing human capacity and infrastructure may enable antiretroviral provision and monitoring to be undertaken by some SRH organizations.

SRH-related information and services can also be integrated within antiretroviral programmes. For example, ongoing safer sex counselling should be provided alongside drug adherence counselling in antiretroviral therapy programmes. Such programmes have been shown to be effective in reducing

unsafe sex among people living with HIV. STI screening and treatment of people living with HIV should be part of antiretroviral therapy programmes due to the increased rates, consequences and severity of STIs among people living with HIV.

There are particular concerns about antiretroviral therapy for HIV-positive women, which directly impinge on reproductive health. As the health and well-being of HIV-positive women improve with antiretroviral therapy, women may reconsider previous decisions regarding their sexuality and reproduction. Women living with HIV can safely and effectively use most contraceptive methods. However, several antiretroviral drugs have the potential to either decrease or increase the bioavailability of steroid hormones in hormonal contraceptives. The selection of an antiretroviral therapy regimen for women should consider the possibility of a planned or unintended pregnancy and whether the prescribed drugs may be taken in the first trimester of pregnancy, perhaps, before the pregnancy is recognized, and when foetal organ development is taking place. For women receiving antiretroviral therapy, special efforts to support adherence may be needed during pregnancy, childbirth and the early postpartum period.

Scale up what works:

Training

- Train SRH workers to provide high-quality information on HIV prevention, referral to antiretroviral therapy programmes, and guidance on treatment, side effects and adherence.
- Train SRH workers to provide clear information to HIV-positive women on the effects of interactions between antiretroviral drugs and hormonal contraceptives.

Services

- Provide effective referrals for antiretroviral therapy within VCT programmes in SRH settings.
- Provide antiretroviral therapy and monitoring within SRH settings, if feasible.
- Integrate guidance on antiretroviral treatment, side effects and adherence with SRH services.
- Integrate SRH-related information and services within antiretroviral programmes.

Capacity Assessment

- Assess whether SRH services have the capacity to distribute antiretroviral therapy and to provide blood monitoring services.

Box 2 Family Planning Association of Kenya (FPAK) integrating antiretroviral therapy into services

The Kenyan pilot Models of Care project was a GTZ funded initiative of the IPPF Member Association, the Family Planning Association of Kenya (FPAK), to integrate comprehensive HIV care into four of its existing services. The project built on HIV prevention and care work already undertaken by FPAK, including peer education and behaviour change communication, VCT, PMTCT, and support groups to promote positive living and psychosocial care. The pilot aimed to increase access to and use of HIV care and support services for people living with HIV by strengthening the capacity of FPAK to provide HIV care and support services and to gradually increase the level of access to HIV care and support services for people living with HIV.

Assessments were undertaken to evaluate current site and programme preparedness (strengths and gaps) to start, manage and sustain antiretroviral therapy programmes using VCT and PMTCT as the entry points. FPAK also began to develop site-specific strategies for starting, managing and sustaining ARV programmes. Assessment tools were developed covering leadership and management experience and capacity, services and clinical care, monitoring and evaluation, human resource capacity, laboratory capacity, and drug management and procurement.

A core service delivery team (one from each of the four sites and three from FPAK head office) was trained in a six-day HIV care course in South Africa. With other Kenyan HIV care training professionals, a 'step-down' training for other FPAK staff in two six-day sessions was designed. Further training focused on HIV programme management, other specialist skills such as adherence counselling, experiential training and mentoring, and training of community-based resource people, including distributors of contraceptives, peer educators, and people living with HIV as mobilizers and supporters of other people living with HIV.

FPAK has had to modify its existing service delivery to accommodate providing antiretroviral therapy. This has included more integrated counselling and psychosocial support, more sophisticated client monitoring, and introducing procedures for buying antiretroviral drugs and additional equipment such as refrigerators and computers. Antiretroviral therapy is not free, but provided at the current rate of about one-tenth of the market rate, under the Government's subsidized programme. Treatment for STIs and opportunistic infections is integrated into the regular medical care and fees charged at the clinics.

The pilot aimed to provide antiretroviral therapy to 100 clients annually. By October 2005 statistics indicate that since January 2005:

- A total of 1722 clients receiving VCT – 223 people tested HIV positive.
- Out of 328 pregnant mothers receiving PMTCT counselling and having an HIV test, 20 women tested HIV positive – they all received nevirapine-based PMTCT treatment.
- Antiretroviral therapy started in June 2005 – by the end of October, 25 people were eligible and had commenced therapy.

HIV care and support demands more than just providing antiretroviral therapy and managing STIs and opportunistic infections. The initial project design did not fully address the full range of care and support needs such as psychosocial support, ongoing education and treatment support groups. These needs must be addressed for people on antiretroviral therapy, those considering antiretroviral therapy, and people not yet needing antiretroviral therapy.

People living with HIV have been employed as paid staff, included on the site advisory committee, and integrated onto the management and advisory board for FPAK. Greater involvement has given people living with HIV a stronger sense of commitment to this as long-term work, with possibilities of career development, and it has reduced stigma and discrimination from other staff. People living with HIV have added much credibility to the HIV services of FPAK within the communities served, among other HIV service organizations, and most crucially among other people living with HIV.

5. SCALING-UP OF ADOLESCENT STI AND HIV PREVENTION PROGRAMMES

Of the over 1 billion young people (15-24 year olds) worldwide, some 10 million are living with HIV. In countries with high HIV prevalence rates, young people, and especially young women, are at particular risk of contracting HIV as soon as they become sexually active. Further, orphans and vulnerable children whose families and communities have been affected by HIV/AIDS are often especially vulnerable. In recent years over half of all new HIV infections—approximately 7,000 every day—are among young people aged 15 to 24 years.¹⁷

Current HIV prevention efforts do not reach most at-risk adolescents. A minimum of 80% of at-risk adolescents must be reached in high-prevalence countries.¹⁸ Adolescents cannot protect themselves if they do not know the facts about HIV transmission and how to prevent it. In many parts of the world, knowledge about HIV transmission is still low, particularly among women. In none of the 34 countries in sub-Saharan Africa surveyed for a Demographic and Health Survey were more than half of young women aged 15–24 aware of modes of HIV transmission and prevention methods.¹⁹ Furthermore, young men were on average 20% more likely to have correct knowledge about HIV than were young women. One consequence is that millions of young people are becoming sexually active each year with little or no access to basic HIV information or prevention services.

¹⁷ UNAIDS. 2004. At the Cross Roads: Accelerating Youth Access to HIV/AIDS Interventions.

www.unfpa.org/upload/lib_pub_file/316_filename_UNFPA_Crossroads.pdf

¹⁸ UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

http://www.unaids.org/html/pub/publications/irc-pub06/resourceneedsreport_en_pdf.pdf

¹⁹ AIDS Indicator Surveys (AIS), Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) for 2000–2004.

Double standards with regard to male and female sexual behaviour are widespread in many societies. For example, risky sexual behaviour of boys is often condoned, while girls are denied even the most basic sexual and reproductive health information and services. Among other things, these double standards severely restrict girls' ability to negotiate safe sex.

Many boys and young men see themselves as somehow invulnerable to illness and, as a result, do not use health care services, or go to them only when faced with serious symptoms. Because of this, many health services, including sexual and reproductive health services, are not oriented towards boys and young men. However, boys and young men need to have access to confidential and affordable services, provided at a time and location convenient to them.

Adolescents have the right to accurate information and skills, youth-friendly services for HIV prevention and AIDS treatment, care and support. They have the right to know about HIV and how to protect themselves. They have the right to information that is appropriate for their age—whether they are in or out of school—before they become sexually active and/or use drugs. Such information could include ABC (Abstinence, Be Faithful, Condom use). At the same time, life-saving commodities, including condoms for those who are sexually active, clean needles and syringes for those who inject drugs, and antiretroviral drugs and treatment of opportunistic infections for those who are HIV positive, must be made available.

Adolescents have the right to youth-friendly services, including voluntary HIV counselling and testing, diagnosis and treatment of STIs, and drug dependency treatment. The prevention of HIV infection works best when adolescents and young people can control their health and their futures, are empowered to make informed choices and possess the skills needed to change their behaviour(s) or to choose safer behaviours before becoming sexually active and/or commencing drug use. Peer-to-peer approaches are known to be particularly effective.

Adolescent risks and vulnerabilities to HIV can be reduced by increasing access to sexual and reproductive health information and services, diagnosis and treatment of STIs and knowledge of HIV status. However, in many countries adolescent access to such services is legally restricted, such as by requirements for parental consent, age of consent laws, or by providing services only to married people.

Recent programming has emphasised the need to support community-level interventions that recognize those sections of the community that influence young people, such as schools, or identify role models from within the immediate community, including parents, community and faith-based leaders. Interventions that support a "whole-community site" approach to adolescent HIV prevention should be supported.

Scale up what works:

Services

- Organize SRH facilities to make them accessible, appropriate and affordable for adolescents, including partnerships with and referrals to other service providers.
- Develop health communication programmes that provide age-relevant, culturally-contextualized, gender-sensitive sexual and reproductive health information, skills, and services to reduce adolescent risk and vulnerability to all STIs, including HIV, and unwanted pregnancy.
- Promote voluntary counselling and testing so that adolescents know their HIV status to be able to prevent HIV transmission, and to enable people to access treatment, care and support programmes.
- Provide access for all adolescents to STI, HIV and family planning information and services within VCT, SRH, PMTCT+ and maternal child health services.
- Ensure that sexual and reproductive health services for young people are confidential, accessible and free from judgment and offer a complete range of services such as counselling, outreach, referral to services, diagnosis and treatment of STIs, and VCT for HIV.
- Include sexual and reproductive health interventions in programmes for orphans and vulnerable children.
- Support behaviour-change interventions, including male and female condom promotion and distribution.

- Develop programmes to empower girls to negotiate safer sex, including programmes that address gender-based violence.
- Provide information and education about dual protection and positive prevention.
- Scale up HIV prevention for vulnerable adolescents, including for adolescent injecting drug users and for those adolescent boys who have same-sex sex.
- Develop life skills-building programmes for young people, including for those who are HIV positive, covering sex and sexuality education to help support safer sex, gender equality, empowerment and respect.
- Support whole-of-community site interventions, which respond to the local and cultural determinates of young people's vulnerability to STIs, HIV and unwanted pregnancies.
- Provide school- and community-based life skills interventions supporting balanced and comprehensive prevention strategies that promote abstinence, faithfulness, partner reduction and correct and consistent condom use, as well as other contraceptive choices (e.g., emergency contraception and dual protection) and post-exposure prophylaxis.
- Support gender-based violence outreach and gender sensitivity training for boys through school- and community-based life skills interventions.
- Provide post-rape care, including emergency contraception, pregnancy testing, abortion in countries where legally permitted, STI diagnosis and treatment, and post-exposure prophylaxis.
- Support peer education programmes, particularly for adolescents out of school.
- Provide or refer to tuberculosis, hepatitis C and drug treatment services.
- Provide or refer HIV-positive adolescents to antiretroviral therapy, treatment of opportunistic infections, and care and support programmes.
- Ensure equitable access for HIV-positive adolescents to antiretroviral therapy.
- Increase the number of trained birth attendants present at adolescent deliveries to reduce adolescent-maternity obstetric fistula, which increases the risk of future HIV infection.²⁰

Advocacy

- Advocate for the prevention of early or child marriages and forced marriages.
- Strengthen political, legal and social frameworks to ensure greater attention is given to survivors of rape and sexual assault to ensure that the maximum steps are taken to prevent HIV and other STI infection, and pregnancy.
- Advocate for policy and legal reform so that adolescents can access comprehensive, evidence-based sexual and reproductive health services and information in confidence.

Monitoring and Evaluation

- Implement national monitoring and evaluation systems for HIV prevention based, for example, on the Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People.²¹

²⁰ Obstetric fistula, the most severe of all pregnancy-related disabilities, is an injury caused by prolonged or obstructed labour. It usually arises when a young woman with a small birth canal has obstructed and prolonged labour and cannot obtain a needed Caesarean section due to geography, economics, or both. The baby usually dies and the mother suffers from extensive tissue damage to her birth canal, causing tears in the vaginal wall and rendering her incontinent. Untreated women not only face a life of shame and isolation, but may also face a slow, premature death from infection and kidney failure. The open wounds in the vaginal tract facilitate access of HIV, increasing the risk of transmission. Obstetric fistula affects at least 50,000 to 100,000 women every year. Most of these cases can be corrected surgically, even after several years.

²¹ UNAIDS, WHO, UNICEF, UNFPA, UNESCO, USAID, MEASURE DHS, World Bank, FHI (2004). Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People. http://www.who.int/hiv/pub/me/en/me_prev_intro.pdf.

Box 3 Togo: Successful funding²²

The Association Togolaise pour le Bien-Etre Familial (ATBEF) is a member of the Fédération des ONG du TOGO (FONGTO), which is a member of the CCM. ATBEF was involved in the development of the Togo Government's Global Fund proposal in 2002, which was approved in 2003. The disbursement of US \$14,185,638 under the two year proposal (July 2003–June 2005) actually began in 2004.

ATBEF is a sub-beneficiary of the Global Fund and has received **US \$60,000 for 2004** to implement:

- training of some 200 peer educators for young people both in and out of school;
- treatment of 30 HIV-positive women with ARV therapy, the provision of information on nutrition and social support to PLHIV;
- a national telephone HIV counselling hotline open from 7:00-20:00 daily; and
- counselling at two VCT centres, one in Lomé and the other in Sokode, a town 350 km from Lomé in the interior.

In 2005, ATBEF received approximately **US\$ 20,000** to implement the above activities.

Box 4 Dominican Republic²³

In the Dominican Republic, the HIV proposal was developed in 2002-3. Originally, funding should have been released in May 2004, yet only some US \$5 million has been received from a total of US \$47 million for the period 2004-2008. Under the HIV proposal, Profamilia has submitted proposals for two programmatic areas: social marketing of condoms and youth-based HIV prevention. A percentage of the funds would be used to support administrative and staff costs.

The condom social marketing proposal for **US \$2.5 million over five years** is to buy and distribute condoms to all the other organizations, such as nongovernmental organizations and government, as well as to non-traditional selling points such as motels and hotels that are part of the Dominican Republic's Global Fund proposal.

The youth-based HIV prevention programme focuses on HIV and pregnancy in *barrios*, scaling up existing programmes. It involves peer education of youth who, where allowed, provide sex education to their peers in schools, as well as to youth in communities and street-based young people. The proposal is for **US \$400,000 for the first two years**. Profamilia presented this proposal in alliance with two other NGOs working with youth and the amount reflects only Profamilia's application. The latest information is that funding for youth-based programming is probably going to be reduced.

6. INTEGRATE SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR VULNERABLE POPULATIONS

Injecting drug users

Worldwide, more than 55 million people use opiates, cocaine and amphetamine-type stimulants, and an estimated 13.2 million people inject these drugs. Most (78%) injecting drug users live in developing and transitional countries²⁴ and it is estimated that injecting drug use accounts for some 5-10 percent of HIV infections globally. Once HIV enters a community of injecting drug users, extremely rapid HIV transmission is possible. Shared injecting equipment is also a main driver of HIV transmission in prisons worldwide.

²² IPPF (2005). *Models of Care Country Coordinating Mechanisms Research*. <http://content.ippf.org/output/ORG/files/13139.pdf>.

²³ IPPF (2005). *Models of Care Country Coordinating Mechanisms Research*. <http://content.ippf.org/output/ORG/files/13139.pdf>

²⁴ Aceijas C, Stimson GV, Hickman M, Rhodes T (2004). *Global overview of injection drug use and HIV infection among injection drug users*. London: Centre for Research on Drugs and Health Behaviour on behalf of the United Nations Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries, 2004.

Injecting drug-related HIV epidemics do not remain limited to injecting drug users. HIV infection associated with injecting drug use can affect drug users' sexual partners with sexual and mother-to-child transmission, resulting in HIV transmission to the non-drug using population.

There needs to be a greater focus on young injecting drug users, given the high HIV prevalence among injecting drug users in many countries. Action is needed to reduce the number of adolescents initiating drug use, along with large-scale harm-reduction programmes. Harm reduction has been proven to reduce risk without promoting drug use.²⁵ Information on sexual HIV transmission also needs to be provided to drug users, as the risk of sexual HIV transmission to them and their partners is often neglected, with service providers focusing on drug use rather than responding to the total needs of the person and providing comprehensive services.

Many female injecting drug users engage in high-risk sexual activities in addition to their injecting drug use. Many drug-using females are of child-bearing age and, as there are intimate connections between unsafe injecting practices and HIV transmission and also between unsafe sexual practices and HIV transmission, countries have experienced increasing numbers of pregnant females who are found to be HIV positive with a history of past or current drug use. There is a need to develop tailored programmes for subgroups of female injecting drug users such as female injecting drug users living with HIV, pregnant injecting drug users, female injecting drug users with children and female injecting drug users in prison.

Experience has shown that HIV epidemics among injecting drug users can be halted if injecting drug users are supported through a comprehensive approach in the early stage of the epidemic. A holistic package of prevention and care interventions for injecting drug users and their partners includes information and education, needle, syringe and condom provision, drug use treatment, drug substitution maintenance therapy for opioid dependence, and treatment of STIs, as well as demand-reduction activities.²⁶

It is in the context of a comprehensive package of services that the sexual and reproductive health needs of drug users, including those who are HIV positive, can be addressed. Trust is key to successful interventions, and fulfilling the immediate needs of drug users can, over time, open the way for other interventions or referrals to services covering their sexual and reproductive health.

Scale up what works:

Training

- Educate SRH staff to overcome ignorance and prejudices about (injecting) drug users.

Services

- Organize SRH facilities to make them accessible, appropriate and affordable for drug users, including partnerships with and referral to other service providers.
- Ensure that VCT programmes provide VCT services to injecting drug users.
- Support safer-sex campaigns and information about HIV transmission modes, reducing the number of partners, condom use and alternatives to penetrative sex, as well as providing information on other STIs.
- Undertake community-based research with drug users to assess their sexual and reproductive needs, and how services should be delivered.
- Integrate SRH and VCT into drug treatment, drug substitution, and needle and syringe exchange programmes.
- Support behaviour-change interventions, including condom promotion and distribution.
- Provide information and education about positive prevention, dual protection and other family planning options to drug users.
- Support peer education among drug users, along with outreach programmes by volunteers, or social or health workers.

²⁵ See WHO Series: Evidence for Action on HIV/AIDS and Injecting Drug Use.

<http://www.who.int/hiv/pub/idu/idupolicybriefs/en/index.html>

²⁶ UNAIDS (June 2005). Intensifying HIV prevention: UNAIDS policy position paper. Geneva, Switzerland. Endorsed by the 16th meeting of the UNAIDS Programme Coordinating Board.

http://www.unaids.org/NetTools/Misc/DocInfo.aspx?LANG=en&href=http://gva-doc-owl/WEBcontent/Documents/pub/Governance/PCB04/pcb_17_05_03_en.pdf

- Provide clean needle and syringe distribution or exchange, or referral to these services.
- Provide referral to opioid substitution therapy programmes.
- Provide primary health care, such as hepatitis B vaccination and vein care.
- Provide or refer drug users living with HIV to antiretroviral therapy (treatment of opportunistic infections), care and support programmes.
- Ensure equitable access for HIV-positive injecting drug users to antiretroviral therapy.
- Ensure that pregnant HIV-positive injecting drug users have access to PMTCT+ programmes.
- Provide (or refer to) services for the diagnosis and treatment of STIs, tuberculosis, malaria and hepatitis C, when indicated, and treatment for drug dependency.
- Institute demand-reduction activities.
- Support the empowerment of drug users and build the capacity of their organizations to reduce their personal, social, economic, and legal vulnerability.
- Build the capacity of drug users to be involved in policy-making and programme design, implementation, monitoring and evaluation.

Advocacy

- Advocate for policy and legal reform, along with efforts to ensure that authorities such as police and health care workers respect and protect the human rights of drug users.
- Include drug users as a separate category in HIV surveillance and in behavioural surveillance surveys.

Sex workers

Sex work and transactional sex have become an increasingly important factor in many countries' HIV/AIDS epidemics. There is a great diversity of people involved in sex work (men, women, children and transgender) and the pathways into sex work include poverty, exploitation, occupation and trafficking. The motivations for involvement in sex work are also diverse, including money, drugs, favours, shelter, comfort, and immediate survival needs.

Furthermore, the exchange of sex for drugs, or the use of sex to support drug use links these two pathways of HIV transmission. When these two routes of transmission—sex and injecting drug use—intersect, and when effective HIV prevention services are absent, the effects are dramatic. For example, a study of sex workers in St. Petersburg, Russia, showed that 33% of sex workers younger than 19 years of age were HIV positive.²⁷

The context of sex work usually includes a concentration of a sexually active population, sufficient anonymity, a high ratio of males to females, and, more importantly, the socio-economic disparities that make sex work affordable to the client and an economic opportunity for the worker. For example, in Latin America and the Caribbean, the most common determinant of sex work is economic necessity, due to difficulties in entering the labour market compounded by limited schooling, a lack of opportunity and/or absence of professional qualifications.²⁸

A comprehensive, rights-based approach to responding to sex work includes:

- 1) reducing vulnerabilities, expanding choices and addressing structural issues related to HIV and sex work;
- 2) supporting scale-up of HIV, SRH and other health and social services and addressing barriers to access in the sex work context; and
- 3) promoting participation, empowerment, choices and opportunities for sex workers and their communities.

In many countries, programming among sex workers is one of the most cost-effective HIV prevention interventions. Sex workers are most likely to respond effectively to HIV prevention and care programmes when they are conducted without stigmatization or infringement on their human rights. Strengthening family planning, SRH and STI services to better respond to the needs of sex workers is an essential step to responding to and preventing HIV.

The risks to those selling or exchanging sex can be reduced through the promotion of condoms, providing services to prevent, diagnose and treat STIs in sex workers, their partners and clients, and

²⁷ Smolskaya, et al (2004). XV International AIDS Conference, 11-16 July 2004. Abstract No. ThOrC1371.

²⁸ UNAIDS (2002). *Sex work and HIV/AIDS*, Best Practice Collection. Technical update. UNAIDS, Geneva. http://pdf.dec.org/pdf_docs/Pnacp800.pdf

to respond to the reproductive health needs of sex workers. The overlap between injecting drug use and sex work requires coordination among services. It is essential to understand the dynamics that underpin sex work in a given setting and to recognize the relationships between sex work and survival—both economic and physiological—and sex work and economic gain.

Scale up what works:

Training

- Educate SRH staff to overcome ignorance and prejudices about sex workers.

Services

- Organize SRH facilities to make them accessible, appropriate and affordable to sex workers, including through partnerships with and referral to other service providers.
- Promote safer sexual behaviours among sex workers, their partners, and clients (e.g., condom promotion and negotiation skills).
- Support safer-sex campaigns and information about HIV transmission modes, reducing the number of partners, condom use and alternatives to penetrative sex, as well as providing information on other STIs.
- Undertake community-based research with sex workers to assess their sexual and reproductive needs, and how services should be delivered.
- Provide primary point-of-care comprehensive diagnosis and treatment of STIs, including screening and treatment for syphilis, access to commodities, such as male and female condoms and lubricants, and VCT.
- Assess the use of presumptive antibiotic treatment of sex workers, a form of epidemiologic treatment,²⁹ which can be an effective short-term measure to rapidly reduce rates of sexually transmitted infections even in asymptomatic individuals, and bypasses the limitations and costs of screening tests.
- Support peer education and outreach work, including information on positive prevention, dual protection and sexual and gender-based violence and referrals to health, social and legal services.
- Integrate the sexual and reproductive health needs of sex workers into existing services such as family planning, VCT and STI management programmes.
- Provide referrals to treatment services for HIV, tuberculosis, hepatitis C and drug dependency as necessary.
- Ensure that pregnant HIV-positive sex workers have access to PMTCT+ programmes.
- Provide or refer sex workers living with HIV to antiretroviral therapy (treatment of opportunistic infections), and care and support programmes.
- Ensure equitable access for HIV-positive sex workers to antiretroviral therapy.
- Institute rights-based programmes to prevent entry into sex work by providing alternatives and to assist people to leave sex work when they choose to do so, including access to education, vocational training and income generation activities.
- Support the empowerment of sex workers and build the capacity of their organizations to reduce their personal, social, economic and legal vulnerability.

²⁹ The primary criteria for presumptive treatment are epidemiological (STI incidence and prevalence), behavioural (rates of partner change and condom use) and structural (commercial sex conditions, access to health care services and respect for human rights). A number of operational issues are important including the optimal interval between presumptive treatment (or screening) visits, how and when to taper or withdraw presumptive treatment, choice of antibiotics, the target STI pathogens and monitoring of antibiotic resistance both of STI and other community pathogens, such as respiratory or diarrhoeal. Presumptive treatment given on a one-time or periodic basis has been shown to be effective in rapidly lowering STI prevalence, but requires longer-term strategies to maintain low rates.

Steen, R and Dallabetta G (2003). Sexually Transmitted Infection Control with Sex Workers: Regular Screening and Presumptive Treatment Augment Efforts to Reduce Risk and Vulnerability, *Reproductive Health Matters* 2003;11(22):74–90.

Also see World Health Organization Regional Office for the Western Pacific (2002). Guidelines for the management of sexually transmitted infections in female sex workers.

http://www.wpro.who.int/NR/rdonlyres/90F80401-5EAO-4638-95C6-6EFF28213D34/0/Guidelines_for_the_Mgt_of_STI_in_female_sex_workers.pdf#search=%22Guidelines%20for%20the%20management%20of%20sexually%20transmitted%20infections%20in%20female%20sex%20workers%22.

- Support the capacity building of sex workers to be involved in policy-making and programme design, implementation, monitoring and evaluation.
- Support anti-trafficking measures, including protection of and assistance to trafficked women and girls.

Advocacy

- Advocate for policy and legal reform, along with efforts to ensure that authorities such as police and health care workers respect and protect sex workers' human rights.
- Include sex workers as a separate category in HIV surveillance and in behavioural surveillance surveys.

Men who have sex with men

Sex between men occurs in every culture and society, though its extent and public acknowledgement vary from place to place.³⁰ In terms of HIV, sex between men is significant because it can involve anal sex, which, when unprotected carries a very high risk.³¹ At least 5–10% of HIV infections worldwide is estimated to occur through sex between men, though this figure varies considerably between countries and regions.³²

Sex between men occurs in diverse circumstances and among men whose experiences, lifestyles, behaviours and associated risks for HIV vary greatly. It encompasses a range of sexual and gender identities among people in various socio-cultural contexts. It may involve men who identify as homosexual, gay, bisexual, transgender or heterosexual. Many men who have sex with men are married, particularly where sex between men is illegal,³³ or discriminatory laws or social stigma of male-male sexual relations exist.

Males and transgender people who sell sex to other males are at particularly high risk, because their turnover of partners tends to be high. When male-male sexual behaviour overlaps with drug use, including drugs that are injected and other drugs like amphetamines, the risk of HIV infection may increase either through injecting equipment or unsafe sex or both.³⁴

As many men who have sex with men may also have sex with women, if HIV positive they can transmit the virus to their female partners or wives.³⁵ Men who have sex with men and men who sell sex have restricted access to sexual and reproductive health services because of homophobia or their fear of people's reactions. This means that even when men who have sex with men access sexual and reproductive health services, they may not provide accurate information about their symptoms, particularly anal STIs. Where programmes for men who have sex with men do exist they tend to ignore their sexual relationships with women, meaning that issues such as HIV and STI prevention during vaginal intercourse, family planning and fertility desires are inadequately addressed.

HIV prevention programmes for men who have sex with men are vitally important to stopping HIV transmission. However, they are often seriously neglected due to factors such as the relative invisibility of men who have sex with men, government denial, lack of research, stigmatization and legal discrimination. In many countries, men who have sex with men are missing from HIV epidemiological data. Another barrier to HIV prevention with men who have sex with men is varying beliefs around what defines sex, such as the belief that only sex with a woman is "sex", which means that MSM may not listen to safe sex messaging. In many countries, there is real concern that hidden epidemics might be occurring among males who have male-to-male sex, many of whom are married and/or have female sexual partners.

³⁰ "Men who have sex with men" refers to any man who has sex with a man, thus accommodating a variety of sexual identities as well as those who do not self-identify as homosexual or gay. In some contexts, "males who have sex with males" may be a more accurate definition, since programming may be directed at males who are not yet adults (individuals under 18 years of age). Sexual orientation is not to be regarded as a disorder (World Health Organization, International Classification of Diseases-10, 2006).

³¹ US Centers for Disease Control and Prevention <http://www.cdc.gov/hiv/pubs/faq/faq22.htm>

³² UNAIDS (2001). I care...do you? World AIDS Campaign

³³ As of 2005, nearly 70 countries had legal prohibitions against sex between individuals of the same sex. SIDA (2005), LGBTI issues in the world: A study on Swedish policy and administration of lesbian, gay, bisexual, transgender and intersex issues in international development cooperation. Stockholm: Government offices of Sweden.

³⁴ Ibid.

³⁵ Men who have sex with men may also acquire HIV from their female partners if they are infected.

Scale up what works:

Training

- Educate SRH staff to overcome ignorance and prejudices about men who have sex with men.

Services

- Organize SRH facilities to make them accessible, appropriate and affordable to men who have sex with men.
- Promote the targeted and general use of high-quality condoms and water-based lubricants, and ensure their continuing availability.
- Support safer-sex campaigns and provide information about HIV transmission modes, reducing the number of partners, condom use and alternatives to penetrative sex, as well as providing information on STIs.
- Support peer education among men who have sex with men, along with outreach programmes by volunteers, or social or health workers.
- Promote sexuality education, which includes respect for sexual diversity, gender equality and gender identity.
- Provide (or refer to) services such as VCT, STI management, tuberculosis and hepatitis C care, harm reduction and drug treatment.
- Provide or refer men who have sex with men living with HIV to antiretroviral therapy (treatment of opportunistic infections), care and support programmes.
- Ensure equitable access for HIV-positive men who have sex with men to antiretroviral therapy.
- Provide education and outreach to the female sexual partners of men who have sex with men.
- Develop HIV and STI information campaigns targeting the female partners of men who have sex with men.
- Support programming and outreach tailored to the particular needs of sub-groups of men who have sex with men, such as those in the uniformed services, prisoners, male sex workers and those who use drugs.
- Empower individuals and strengthen organizations of self-identified gay men, enabling them to promote HIV prevention and care programmes.
- Support the capacity building of men who have sex with men to be involved in policy-making and programme design, implementation, monitoring and evaluation.

Advocacy

- Advocate for policy and legal reform, along with efforts to ensure that authorities such as police and health care workers respect and protect the human rights of men who have sex with men.
- Include men who have sex with men as a separate category in HIV surveillance and in behavioural surveillance surveys.

People living with HIV

HIV-positive people have the same human rights as all other people. Nevertheless, some States have forcibly restricted the reproductive rights of positive people. For example, until recently, HIV-positive people in certain parts of India had no right to marry.³⁶ Implicit in this prohibition on marriage was the assumption that one is not fit to marry if HIV positive. Inheritance, divorce and property laws can also place HIV-positive women at risk of loss of income and of transmitting HIV. Other laws such as criminalization of transmission and partner notification laws specifically target people living with HIV who know their HIV status. In addition, many States have introduced laws that discriminate against people living with HIV, for example, in the areas of employment, housing, insurance, immigration, etc.

For years, HIV-related stigma and the fear of such stigma have acted as barriers to the successful implementation of HIV prevention, care and support, and treatment programmes. The health care sector has often been cited as a primary site for stigma and discrimination against people living with HIV.³⁷ It has been demonstrated that HIV-related stigma impacts negatively upon the willingness of

³⁶ Lawyers Collective HIV/AIDS. A, C and Ors. V Union of India and Ors. (1999). Bombay High Court (Right to Marry).

³⁷ Pan American Health Organization (PAHO) (2003). Understanding and Responding to HIV/AIDS-Related Stigma and Discrimination in the Health Sector.

people living with HIV to disclose their status, which can act as a barrier to accessing care and treatment, and sexual and reproductive health services.³⁸ It was hoped that as antiretroviral therapy became widely available stigma surrounding HIV would dissipate, but to date there is no conclusive evidence to support this.

Many people living with HIV are coinfecting with malaria, hepatitis B and C, or tuberculosis. TB, in particular its multi-drug and extensively drug-resistant forms, is a common and growing problem in many countries. Integration of, referral to and management of services, i.e., to prevent more TB infections among clients and health care workers, requires coherent planning as well as increased human and financial resources.

In most ways, the sexual and reproductive health-related rights, needs and aspirations of HIV-positive people are no different from those of people who are HIV negative. For example, all people have the right “to decide freely and responsibly the number, spacing and timing of their children and to have the means to do so...”³⁹ All women need a skilled attendant at birth to reduce the risk of maternal and newborn morbidity and mortality and of complications of delivery, such as obstetric fistula. Most young people, whether or not they are living with HIV, aspire to understand the physical changes of their bodies and how to responsibly enjoy their emerging sexuality.

Sexually transmitted infections and treatment regimens are mostly the same regardless of HIV status; however some STIs (i.e., human papillomavirus in women, which can result in cervical cancer, anogenital cancers and syphilis) in people living with HIV may be more severe, difficult to treat and appear with higher rates of infection. A focus on early treatment of STIs in people living with HIV is important, as it helps reduce the severity of infection and the incidence of chronic infection, as well as reducing the risk of further HIV transmission.

Dual protection should also be promoted among people living with HIV. This refers to the simultaneous prevention of unwanted pregnancy and sexually transmitted infections, including HIV. This can be achieved through the consistent and correct use of condoms alone or in combination with another contraceptive method. The challenges to achieve dual protection are closely linked to the challenges of using condoms consistently and correctly.

Providers of HIV-related care and treatment need to be aware that for most HIV-positive men and women, a HIV diagnosis does not mean an end to their sexual lives or to their childbearing aspirations. HIV-positive individuals will have continuing sexual and reproductive health wants and needs that must be responded to. For example, some people may want to have a baby, whereas other people may choose to avoid or terminate pregnancy. SRH services can provide counselling on reproductive choices for people living with HIV and their partners

All women have the same rights concerning their reproduction and sexuality, but women living with HIV require additional care and counselling during their reproductive lives. HIV infection accelerates the natural history of some reproductive illnesses and may increase their severity, as well as adversely affecting a woman's ability to become pregnant. High-quality programmes and services that address a woman's sexuality positively and promote the sexual health of women living with HIV are essential for them to have responsible, safe and satisfying sexual lives, and to ensure their reproductive health.

Despite the rhetoric about the rights of people living with HIV to participate in a meaningful way at all stages and levels of planning and developing policies and programmes in sexual and reproductive health and HIV, there has been little progress to date in ensuring such meaningful involvement. Furthermore, as people living with HIV can reach other HIV-positive people much more effectively

http://www.paho.org/English/AD/FCH/AI/Stigma_report_english.pdf

Panos Institute/UNICEF (2001). Stigma, HIV/AIDS and prevention of mother-to-child transmission: a pilot study in Zambia, India, Ukraine and Burkina Faso.

www.unicef.org/aids/aids_panosreportBS.pdf

PLoS Medicine (2005). Discriminatory Attitudes and Practices by Health Workers toward Patients with HIV/AIDS in Nigeria. August 2005, Volume 2, Issue 8.

³⁸ Nyblade, L., Pane, R., Banteyerga, H., Bond, V., Kilonzo, G., Mbwambo, J., Kidanu, A. (2004). Family and Community-Level Stigma Impedes HIV Prevention and Care, and Lowers the Quality of Life for People Living with HIV and AIDS. Bangkok Abstract [ThPeD7783].

³⁹ United Nations Declaration and Platform for Action of the Fourth World Conference on Women (1994). UN Doc. A/CONF.177/20. <http://www.un.org/womenwatch/daw/beijing/platform/>.

than other institutions can, there is a huge unmet need for capacity building and training for people living with HIV to provide support, counselling, and treatment literacy services.

Scale up what works:

Training

- Educate SRH staff to overcome ignorance and prejudices about people living with HIV.
- Train health care workers in the sexual and reproductive health of HIV positive people.

Services

- Organize SRH facilities to make them accessible, appropriate and affordable for people living with HIV, including partnerships with and referrals to other service providers.
- Promote voluntary counselling and testing so that people know their HIV status to be able to prevent HIV transmission and to enable people to access treatment, care and support programmes.
- Provide information on dual protection, counselling and access to condoms in VCT programmes.
- Support safer-sex campaigns and provide information about HIV transmission modes, reducing the number of partners, condom use and alternatives to penetrative sex, as well as providing information on other STIs.
- Provide information and education about dual protection and positive prevention, and the reproductive health needs of HIV-positive women.
- Support behaviour-change interventions, including condom promotion and distribution.
- Provide male and female condoms.
- Provide (or refer to) services for the diagnosis and treatment of STIs, tuberculosis, malaria and hepatitis C, when indicated.
- Provide antiretroviral therapy and treatment of opportunistic infections, care and support programmes for people living with HIV.
- Support the empowerment of people living with HIV and build the capacity of their organizations to reduce their personal, social, economic, and legal vulnerability, as well as to provide support, counselling, and treatment adherence and literacy services.
- Undertake community-based research with people living with HIV to assess their sexual and reproductive needs and aspirations and how services should be delivered.
- Support the capacity building of people living with HIV to be involved in policy-making and programme design, implementation, monitoring and evaluation.
- Support programmes that seek to counter stigma and discrimination against people living with HIV.

Advocacy

- Advocate for policy and legal reform to remove laws that discriminate against people living with HIV and to create a supportive environment.

7. COMBATING GENDER-BASED VIOLENCE

Gender-based violence applies to men and boys and transgendered people, as well as to women and girls, and describes a range of abuses based on one's gender, including rape, sexual assault and incest; physical abuse and domestic violence; community violence; and psychological or emotional abuse. However, research shows that women and girls are disproportionately affected by gender-based violence in all its forms.⁴⁰

Gender-based violence, including sexual violence against women, correlates strongly with women's risk of HIV infection. When surveyed, between one-third and one-half of women in Bangladesh, Brazil, Ethiopia, Namibia and Thailand, said their partners had physically and/or sexually assaulted them.⁴¹ For substantial numbers of girls, their first experience of sex is coerced. For example, of

⁴⁰ Poptech (2004). Addressing Gender-Based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis.

www.prb.org/pdf04/AddressGendrBasedViolence.pdf.

⁴¹ WHO (2005) *Multi-country study on women's health and domestic violence against women*. Geneva in UNAIDS (2005). AIDS Epidemic Update. December 2005. data.unaids.org/Publications/IRC-pub06/epi_update2005_en.pdf.

women surveyed in Rakai, Uganda, 14% said their first sexual experience had been coerced.⁴² In addition, there is a cyclical nature to gender-based violence; for example, of women whose first sex is forced, 60% later experiences intimate partner violence, compared with only 25% of women whose first sex is consensual.⁴³

Basic HIV-prevention strategies, such as abstinence, fidelity and condom promotion, are often insufficient or irrelevant in the face of gender-based violence. Violence or the threat of it may limit a women's ability to protect herself from HIV. Women in abusive relationships may:

- risk violence if they insist on protection;
- stay in violent relationships because of a lack of property rights, economic dependence, etc.;
- or
- give in to male demands for unprotected sexual relations, even when they know the dangers.

Furthermore, fear of violence, as well as the violence itself, reduces the effectiveness of HIV testing and care initiatives, as women may hesitate to seek testing, return for their results or begin or adhere to a treatment regimen. Another consequence of violence is that violent sex can result in physical trauma such as traumatic gynaecological fistula, a biological risk factor for HIV infection.

Many health care systems are not equipped to respond adequately to gender-based violence, clinically, forensically, or in terms of psychological and social support. HIV prevention efforts, including those provided by SRH services, need to address gender-based violence, which will require training. At the same time, organizations and networks working on gender-based violence need to incorporate HIV prevention into their activities in view of the relationship between the two.

Working preventively with men to change their attitudes and behaviours around gender-based violence is a key component in responding to it. In this context, work with young men may be particularly important in preventing violence since it may be more feasible to effect change at a time when norms and behaviours are not as deeply rooted. Adult men have an important role by serving as positive examples to younger men, helping them to see gender-based violence as an unhealthy behaviour, and publicly challenging norms that deem gender-based violence to be acceptable. There is a great need for more programming in this area.

In many countries, inequitable divorce and property laws make it difficult for women to leave abusive relationships. While many developing countries have gender-based violence legislation in place, there is often a serious lack of resources for proper implementation of legal frameworks, and male judges and law enforcement agents who may be sympathetic to perpetrators often implement laws inappropriately or not at all. Ensuring that adequate laws and policies exist and that they are properly implemented is critical.

At the other end of the continuum are those policies and programmes that empower women and girls. These types of interventions seek to equalize the balance of power between women and men in order to reduce female vulnerability in the epidemic. Interventions that see empowerment as an end goal also tend to treat HIV within a larger context of social and economic development.

Programmes should work to promote long-term changes in girls and women's self-esteem and control over their own bodies, but they should also work to address empowerment of women, such as by enabling women to continue in school by ensuring that schools are safe, providing economic (e.g., microfinance) and educational opportunities for girls and women, and eliminating discriminatory laws and policies in education, at home and in the workplace.

⁴² Wawer M et al. (2005). *Declines in HIV prevalence in Uganda: Not as simple as ABC*. Abstract 27 LB, 12th Conference on Retroviruses and Opportunistic Infections, February 22-25, 2005. Boston U.S.A. in UNAIDS (2005). *AIDS Epidemic Update*. December 2005.

data.unaids.org/Publications/IRC-pub06/epi_update2005_en.pdf.

⁴³ The Population Council (2004). *The Adverse Health and Social Outcomes of Sexual Coercion: Experiences of Young Women in Developing Countries*. New York: The Population Council
www.popcouncil.org/pdfs/popsyn/PopulationSynthesis3.pdf.

Jejeebhoy, S. J., and S. Bott. 2003. *Non-consensual Sexual Experiences of Young People: A Review of the Evidence from Developing Countries*. South and East Asia Regional Working Paper. No. 16. New Delhi: Population Council.

Scale up what works:

Training

- Train SRH and HIV service providers to recognize the signs and symptoms of gender-based violence during consultations and support them to provide treatment and counselling.
- Train VCT providers on the signs and symptoms of gender-based violence and its treatment, including psycho-social aspects and forensics examinations, as well as provide information for referring people to other health and legal services.
- Train VCT and SRH providers to identify and counsel women who may be at risk of violence if they disclose their HIV-positive status, as well as the men who may perpetuate violence.

Services

- Ensure that all HIV and sexual and reproductive health programmes address gender-based violence and adapt services accordingly.
- Initiate interventions with men and boys to change social norms around gender roles, and gender-based violence through school- and community-based life skills programmes.
- Implement a comprehensive approach to reducing gender-based violence, including:
 - ◆ Community awareness and education;
 - ◆ Health sector interventions, including:
 - Screening and referral for HIV infection of victims of rape. If available, post-exposure prophylaxis for HIV should be given within 72 hours of sexual assault, together with counselling;
 - Emergency contraception;
 - Forensics examinations;
 - Diagnosis and treatment of STIs;
 - VCT or providing referral to VCT services; and
 - PMTCT services or referral to these services, where appropriate.
 - ◆ Education sector interventions such as training education professionals to recognize the signs and symptoms of gender-based violence and to provide counselling and referrals; gender-sensitivity trainings of education professionals to reduce the chance that teachers will become perpetrators of sexual violence; reform of nationally mandated curricula to include gender sensitivity and violence awareness and prevention; and attention to the physical layout of schools so that, for example, girls have private toilet areas;
 - ◆ Policy and law reform, including education of parliamentarians and members of the legal system, and consistent and reliable implementation of laws;
 - ◆ Income generating projects through microfinance and other related programmes, and literacy classes for women; and
 - ◆ Establishment of women-only HIV and gender-based violence support groups and community centres.

Box 5 The Costa Rican Experience

FUNDESIDA is a NGO working with vulnerable groups, including sex workers, street children and girls, who have been sexually exploited—groups that are particularly susceptible to violence in Costa Rica. The organization has been providing professional services to the Department of AIDS of the Ministry of Health over the past decade, although it is not a member of the CCM. In Round 2, Costa Rica's HIV/AIDS component proposal, which included an element on the SRH needs of girls who have experienced sexual violence and exploitation, was successful. As part of the proposal, FUNDESIDA coordinated with the National Child Protection Institute (PANI) to establish a protocol for working to prevent and respond to child sexual exploitation. FUNDESIDA received **USD \$320,899** as a sub-recipient.

Elements of the program include:

- Developing an inter-agency protocol on children and adolescents who have experienced sexual violence or exploitation;
- Increasing the detection rate of girls, who are being sexually exploited;
- Providing medical care, including STI and HIV screening and treatment, to girls aged 8-18 who have been sexually violated; and
- Providing psychological care, life skills education, empowerment and SRH training to protect girls from further abuse.

Annex 1 Integrating SRH into the HIV/AIDS Component of a Country Coordinated Proposal

Reproductive and sexual ill-health accounts for 20% of the global burden of ill-health for women and 14% for men.⁴⁴ More than half a million women die annually in pregnancy and childbirth from largely preventable causes; almost all of these deaths occur in resource-constrained settings.⁴⁵ Globally, 13% of all maternal deaths is due to the complications of unsafe abortion, resulting from the estimated 19 million unsafe abortions occurring annually.⁴⁶ More than 340 million new cases of curable STIs occur annually, and sexually transmitted human papillomavirus (HPV) infection—closely associated with cervical cancer—is diagnosed in more than 490,000 women and causes 240 000 deaths every year.⁴⁷

The five core aspects of sexual and reproductive health are:

1. improving antenatal, perinatal, postpartum and newborn care;
2. providing high-quality services for family planning, including infertility services;
3. eliminating unsafe abortion;
4. combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and
5. promoting sexual health.

Most of the 17.6 million women living with HIV are of childbearing age and face difficult choices concerning their sexuality and childbearing.⁴⁸ Women's choices are made at a particular time and in a given context and are complex, multi-factorial and subject to change. Moreover, their choices may be limited by direct or indirect social, economic, medical and cultural factors, as well as by gender-based violence and its consequences. Accurate information and counselling are critical components of all sexual and reproductive health services to support women in making these choices and carrying them out safely and voluntarily.

The majority of HIV infections is sexually transmitted or associated with pregnancy, childbirth and breastfeeding, and are therefore preventable. The interactions between sexual and reproductive health and HIV have finally been widely recognized. In addition, sexual and reproductive ill-health increases the risk of HIV infection. Both sexual and reproductive ill-health and HIV infection share root causes, including poverty, gender inequity and social marginalization of the most vulnerable populations.⁴⁹

HIV affects or potentially affects all dimensions of women's sexual and reproductive health—pregnancy, childbirth, breastfeeding, abortion, use of contraception and exposure to, diagnosis and treatment of STIs, as well as exposure to gender-based violence. For instance, HIV infection accelerates the natural history of some reproductive illnesses and increases the severity of others. HIV also adversely affects a woman's ability to become pregnant.

At its heart, AIDS is a crisis of gender inequity, with women less able than men to exercise control over their bodies and lives. In many settings, cultural expectations have encouraged men to have multiple partners, while women are expected to abstain or be faithful. There is also a culture of silence around some components of SRH. Simply by fulfilling their expected gender roles, men and women are likely to increase their risk of HIV infection.

⁴⁴ <http://www.who.int/reproductive-health/strategy.htm>

⁴⁵ World Health Organization, United Nations Children's Fund and United Nations Population Fund, (2004). *Maternal mortality in 2000: estimates developed by WHO, UNICEF and UNFPA*. http://www.who.int/reproductive-health/publications/maternal_mortality_2000/index.html

⁴⁶ World Health Organization (2004). *Unsafe abortion – global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000*. 4th ed. http://www.who.int/reproductive-health/publications/unsafe_abortion_estimates_04/index.html

⁴⁷ World Health Organization (2004). *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets*. <http://www.who.int/reproductive-health/strategy.html>

⁴⁸ UNAIDS and World Health Organization (2005). *AIDS epidemic update: December 2005*. <http://www.who.int/hiv/epiupdate2005/en/index.html>

⁴⁹ WHO, UNFPA, UNAIDS and IPPF (2005). *Sexual and Reproductive Health & HIV/AIDS: A framework for priority linkages*. http://www.who.int/reproductive-health/rtis/docs/framework_priority_linkages.pdf

Gender plays an important role in determining a woman's vulnerability to STIs, HIV infection and violence, her ability to access treatment, care and support and to cope if HIV positive or otherwise affected by HIV. The current scope of HIV interventions and policies needs to be expanded to make gender equity a central component in the fight against HIV.⁵⁰

However, gender disparities go far deeper than sexual relations. Women in many regions do not own property or have access to financial resources, increasing their dependence on men—husbands, fathers, brothers and sons—for support. Without resources, women are susceptible to abuses of power. Poverty pushes some women into risk-taking behaviours. With no other options, women may resort to sex work to feed their families or transactional sex to meet short-term needs. For example, in southern Africa, many older men seek out young women and adolescent girls for sexual favours, providing them with school fees, food and highly sought after consumer goods.

Engaging men is a critical component of HIV prevention and care as, in many contexts, men are the decision-makers in matters related to reproductive and sexual health and women's access to health care overall. Men's roles and responsibilities in relation to the health of their female sexual partners have a significant bearing on the course of the epidemic. Men and women need to be motivated to talk more openly about sex, sexuality, drug use and HIV; while men need to be encouraged to take greater care of themselves, their partners and families. Programmes need to respond to the needs of both men and women.

The sexual and reproductive health needs of vulnerable populations such as men who have sex with men, drug users and sex workers, as well as those of people living with HIV, must be addressed within a framework larger than HIV prevention, responding to the human rights of these people so that they are able to enjoy a fulfilling and safe sex life and to make their own sexual and reproductive health choices.

The Declaration of Commitment from the UN Special Session on HIV/AIDS in 2001⁵¹ and the Millennium Development Goal (MDG) of halting and beginning to reverse HIV by 2015⁵² are internationally agreed-upon targets for responding to HIV. Three of the eight MDGs are directly related to sexual and reproductive health: improving maternal health, reducing child mortality and combating HIV/AIDS, malaria and other diseases.

Responding to HIV by integrating HIV services with sexual and reproductive health services and programmes will also support:

- the G8 commitment to develop and implement a package of HIV prevention, treatment and care, with the aim of achieving as closely as possible universal access to treatment for all those who need it by 2010, as agreed at the Gleneagles Summit in July 2005;⁵³
- the United Nations General Assembly 2005 World Summit Outcome Document, which also adopted the concept of scaling up toward universal access;⁵⁴ and
- the Political Declaration on HIV/AIDS adopted in June 2006.⁵⁵

As many developing countries face large burdens on their health and family planning systems due to population increases, HIV, lack of governmental commitment to health systems and human resource challenges, the support from developed countries for SRH services and supplies is shrinking in

⁵⁰ UNAIDS, UNFPA, UNIFEM (2004). Women and HIV/AIDS: Confronting the Crisis http://genderandaids.org/downloads/conference/308_filename_women_aids1.pdf.

⁵¹ United Nations General Assembly Special Session on HIV/AIDS. *The Declaration of Commitment*. New York, United States, 25 - 27 June 2001 http://www.unaids.org/Unaids/EN/Events/UN+Special+Session+on+HIV_AIDS/Declaration+of+Commitment+on+HIV_AIDS.asp.

⁵² Millennium Development Goals. Goal 6 <http://www.millenniumcampaign.org/site/pp.asp?c=grKVL2NLE&b=186386>.

⁵³ The Group of 8 (2005). The Gleneagles Communiqué. Paragraph 18(d) http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Communique.0.pdf.

⁵⁴ The United Nations General Assembly. World Summit Outcome. General Assembly fifty-ninth session, 20 September 2005. <http://daccessdds.un.org/doc/UNDOC/LTD/N05/511/30/PDF/N0551130.pdf?OpenElement>.

⁵⁵ High Level Meeting on HIV/AIDS (2 June 2006). Political Declaration on HIV/AIDS. Resolution A/60/262 adopted by the United Nations General Assembly. <http://www.reformtheun.org/index.php/issues/2062?theme=alt4>

relation to the scale of the problem. According to the United Nations Population Fund (UNFPA), the resources needed to buy contraceptives and condoms is projected to rise from US \$954 million in 2002 to US \$1.8 billion in 2015. In spite of this upward trend in costs, donor government support for these supplies actually fell in 2002 to only \$197.5 million. The gap between the need for essential condom and contraceptives supplies and the funds available to purchase them is projected to keep on growing, reaching hundreds of millions of dollars annually by 2015.⁵⁶

The fact that the majority of HIV infections are sexually transmitted, as well as scarce global resources and growing demand for HIV-related health care, necessitate the integration of SRH and HIV services, programmes and research. Establishing links between maternal and neonatal, family planning and other primary health care services to address HIV and STIs, is an effective way to meet the health care needs of individuals and communities in resource-constrained settings. Coordinating investments in different programmes within the health sector can promote harmonization, facilitate the government's management, strengthen health systems and increase impact on related health outcomes, including for men and vulnerable populations.

Medical care in resource limited settings may be provided by just one provider or facility, or a single community health worker. Integrating HIV with family planning and other SRH services allows women and men to receive SRH care through a single provider to meet a range of health care needs: dual protection against pregnancy and STIs, including HIV; pregnancy care for HIV-positive women; care, support and treatment services for people living with HIV; prevention of mother-to-child HIV transmission; and referral to specialized services when required. In addition, integrating VCT into family planning, maternal, antenatal health care and sexual and reproductive health services can also contribute to reducing HIV-related stigma, creating the potential for increasing people's access to VCT and treatment services for HIV and HIV-related infections. Such integration also makes efficient use of sometimes scarce human and financial resources for health.

Linkages between SRH and HIV programmes work in both directions. The integration of HIV issues into ongoing SRH programmes and, conversely, SRH issues into HIV programmes, is mutually reinforcing. Linkages between SRH and HIV programmes should enhance SRH, contribute to reversal of the AIDS epidemic and mitigate its impact.

Based on experience and programming realities, six priority areas for action have been identified:

1. Learn HIV status;
2. Promote safer sex;
3. Optimize connection between HIV and STI services;
4. Identify and intervene in situations of gender-based violence, where possible;
5. Integrate HIV with maternal and child health (MCH); and
6. Integrate HIV with family planning services.⁵⁷

The document HLSP (2006), *Integration between Sexual and Reproductive Health and HIV and AIDS and Malaria: opportunities and strategic options for the Global Fund for AIDS, TB and Malaria* provides an overview of the main issues in relation to SRH and HIV integration.⁵⁸

The selection of which interventions to support will depend on the national context and the local situation, including HIV prevalence, as well as the organization in question and available health services. For example, in settings with high HIV prevalence and high utilization of family planning services, offering all family planning clients the opportunity to learn their HIV status would likely enhance the quality of family planning services and make an important contribution to HIV prevention efforts. This approach may not be as useful, however, in settings with low HIV prevalence and/or poor utilization of family planning services.

⁵⁶ UNFPA (2004). Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2004. http://www.unfpa.org/upload/lib_pub_file/539_filename_donor_2004_report.pdf

⁵⁷ These are based on the World Health Organization (WHO), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS) and International Planned Parenthood Federation (IPPF) (October 2005). *Sexual and Reproductive Health & HIV/AIDS: A framework for priority linkages*. http://www.who.int/reproductive-health/rtis/docs/framework_priority_linkages.pdf

⁵⁸ http://www.globalaidsalliance.org/Global_Fund_SRH_Integration_Report.cfm.

Stronger linkages between SRH and HIV programmes should lead to a number of important public health benefits. Much remains unknown, however, about how to best achieve these linkages so as to have the greatest impact and how best to scale up and strengthen selected linkages to achieve universal access. This provides opportunities for innovative and creative programming. Most commonly, integration has been largely in one direction. For example, provision of information about dual protection during family planning or condoms during a STI consultation are commonly included in counselling guidelines for high HIV prevalence settings; yet equipping VCT centres with contraceptives or testing for syphilis and other STIs is quite rare.

The benefits of integrating HIV with SRH services may be extensive with a broader range of clients accessing a comprehensive range of services. With fewer healthcare providers involved, clients are also more likely to have their confidentiality preserved and have easier access to services through a “one stop” approach. This approach may also serve to minimize stigma associated with entering a dedicated HIV facility. Also, there are multiple entry points for individuals to access integrated care: family planning, antenatal care, mother child health services, post-partum or post-abortion care, VCT, youth services, STI, tuberculosis, malaria and hepatitis diagnosis and treatment services, and others. Coordination of programmes will also facilitate health sector management processes, reducing transaction costs for planning, budgeting and reporting, as well as streamlining other operational procedures and strengthening health systems.

However, scaling up services takes time. It may require a reorganization of clinical services, initially burdening health care workers with limited financial resources and training, who may need to adapt to new procedures and practices (and perhaps build their skill base). Scarce resources mean that services must be efficient and effective, built on evidence from best practices and on knowledge of risks and benefits for different clients. This knowledge must be translated into evidence-based guidelines and tools for use at the point of care.

Principles

Key policies and programmes must build upon the following principles.

Address structural determinants. Root causes of HIV and sexual and reproductive ill-health need to be addressed. This includes action to reduce poverty, ensure equity of access to key health services and improve access to information, education and vocational opportunities.

Focus on human rights and gender. Sexual and reproductive rights of all people, including women and men living with HIV, need to be emphasized, as well as the rights of marginalized populations such as injecting drug users, men who have sex with men, and sex workers. Gender-sensitive policies to establish gender equity and eliminate gender-based violence are additional requirements.

Promote a coordinated and coherent response. Promote attention to sexual and reproductive health priorities within a coordinated and coherent response to HIV that builds upon the principles of one national AIDS framework, one broad-based multisectoral AIDS coordinating body, and one agreed-upon country-level monitoring and evaluation system (Three Ones Principle).

Meaningfully involve people living with HIV. Women and men living with HIV need to be fully involved in designing, implementing, monitoring and evaluating policies, programmes and research that affect their lives.

Foster community participation. Young people, vulnerable populations and the community at large are essential partners for an adequate response and for meeting the needs of affected people and communities.

Reduce stigma and discrimination. More vigorous legal and policy measures are urgently required to protect PLHIV and vulnerable populations from discrimination.

ANNEX 2: ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ARV	antiretroviral
BCC	behavioural change communication
CBO	community based organization
CCM	County Coordinating Mechanism (of Global Fund)
CCP	Country Coordinated Proposal (for Global Fund)
FPAK	Family Planning Association of Kenya
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GAA	Global AIDS Alliance
GBV	gender-based violence
GIPA	greater involvement of people living with HIV
HIPC	Highly-indebted Poor Country
HIV	human immunodeficiency virus
HPV	human papillomavirus
ICPD	International Conference on Population and Development
IDUs	injecting drug users
INGO	international nongovernmental organization
IPPF	International Planned Parenthood Federation
KECOFATUMA	Kenya Consortium of Organizations Fighting AIDS, Tuberculosis and Malaria
MA	Member Association (of IPPF)
MARP	most-at-risk population
MCH	maternal and child health
MCTC	mother-to-child HIV transmission
MDGs	Millennium Development Goals
MoH	Ministry of Health
MSM	men who have sex with men
NGO	nongovernmental organization
PLHIV	people living with HIV
PMCTC	prevention of mother-to-child HIV transmission
PR	Principal Recipient (of Global Fund grants)
PRS	Poverty Reduction Strategy
RCM	Regional Coordinating Mechanism
RO	Regional Organization
RTIs	reproductive tract infections
SR	Sub-recipient
SRH	sexual and reproductive health
STI	sexually transmitted infection
Sub-CCM	sub-national Coordinating Mechanism
SWAps	Sector Wide Approaches
TB	Tuberculosis
ToR	terms of reference
ToT	training of trainers
TRP	Technical Review Panel
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	voluntary counselling and testing
WHO	World Health Organization

ANNEX 3: Glossary

Global Fund-related Terms

Board: The Global Fund's international Board includes representatives of donor and recipient governments, nongovernmental organizations, the private sector (including businesses and foundations), and affected communities. Key international development partners also participate, including the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Bank. The latter also serves as the Global Fund's trustee.

Secretariat: The Global Fund staff is responsible for day-to-day operations, including mobilizing resources from the public and private sectors, managing grants, providing financial, legal and administrative support, and reporting information on the Global Fund's activities to the Board and the public. The Global Fund Secretariat consists of about 170 persons based in Geneva, Switzerland.

Partnership Forum: Every two years, the Global Fund convenes a broad group of stakeholders in a Partnership Forum. In 2004, the first of these Partnership Forums met to allow stakeholders to provide important feedback and guidance to the Global Fund on its impact in fighting these diseases. This also serves as an opportunity for the Global Fund to inform stakeholders of progress and challenges.

Country Coordinating Mechanisms (CCMs): Country-level partnerships that develop and submit grant proposals—Country Coordinated Proposals (CCPs)—to the Global Fund, monitor their implementation, and coordinate with other donors and domestic programs. CCMs are intended to be multisectoral, involving broad representation from government agencies, nongovernmental organizations, community- and faith-based groups, private sector institutions, individuals living with HIV, TB or malaria, and bilateral and multilateral agencies.

Principal Recipient (PR): A local entity nominated by the CCM and confirmed by the Global Fund to be legally responsible for grant proceeds and implementation in a recipient country. Once the Board approves a proposal, the Secretariat negotiates a two-year grant agreement in which disbursement of funds to the PR is based on the achievement of measurable results. There may be multiple public and/or private PRs in a country.

Sub-recipients (SRs): Entities chosen by the PR to implement parts of the grant. SRs often do not have the capacity to take on the responsibility of a PR, but are usually more involved in grassroots, community-level work.

Technical Review Panel (TRP): An independent panel of disease-specific and cross-cutting health and development experts that provides a rigorous review of the technical merit of Country Coordinated Proposals (CCPs). The TRP may recommend to the Board that the CCP be funded without condition, approved conditionally, resubmitted or not approved. To date, the TRP has recommended funding for 40% of the CCPs submitted.

Local Fund Agent (LFA): Independent organizations hired by the Secretariat to assess the PR's capacity to administer funds and provide ongoing oversight and verification of reported data on financial and programmatic progress.

Sexual and Reproductive Health-related Terms

Dual Protection: Many sexually active people need dual protection: protection against unintended pregnancy and protection against STIs, including HIV. Those contraceptives that offer the best pregnancy prevention—such as an intrauterine device or oral contraceptives—do not protect against STIs. Thus, simultaneous condom use for infection prevention is recommended. Condoms used alone can also prevent both STIs and pregnancy if used correctly and consistently; however, they are associated with higher pregnancy rates than condoms used together with another contraceptive method.

Gender-based violence: Gender-based violence describes violence against men and boys and transgendered people as well as women and girls. It consists of all forms of violence targeted at an individual because of his or her gender, including but not limited to domestic violence, rape and sexual assault, community violence, and emotional or psychological abuse.

Key Populations: Key populations are those where risk and vulnerability converge. HIV epidemics can be limited by concentrating prevention efforts among key populations. The concept of key populations also recognizes that these can play an important role in responding to HIV. Key populations vary in different places, depending upon the context and nature of the local epidemic. In most places, they include married women; adolescents; men who have sex with men; sex workers, their clients and regular sexual partners; and injecting drug users. exposed to HIV is essential.

Positive prevention: Positive prevention involves helping people living with HIV to protect their sexual health, to avoid new sexually transmitted infections, to delay HIV disease progression and to avoid further HIV transmission.

Risk and Vulnerability: HIV infection is associated with specific risks, including behaviours such as unprotected sexual intercourse or forced or coerced sex. Vulnerability to HIV is a measure of an individual's or community's inability to control their risk of infection. In many settings, women—and in particular young women—are especially vulnerable to HIV infection, as they may be less able than men to avoid non-consensual or coercive sexual relations, and are often unable to negotiate condom use.

Voluntary counselling and testing: HIV Voluntary Counselling and Testing (VCT) forms the gateway to HIV prevention, care, treatment and support for persons in need. All HIV testing of individuals must be confidential, be conducted only with informed consent (meaning that it is both informed and voluntary) and be accompanied by counselling.

A routine offer of HIV testing should be made by health care providers to all patients in health care settings where HIV is prevalent, where a person shows signs or symptoms consistent with HIV-related disease, to clients receiving STI services, and in the context of antenatal care to facilitate prevention of mother-to-child transmission. Patients retain the right to refuse HIV testing.

At the same time, client-initiated HIV testing for all people who want to learn their HIV status through voluntary counselling and testing remains critical to the effectiveness of HIV prevention. Promotion of knowledge of HIV status among any population that may have been