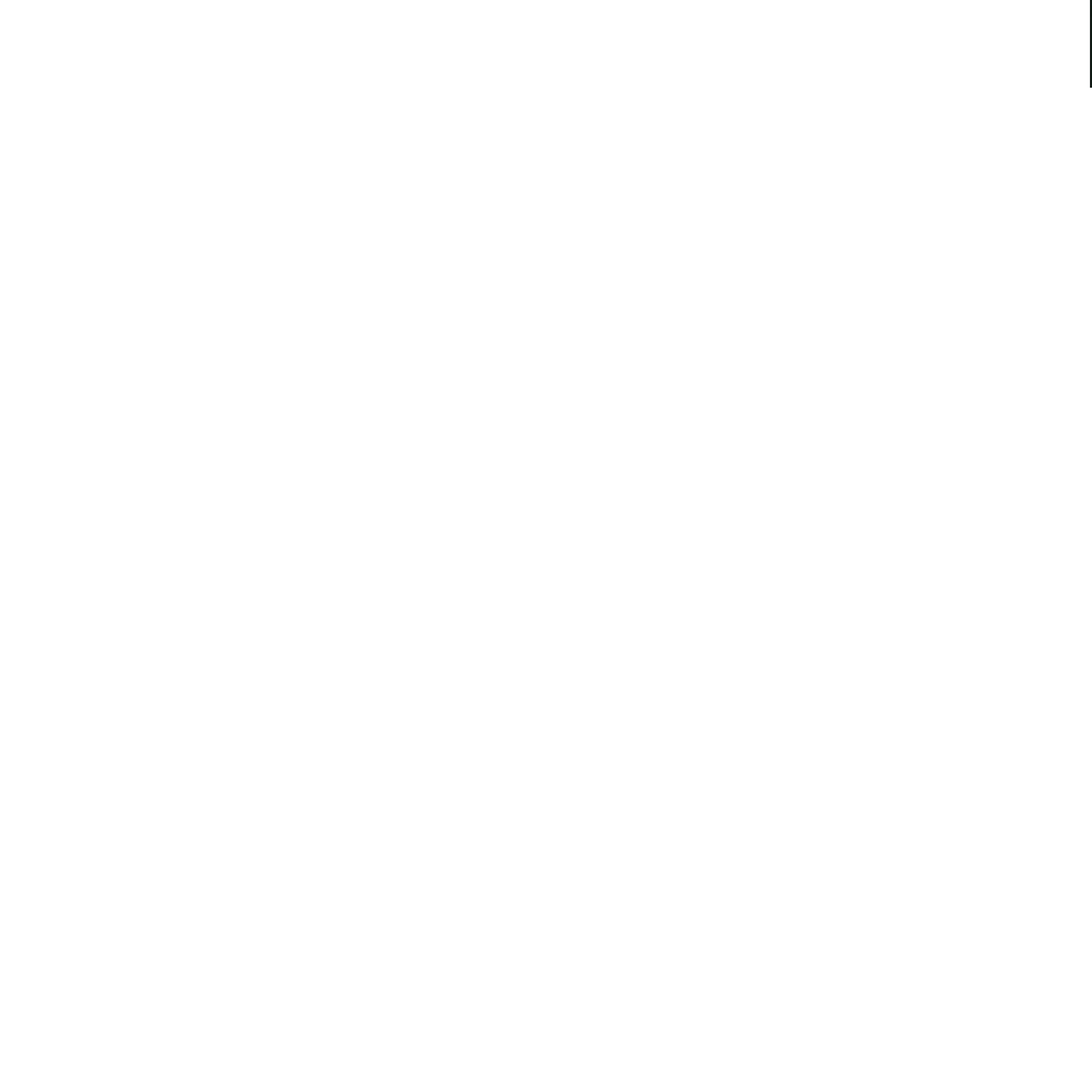
A Handbook for Integrating Sexual and Reproductive Health and Rights into HIV Programmes

SAfAIDS Southern Africa HIV and AIDS Information Dissemination Service

Alliance ZAMBIA Supporting Community Action for Health



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Definition of Terms

There are several terms used throughout this material which need to be defined at the onset to ensure that a common understanding of the terms is achieved.

Adolescent: A transitional stage of physical and mental human development which, according to the World Health Organization, falls between the ages of 10 and 19 years

Culture: Culture is defined as "modes of life, traditions and beliefs; perceptions of health, disease and death; family structures; gender relations; languages and means of communication, including through the performing and creative arts; value systems; and ways of living together" which are embraced by groups of people. In short, culture is defined as ways of living, working and playing.

Discrimination: Discrimination is when a person is treated less favourably in a situation than another person would have been, because of a specific characteristic (for instance being HIV positive, or being thought to be HIV positive).

Dual protection: This refers to protection both against unintended pregnancy and against sexually transmitted infections (STIs), including HIV. This term came about because contraceptives that offer the most reliable protection from unwanted pregnancy (pills and injections) do not protect against STIs. Thus using condoms, in addition to a birth control method, is also recommended.

Family planning: This means an individual or a couple attain their desired number of children and the spacing and timing of their births. This involves use of contraceptive methods and treatment of involuntary infertility.

Gender: The socially and culturally assigned roles of being male or female. Gender roles are dependent on culture, and it is possible to work towards changing cultural pressures experienced by both males and females in their roles.

Gender equality: Gender equality refers to equal treatment of women and men in laws and policies, and equal access for men and women to resources and services. Gender inequality, then, is the situation where there is no equality in these factors.

Gender-based violence: Gender-based violence can be in the form of sexual abuse, physical violence, or emotional or psychological abuse, and includes violence against women when they are pregnant. Although men can experience gender based violence, it is usually perpetrated by men against women and is a key factor in the spread of HIV to women and young girls.

Integration: This refers to how different kinds of sexual and reproductive health (SRH) and HIV services can be connected together to improve the health outcomes of the people served. This can include referrals from one service provider to another, and providing SRH services in HIV programmes, and *vice versa*.

Linkages: The bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV.

Positive health, dignity and prevention: A concept focusing on improving and maintaining the dignity of the person living with HIV, which has a positive impact on the person's health. This, in turn, creates an enabling environment that will reduce the likelihood of new HIV infections.

Service providers: In this handbook, the term 'service providers' refers to anyone who could come in contact with people accessing prevention, treatment and care services. This could include nurses, doctors and counsellors providing VCT or supportive services. It also includes the management staff responsible for designing and monitoring these services.

Sexuality: Refers to how people experience and express themselves as sexual beings. This can include in their behaviour, actions and thoughts.

Stigma: The term refers to when an individual with a certain characteristic or attribute is rejected by their community or society because of that attribute. In the context of HIV, this means that PLHIV are rejected by their communities or even threatened and abused because of their status.

Vulnerability: This refers to how feasible it is for a person to control their risk of infection with HIV. In many communities women are vulnerable because they have difficulty avoiding sexual encounters which they have not consented to, or into which they have been coerced.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral (medicines)
CBO	Community-Based Organisation
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
FBO	Faith-Based Organisation
FP	Family Planning
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
MNCH	Maternal, Newborn and Child Health
MDGs	Millennium Development Goals
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
RTIs	Reproductive Tract Infections
SRHR	Sexual and Reproductive Health and Rights
SRH	Sexual and Reproductive Health (services)
STIs	Sexually Transmitted Infections
SW	Sex Worker
VCT	Voluntary Counselling and Testing
WLHIV	Women Living with HIV

Background

An estimated 1.8 million people were newly infected with HIV in sub-Saharan Africa in 2009. As a result of the successful scale-up of provision of antiretroviral therapy globally, the number of people living with HIV increased from 27.8 million in 1999 to 33.3 million in 2009[1].

Zambia has a generalised HIV epidemic which is fuelled by structural factors such as gender inequality, social norms that encourage multiple concurrent partnerships (MCP)[1] and unequal distribution of wealth. The broad social and cultural factors that have influenced the HIV epidemic in Zambia have been known for some time. However the nature, complexity, and connectedness of these factors make them difficult to address. In the southern Africa region, as in many parts of the world, cultural and social factors lead to gender inequalities in favour of men. Sexual relationships in particular are strongly influenced by cultural belief and practices, to the detriment of women. This is compounded by the fact that due to the sexual nature of HIV transmission, inability to access sexual and reproductive health services makes women more vulnerable to the impacts of HIV. There are also a number of factors which present more barriers to people, and women in particular, accessing sexual and reproductive health services. Young women often fear being judged by service providers because of their age, cultural taboos and the perception that they should not be sexually active and therefore should not need to access sexual and reproductive health services. Women living with HIV may also experience stigma and judgment if they are sexually active and trying to access services.

The response to HIV cannot be successful while women and girls continue to be unable to access relevant services, and to enjoy their rights. Women and girls themselves may not even be aware of their rights. The protective laws of a country are of no value to women unless they are aware of them, thus it is vital that HIV programmes support people in communities to know and access their rights. Achieving this is integral to encouraging and achieving prevention, treatment, care and support for PLHIV.

Ensuring relevant access to HIV prevention and mitigation services for women is crucial because HIV affects women's ability to care for their families. Not only do HIV positive pregnant women have an increased risk of death and their unborn babies have an increased risk of contracting HIV, and of dying, but HIV negatively impacts on mothers' ability to care for their children, contributing to high infant and child mortality.
This is the rationale for the concept of the maternal, neonatal and child health (MNCH) and HIV linkages. The MNCH model of continuum of care is concerned with ensuring availability and access to essential health and reproductive services:

(a) for women from adolescence through pregnancy, delivery, and beyond; and
(b) for newborns into childhood, young adulthood, and beyond.

1. UNAIDS Report on the global AIDS epidemic 2010

HIV contributes both directly and indirectly to increased mortality in women and children. According to the 2010 maternal mortality Inter Agency Estimates HIV accounts for 9 percent of maternal deaths and 12 to 15 percent of child mortality in sub-Saharan Africa. In addition to the opportunistic infections associated with HIV, HIV positive pregnant women and mothers have to deal with stigma and discrimination from, among others, medical health personnel, which affects their comfort with and ability to access quality sexual and reproductive health services.

The role of programmes then is:

i. to ensure an understanding of SRHR for men and women which will set the stage for lasting behaviour change and reduce the impact of the HIV epidemic,
ii. to reduce stigma and discrimination directed at women, PLHIV and young people which prevents them from accessing SRHR, and
iii. to ensure integration of SRHR, MNCH and HIV interventions and aspects at appropriate levels.

This handbook presents key information to support training that will heighten understanding of how SRHR and MNCH are relevant to those of us working in the HIV field, and how these aspects can be integrated into our programmes. There are always concerns when it comes to 'integrating' something, with questions such as "does this not just mean more work?". This handbook is designed to highlight feasible ways of integrating SRHR and MNCH into HIV programmes. This is not a small task, but we should bear in mind that the HIV epidemic calls for strong and innovative action, and that by integrating SRHR and MNCH we have the potential to reduce the impact this disease is having on communities in Zambia.

Day One: Sexual and Reproductive Health, Rights and HIV

Session One: Introduction to the Training

Aim of Session: This session aims to introduce the training and give the facilitator(s) the opportunity to get the group to be comfortable enough to work together and share their experiences.

Learning Objectives:

By the end of the session participants will:

- Have a good understanding of the aims of the training and how it will be conducted.

Registration and Welcome

As each participant comes into the room, greet them warmly and introduce yourself. Each participant should then be provided with the training package (including all handouts and a registration form). The first few minutes of the session, during which participants will probably come in a few at a time, can be used by participants to fill out the registration form with their personal details. Participants should be provided with a name tag, or they can write their names on labels themselves. It is also a good idea to clarify pronunciation of the participants' names.

Once all the participants who are expected have arrived, proceed with a formal welcome. If several participants seem to be running late, explain to the rest of the group that they will wait a few minutes before starting, so that everyone can be present from the beginning. The facilitator(s) can then introduce themselves and the objectives of the workshop, highlighting to participants the importance of the training and commitment to learning. For example, facilitators could start by saying the following:

Good morning everyone, and welcome to this training on sexual and reproductive health and rights and HIV. I am ____________ and I will be your facilitator for the next four days. I appreciate your attention and look forward to learning from you all and from your experiences.

Icebreaker and Introductions

By setting an open and friendly tone, the facilitator can lead the way for the group to work well together. Explain to the group that the training employs a participatory approach, so they will be working together on various activities which have been designed to take them through a learning process where they will learn both from the material and from each other. Emphasise the need for everyone to contribute – and that everyone's contribution is valuable. At this point introduce the icebreaker activity, which has been designed to familiarise members of the group with each other and to get them thinking about what they have in common with each other, which will help encourage good group dynamics.

Top Tip

Facilitators should also feel free to use their own icebreakers which have worked well in previous trainings. Use this opportunity to gauge whether some participants seem shy or quiet, and make a mental note to engage them more in discussions. Use the energisers when necessary.

Making Expectations Clear

It is important that participants are clear about their expectations from the outset, so that they can feel a sense of achievement from what they get out of the training, but also so that they can identify further training or information needs. Allow the group five minutes to think about and write down three of their overall expectations of the training. Invite each participant to share one expectation with the group, which the facilitator records on a flip chart and displays in the room for the duration of the training. At this point, clarify for participants if there are expectations that will not be covered in the training; for example expectations relating to learning about working with law enforcement in relation to gender-based violence (GBV).

Use this opportunity to explain that the beginnings of Days 2, 3 and 4 will be used to recap the previous day's sessions, and if there are any outstanding questions participants will have the chance to ask them during this time. Next, ask the participants to complete the pre-course evaluation form, which will help you assess the level of knowledge in the group. Also explain that at the end of the workshop, participants will be asked to complete a post-course evaluation to see how well they have incorporated the information and also to assess the quality of the workshop.

Ground Rules

Although this training is designed to encourage participation and sharing of experiences, it is important that participants agree on how they are going to work together as a group. Ask the group to brainstorm on Ground Rules that they feel will be important for achieving their objectives, and ensuring that the training is conducive for learning. Record these on a flip chart, and display them in a prominent position in the training room. Some things that should be mentioned if they do not come up are:

- Any personal information or experience shared by members of the group should remain confidential
- All participants should give their full co-operation and participation
- Participants should respect each other's opinions
- Participants should not start separate conversations while group discussion is going on
- Mobile phones to be switched off, or on silent during the training.

After this session, hand out the training programme which provides details on the sessions for the next four days.

Introduction to Training

To introduce participants to the content of the training, paraphrase the information contained in the background of the handbook on the HIV situation in southern Africa and the need for integrating SRHR into programmes. This links to Session Two by highlighting the need to understand the root causes of the HIV epidemic.

ENERGISERS

a. Energiser - 'Have you ever'

Get participants to stand in a circle. Explain that you will call out different statements that may or may not apply to each person. If the statement applies to a participant then they should go to the middle of the circle and shake hands with whoever else is also in the middle. Use the questions below, but feel free to use your own too.

- Do you have both a brother and a sister?
- Have you ever ridden a horse?
- Have you ever gone without a shower for more than two weeks?

b. Energiser – 'It's all in the name'

Get participants to think of an adjective to describe how they are feeling, or how they are, and then go round the group inviting individuals to share. The adjective should start with the same letter as their name, so for example one could say 'I'm David and I'm feeling Delighted' or 'I'm Grace and I'm feeling Gorgeous'.

c. Energiser – 'The telephone'

Participants stand or sit in a circle. Whisper a message to one of the participants. This participant passes the message in a whisper to the next person and so on. The last person says what they have heard. This works best if a complex and nonsensical sentence is used, and if participants are asked not to repeat the message to the person they are passing it on to.

d. Energiser – 'Two truths and a lie'

With the group sitting in a circle, ask participants to think about two truths about themselves and a lie. Going round the circle, each participant should share the three 'facts' to the rest of the group, and they try to guess which one is a lie. As the facilitator you can go first to get the ball rolling.

B. Sexual and Reproductive Health and Rights and HIV

Session Two: Health and Human Rights

Time: 1 hour 15 minutes

Aim of Session: To convey the idea that rights may seem like an abstract concept but that there are accepted definitions of rights and how they relate to health.

Learning Objectives:

By the end of the session, participants will:

- Understand the concept of human rights in relation to health

Facilitator's Guide

Introduce the idea of human rights as something that we are all aware of, and hear a lot about, but for which we often have differing personal ideas and opinions on what they are and how they can be violated. To work towards integrating SRHR into programmes, we need to start with a common understanding of human rights.

Organisations working in SRH have harnessed the concepts of human rights to cover the diverse situations that can arise in relation to gender and sexuality.

Refer participants to **Handout 2** which outlines twelve sexual and reproductive health rights. Read the explanation of each right, and use the points below to give participants real world examples of what these rights mean **(30 minutes).**

Ensure that both male and female viewpoints come out.

Activity 1 (25 minutes)

Split the group into **three smaller groups**. These groups will then be given **15 minutes** to discuss several questions relating to rights. Encourage group members to listen to the opinions of everyone in the group and then to try and reach group consensus on their ideas.

Write the following questions on the flip chart. It may also be helpful to explain each question further as you are writing it up:

1. What are some of my rights?
2. What rights are most difficult to access, if any – there may be several in each scenario?
3. Who is infringing on or violating the other person's rights?
4. Why could these rights be important in relation to HIV?
5. Do different people have different rights?
   - *Think about young boys and girls, older people, minority groups, sexual minorities, unborn children*
6. What are our rights in relation to health?

Two of the groups should then present a short summary of their discussion back to the room **(**five minutes per group, **10 minutes total)** and other group members can add any points not covered to the discussion after the presentations. This exercise will highlight the variety of opinions and ideas that people have on human rights. From this point you can then move towards consensus of understanding, referring to **Handouts 1 and 2,** which provides information on some important human rights instruments that help our understanding of human rights.

Activity 2 (50 minutes)

Divide participants into **three groups**. Each group is assigned a scenario from **Handout 3** to discuss and analyse **(20 minutes)**, referring to **Handout 2** to remind them of the variety of sexual and reproductive health rights.

Groups should nominate one person to provide feedback to the whole group, leading to a group discussion on rights (10 minutes per group, **30 minutes total)**. During the group discussion, refer participants to **Handout 4** which provides information on some of the important international and regional congresses and conventions that support sexual and reproductive health and rights. Encourage participants to take away these Handouts and read them in their spare time.

Wrap up

- People have a personalised view of what human rights are, which may be influenced by their cultural and family contexts, but human rights are also laid out in International Law (**Handout 1**)
- People need to access their rights and there should be facilitation that supports them to understand their rights better
- These legal instruments outline rights, but the extent to which these are achieved often depends on the actions of individuals
- Rights are universalist (apply to everyone) and egalitarian (everyone is equally entitled to them)
- No one can 'give' or 'take away' rights as such, but rights can be violated through the actions of individuals or groups
- An accepted definition of rights in relation to health could include the right to control your health and body; the right to have an adequate standard of living to access determinants of health, including water, sanitation, food, nutrition, housing and healthcare, the right to information needed to protect health, and the right to health services free from discrimination
- The HIV epidemic has led to increased violations of the human rights of men, women and children, and of PLHIV and women in particular, in terms of these health rights
- As individuals, we are entitled to our human rights, but we should also respect the human rights of others. With rights come responsibilities
- Zambia, like many other African countries, signed various conventions, among them the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Conference on Population and Development (ICPD) and others. This means that the countries have responsibility to act in the areas covered by the declarations and conventions
- In particular, women need to be supported in accessing their rights to health because women are more vulnerable to the impacts of HIV than men. The gendered nature of the HIV epidemic is covered in the next session.

Session Three: Gender, Sexuality and Culture

Time: 1 hour 50 minutes

Aim of Session: This session aims to ensure that participants have a good understanding of sexuality, gender and culture and how these can impact on individuals' ability to access and enjoy their rights.

Learning Objectives:

By the end of the session, participants will:

- Understand the concepts and definitions of gender and culture
- Understand the meaning of the terms 'sexuality' and 'sexual and reproductive rights'

Facilitator's Guide

Begin by explaining that 'gender' and 'culture' are terms that we often hear in our day-to-day lives, but that we often do not have a common understanding of these terms. Ask participants to share their own ideas about what these two concepts mean, recording key points on the flipchart. After five minutes of discussion, introduce the group to Activity 1. **(10 minutes)**

Activity 1 (65 minutes)

Divide participants into **four groups** and give each group a flipchart and some markers. Assign two groups to work on 'women', and the other two groups to work on 'men'. The groups have **20 minutes** to draw a stylised representation of what their society expected of men or women 50 years ago, and what is expected now, with labels to explain each characteristic. This is intended to be a fun exercise, so participants should feel free to be creative and enjoy the activity. One group each from the male and female groups should present their drawing, explaining what they have labelled, and sharing some of the discussions that the group had (five minutes per group, **10 minutes total**). At this point you can share the definition of gender below.

What is Gender?
Often people think that 'gender' is simply another word for 'sex' – to denote whether a person is male or female. 'Gender' actually refers to the socially defined roles of men and women.

Next, use the drawing by the group who presented on the women to illustrate how gender and culture are linked. For each label that the group has given, ask participants how this factor is influenced by culture. You can then share the definition of culture which is in the box below. The key concept of this activity is that gender is strongly influenced by social norms and culture.

What is Culture?
Culture is the collection of values, symbols, behaviours and ways of thinking that makes one group of people different from another. Culture relates to how we organise ourselves as individuals within groups, and it is a dynamic concept, changing constantly in response to events.

Facilitator's Guide

The facilitator asks the participants to share some common cultural practices, beliefs and the associated disadvantages of these practices. For instance:

- Which of the two parents is blamed when a teenage daughter becomes pregnant?
- When a woman is pregnant who decides who cares for her? Who decides whether she goes for antenatal care or not? Who helps her to deliver her baby and decides where she delivers from?
- What are some common beliefs about sex during pregnancy?

Wrap Up

- Gender and culture are strongly linked, ascribing particular roles and expectations to women and men, and making it difficult for women to access and enjoy their rights
- In many societies gender and cultural factors ascribe more power to men
- Women are at a disadvantage in terms of accessing health rights **Quick Link to Gendered Epidemic session**
- Roles and expectations of men and women have changed over time, showing that it is possible to change societies and culture
- There are positive aspects to culture, for example, women's key role in nurturing and supporting within the family and home. But there are also negative aspects, for example where women are not expected to, or given space to make decisions on their own
- In many cultures, women are not seen as sexual beings. This impacts on their ability to access SRHR.

Top Tip

Ideas should be shared about how participants could facilitate community meetings where men and women gather together to discuss topics such as domestic violence and encourage attitudes that promote gender equality.

Activity 2 (30 minutes)

1. To introduce the concept of sexuality, lead a brainstorming session on what is 'sexuality', writing up key words on a flip chart. This will highlight to the group that sexuality is personal for each individual. End the first part of this activity by sharing the definition of sexuality below. Then move to the next part of the activity.

2. Ask the group to brainstorm all the words that they can think of which are associated with sexuality. Probe for missing words: Any positive associations? What part of sexuality does society not like to talk about openly? Try to pull out the hidden aspects of sexuality. What are some negative consequences or actions related to sexuality?

Use the cycles of sexuality to summarise the brainstorming session.

What is Sexuality?

Sexuality is a central aspect of being human throughout the life cycle. It encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed.

Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.
Source: WHO draft working definition, October 2002

Facilitator's Guide

Definitions of Circles of Sexuality

Sensuality

Awareness and acceptance of one's own body and other people's bodies, including physiological and psychological enjoyment of the same.

Intimacy

The ability and need to be emotionally close to another human being and to accept closeness in return.

Sexual identity

Development of a sense of who one is sexually, including the sense of being male or female, culturally-defined gender roles, and sexual orientation. Sexual orientation refers to which sex a person is primarily attracted to; the opposite sex to their own.

Sexual health and reproduction

Attitudes and behaviours related to producing children and those which make sexual relationships healthy and enjoyable.

Sexual power over others or sexualisation

The use of sexuality to influence, control and manipulate others, for instance through seduction, flirtation, harassment, sexual abuse or rape.

Activity 3 (15 minutes)

Go through the list of sexual rights below with the participants and discuss the meanings together.

Sexual and Reproductive Health and Rights

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.
Source: WHO draft working definition, http://www.who.int/reproductivehealth/gender/sexual_health.html

Wrap Up

- Men have an important role to play because of their role in preventing women from accessing their rights. Young people and minorities are also disadvantaged and need special consideration
- If women are not aware of their rights, they cannot take steps to access them to reduce their risk of HIV infection
- Using a rights-based approach allows us to work towards equality and begin to address the root causes of the HIV epidemic (cultural, social and gender factors)
- By enabling people who access services to know their rights and take control of their lives, they become 'actors' who have influence over their own lives
- If men are not aware of reproductive rights they cannot take steps to facilitate change.

Session Four: HIV as a Gendered Epidemic - The Vulnerability of Women and Girls

Time: 30 minutes

Aim of Session: The aim of this session is to show how gender inequalities contribute to the vulnerability of women and girls to HIV infection, and the greater impact of HIV on women and girls.

Learning Objectives:

By the end of the session, participants will:

- Be able to describe the common root causes of HIV and SRH problems.
- Have a good understanding of how gender contributes to vulnerability to HIV infection.

Facilitator's Guide

Introduce this session by explaining that the root causes of HIV include biological factors and sociocultural factors. Refer to **Handout 5** and paraphrase the information in this handout for participants **(10 minutes).** Emphasise that these factors also make women vulnerable to SRH problems.

Activity 1 (20 minutes)

Divide participants into pairs. In their pairs, participants should role play one of the scenarios of SRHR infringement in **Handout 6 (10 minutes).** Ask for volunteers to share their thoughts on the way they felt about the role of the disempowered woman or girl, and how the infringement of her SRHR affected them. Lead a group discussion on the key challenges faced by women in these contexts **(10 minutes).** Record the key points from the discussion on the flip chart.

Activity 2 (10 minutes)

Discuss the following statements with participants:

1. It is better to invest in a boy child's education than a girl child's
2. A man always needs other women besides his wife
3. Even when a man is being unfaithful, his wife has no right to refuse to have sex with him
4. It is wrong to suggest the use of condoms in a marriage.

Wrap up

- Women and girls often have less information about HIV and fewer resources to allow them to take preventive measures
- They face barriers in negotiating for safer sex, with factors like economic dependency and unequal power relations affecting ability to successfully negotiate
- Gender inequality and violations of women's rights make women and girls particularly vulnerable, leaving them with less control than men over their own bodies and their lives
- Sexual violence; a widespread and brutal violation of women's rights, exacerbates the risk of transmission
- In many cases, HIV positive women face stigma and exclusion, which is aggravated by their inability to access and enjoy their rights
- Women widowed by AIDS and those known to be, or suspected of being HIV positive may face property disputes from in-laws
- Regardless of whether they themselves are HIV positive or not, women generally assume the burden of home-based care for others who are sick or dying, along with orphans left behind
- Service providers and managers have an important role to play in ensuring awareness of human and sexual rights by men and women, and in ensuring that people are exercising their rights and are treated with respect.

Day Two: Linkages and Integration of SRH and HIV Programmes

Session One: The Links between SRHR and HIV

Time: 45 minutes

Aim of Session: This session aims to clearly define the link between SRHR and HIV.

Learning Objectives:

By the end of the session participants will:

- Be able to explain the difference between linkages and integration
- Describe the ways that failure to attain SRHR can negatively impact on peoples' HIV risk and coping mechanisms (particularly for women and young girls).

Facilitator's Guide

- Introduce this activity by explaining that the majority of HIV infections are sexually transmitted, or associated with pregnancy, childbirth and breastfeeding
- SRHR and HIV share the same root causes, among them poverty, gender inequality, gender-based violence, human rights violations, marginalisation of key populations, and stigma and discrimination. **(10 minutes)**.

Activity 1 (35 minutes)

a) Divide group into two

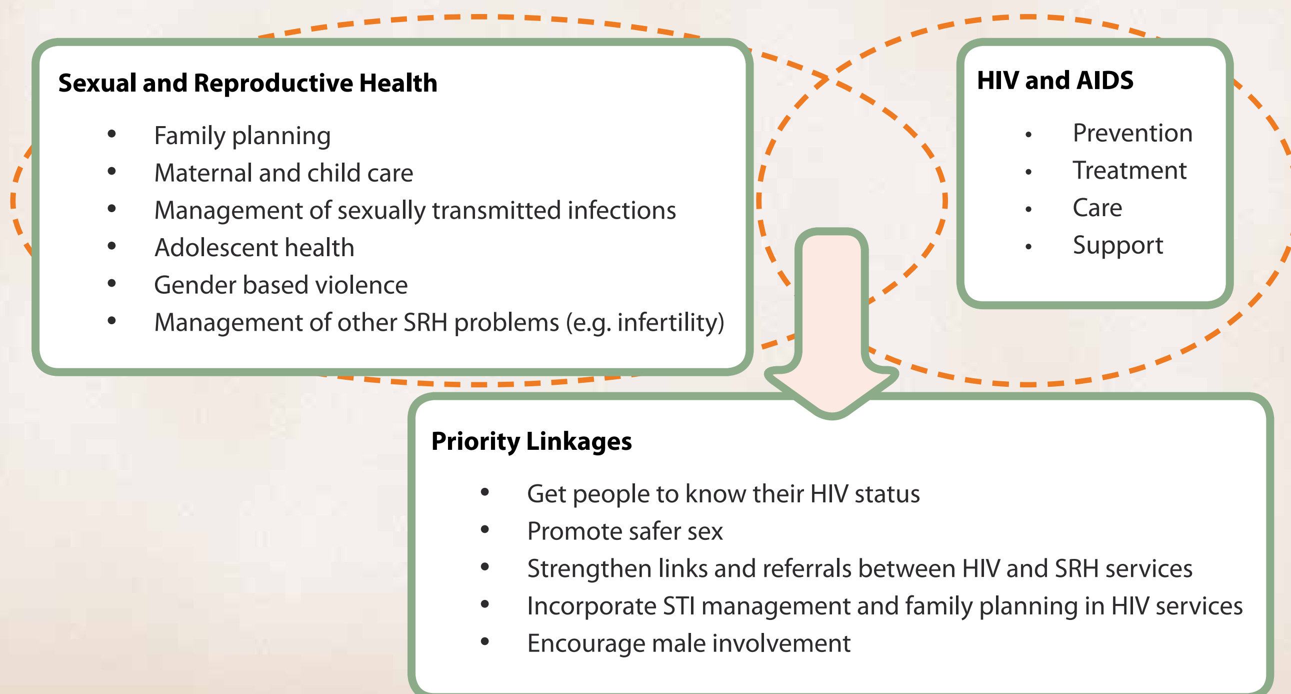
Ask both groups to write down SRH and HIV components on colour coded cards, e.g. blue for SRH and yellow for HIV. The facilitator should then draw blank circles on a flip chart; one representing SRH and the other HIV. Participants then stick what they have written in the appropriate circles. Discuss commonalities and differences.

b) During a brainstorming session, define linkages and integration. The facilitator should harmonise the answers, then ask the group to give examples of linkages. Feel free to get the discussion started by using examples that you are familiar with, or that you think are relevant to the participants you are working with. Record the points from your discussion on a flipchart, and ask participants to share their ideas or experiences of how SRHR and HIV are linked.

Wrap up using figure 1

c) Ask volunteers to share some practical experience of where they have seen SRHR violations with an impact on HIV outcomes (e.g. lack of access to SRH services, condoms etc). To guide your discussion, use **Handout 7** which gives a detailed overview of how basic human rights, sexual and reproductive health and HIV and AIDS are linked. Don't feel pressurised to get through the whole handout, but try to get as far as you can in the time allowed, and encourage participants to read this Handout in their spare time. The key points on how SRHR and HIV are linked are covered in the diagram below.

Figure: 1 Priority Linkages for SRH and HIV Services



Top Tips:

- Linkages - The bi-directional synergies in policy, programmes, services and advocacy between sexual and reproductive health and HIV. It refers to broader human rights-based approaches, of which service integration is a subset
- Integration - Different kinds of sexual and reproductive health and HIV services or operational programmes that can be joined together to ensure and perhaps maximise collective outcomes. This would include referrals from one service to another, for example. It is based on the need to offer comprehensive services
- One of the most important linkages SRHR and HIV prevention is the concept of 'dual protection'. This refers to the fact that condoms can prevent exposure to HIV infection, and that they can also prevent unwanted pregnancy.

Wrap up

- The rationale for linking SRHR and HIV is that:
    - The majority of HIV infections are sexually transmitted, or associated with pregnancy, childbirth and breastfeeding.
    - SRHR and HIV share the same root causes, among them poverty, gender inequality, gender-based violence, human rights violations, marginalisation of key populations, stigma and discrimination.

- Why the linkages? Some practical examples:
    - Experiencing sexual violence increases HIV risk. This includes forced sex in marriage
    - Transactional sex, often without condoms, increases risk of contracting STIs and HIV
    - Intergenerational sex, young age at marriage and forced marriage can expose young women to STIs and HIV at a very young age
    - Failure to treat STIs puts people at increased risk of HIV infection
    - Lack of access to family planning (FP) and prevention of mother-to-child transmission (PMTCT) services for PLHIV increases their risk of having an unwanted pregnancy and/or re-infection with HIV
    - Lack of information and access to condoms for dual protection increases the risk of HIV and unwanted pregnancy, especially for young people.

Moving on from understanding these links between SRHR and HIV, in Day 2 we begin to look at how SRHR can be integrated into HIV programmes so that we can address SRHR and HIV.

Session Two: Benefits of SRH and HIV Integration

Time: 1 hour 15 minutes

Aim of Session: This session aims to present information on integration of SRH and HIV services and to highlight some benefits of doing so.

Learning Objectives:

By the end of the session participants will be able to:

- Describe the benefits of integrating SRHR and HIV services
- Explain the different roles of different service providers in integration
- Explain the term 'dual protection'
- Demonstrate on a model the correct way of using both male and female condoms.

Facilitator's Guide

Benefits of SRH and HIV Integration

- Reduction in HIV-related stigma and discrimination associated with accessing non-integrated HIV services (with integrated services people do not know whether one is accessing HIV services or SRH services)
- Improved access to SRH services for PLHIV, thereby enabling them to attain their SRHR
- Promotion of dual protection - Dual protection is a strategy for preventing both transmission of HIV and other STIs, and unintended pregnancy through (i) use of condoms alone, (ii) use of condoms and other methods of contraception or (iii) avoidance of unsafe sex
- Reduction in duplication of efforts and competition for scarce resources (many resources are now directed away from HIV programming)
- Increased effectiveness and relevance of programmes.

Activity 1 (20 minutes)

Refer participants to **Handout 8.1** which explains how different service providers can integrate services. Go through this handout with participants, and then use the flipchart to get the group to brainstorm on the benefits of integrating SRH and HIV services **(20 minutes**)

Role plays: Introduce the activity by explaining to the participants that they will be exploring the concept of dual protection and condom negotiation and thinking about ways of working with women (married or single) to meet their needs for dual protection and negotiate the use of condoms in their relationships.

a. Scenario One

Client

You are a 25 year old woman who has been married for four years. You have two young children and recently discovered that your husband has other partners. You are not quite ready for another child, but are also worried about contracting HIV and/or other STIs. Your husband is agreeable to the use of pills for family planning and you are quite uncomfortable about confronting your husband on the issue of using condoms. You are confused and worried about whether you should continue having sex with him or not. If you are going to continue having sex, you really must use a condom. You would like to talk with the provider but are really scared. If the provider can make you comfortable you are willing to discuss your concerns.

Provider

A 25 year old woman has come to see you. She is married and has two young children. She and her husband have used pills as their method of contraception. Though not pregnant she is very worried. Why has she come to see you? Your task is to find out why she has come to the clinic and address any concerns that she may have.

b. Scenario Two

(Scenario two can be acted in two ways, one provider tells off the girl and the other counsels the girl appropriately)

Client

You are a sixteen year old girl who's just entered into a relationship with this cool guy. Your previous relationship did not last because you would not give in to your boyfriend's sexual advances. You are scared of becoming pregnant or contracting HIV. On the other hand, you do not want to lose this new guy. You are confused and worried and would like to talk to someone but don't know how and whether you can entrust yourself and your problem to the service provider.

Provider

A 16 year old girl has come to see you looking very worried. She has just started a relationship with this guy she thinks is very cool. Why has she come to see you? Your task is to find out why she has come to the clinic and address any concerns that she may have. The girl happens to be the daughter of your close friend.

Ask for volunteers to demonstrate how to use a male and female condom. The facilitator should give out **handouts 12 and 13.**

Wrap up

- Simply put, to integrate SRH into HIV services, we need to ensure that basic SRH services are available in HIV services and that there are good referral links between HIV and SRH services
- Another benefit of integrating SRH into HIV services is that it means we are taking into consideration the rights and needs of PLHIV, an aspect which will be covered in more detail in a later session.

Session Three: Integration of Adolescent Health into SRH & HIV Services

Time: 50 minutes

Aim of Session: This session aims support participants to understand the challenges faced by adolescent boys and girls in accessing SRHR and HIV services and to identify solutions on how to effectively integrate adolescent health into SRH and HIV services

Learning Objectives:

By the end of the session participants will:

- Understand why young people are a group that needs special attention
- Be able to identify difficulties faced by adolescents in accessing SRH and HIV services offered
- Be able to explain what should be done to make services adolescent friendly.

Facilitator's Guide

There are some aspects of SRHR that are particularly relevant for young people.

Young people have the right to:

- Sex education that gives them all the relevant information for good sexual and reproductive health
- Be able to choose their sexual partner(s) for themselves, meaning that they should not be coerced into sex (for example, by a teacher)
- Decide to be sexually active or not, free from peer pressure
- Consent to sexual relations and to marriage
- Avoid illnesses, and to say no to sex.
- Ensure that issues around the mind-set from both provider and beneficiary are brought out.

Activity 1 (35 minutes)

Divide participants into three large groups (different to the groups from Day 1). Ask for one volunteer from each group who will explain to other members of their group the services their organisation provides, and why there are problems of youth not accessing these services, or of stigma and discrimination directed at young people by service providers. The groups then have **25 minutes** to discuss what would be the best way of making the services youth-friendly so that young people can better access SRHR. One group then has **10 minutes** to share their strategies, and the whole group can add points to this discussion. Refer participants to **Handout 8.2** for a checklist of how to make services more youth-friendly to help them come up with strategies for making their services more youth friendly. The group should also discuss the types of marginalisation affecting adolescents.

Ensure that issues around mind-set from both provider and beneficiary are brought out.

Examples of Stigmatisation and Discrimination of Adolescents

<table>
<tr><th>Type of Marginalisation or Vulnerability</th><th>Examples of Affected Adolescents</th><th>Examples of How Adolescents are Affected</th></tr>
<tr><td>Gender and Associated Norms</td><td>Those in early marriages
Unmarried sexually active young women
Adolescent survivors of gender based violence
Adolescent females in conservative communities
Adolescent males</td><td rowspan="3">Adolescent needs not streamlined in the SRHR services being offered by the government
Decisions on SRHR are taken by others and these are usually not based on what adolescents themselves want
Adolescents not able to independently access SRHR services
Lack of friendly services at appropriate locations and times for adolescents
Discriminatory attitudes of health workers towards adolescents (e.g. those requesting for contraceptives)
Limiting confidentiality of SRHR services
Inadequate parental guidance in sexual and reproductive health issues
Lack of appropriate SRHR information materials
Exposure to sexual harassment
Rights to sexuality (e.g. of adolescents with physical disabilities) not acknowledged
Social stigma related to health status prevents adolescents from accessing SRHR services
Lack of understanding of specific SRHR needs
Management of adolescent sexual harassment not adequately addressed at all levels</td></tr>
<tr><td>Socio-cultural & Socio-economic Status</td><td rowspan="2">Unmarried adolescents with children
Out-of-school adolescents
Orphaned adolescents
Adolescents exposed to sexual pressure and risk (e.g. in shanty compounds)
Adolescents from poor families and those with low levels of education
Child labourers and adolescent household heads
Adolescents living with HIV
Pregnant adolescents
Adolescents with mental and physical disabilities
Adolescent survivors of sexual and gender based violence
Adolescents of minority sexual orientations</td></tr>
<tr><td>Health Status</td></tr>
</table>

Wrap up (15 minutes)

When aiming to make services youth-friendly, key considerations include:

- Supporting the ability of young people to make informed decisions on pregnancy and preventing HIV infection
- Providing for the specific needs of young people in relation to preventing unwanted pregnancy – e.g. emergency contraception
- Provision of comprehensive information on abortion and post-abortion care
- Stigma and discrimination can stop people from accessing their SRHR. For this to change, service providers and people in communities need to change their behaviour to support everyone in the community, especially women, young people and PLHIV in accessing their rights
- CBO programmes have a role to play in this behaviour change, but first there is need to understand what influences stigmatising behaviour
- Stigma, discrimination and behaviour change will be discussed in later sessions (Session two on day three will dwell more on stigma and discrimination).

Session Four: Intergrating Family Planning and HIV Services

Time: 55 minutes

Aim of Session: This session aims to discuss the similarities between family planning (FP) and HIV services, and the benefits of family planning.

Learning Objectives:

By the end of the session, participants will be able to:

- Explain what the term family planning means
- Describe the different types of family planning and explain some of the associated myths and misconceptions which may affect certain groups ability to access and use family planning methods
- Explain the benefits of family planning and the importance of integrating family planning and HIV services
- Present and explain key safer pregnancy messages for HIV positive concordant or discordant couples desiring a pregnancy.

Facilitator's Guide

Contraceptive Methods

a. Male and female condoms (offering dual protection)
b. Oral contraceptive pills (OCPs), including combined oral contraceptives (COCs) and progestin-only pills (POPs)
c. Injectable contraceptives
d. Implants (e.g. Jadelle and Implanon)
e. Intrauterine contraceptive devices (IUDs)
f. Permanent methods (tubal ligation and vasectomy)
g. Emergency contraceptive pills (ECPs)
h. Natural and fertility-awareness methods.

(Refer to Handout 9)

Activity 1 Brainstorming (five minutes)

- The trainer asks Participants to define family planning
- Allow two or three responses, and then share the prepared flip chart with the definition already written on it.
- Ask a volunteer to read the definition aloud.

Activity 2 Presentation and Group Exercise (25 minutes)

The trainer should assign Participants to three groups

- Group 1 will brainstorm on the benefits of family planning.
- Group 2 will brainstorm on the different methods of family planning.
- Group 3 will brainstorm on the myths and misconceptions surrounding family planning and how they can be dispelled.
- Each group will be given flipchart paper and markers. After **10 minutes** ask the groups to return to their seats and present their assignment through their group representatives **(five minutes each)**.
- Allow for additions from the group members in the larger group.

Activity 3 (25 minutes)

Divide the participants into **two groups.**

- Group 1 should discuss: Reasons clients with HIV may consider pregnancy.
- Group 2 should discuss: Reasons clients with HIV may want to avoid pregnancy **(10 minutes)**.

Each groups presents **(five minutes each)** and the facilitator harmonises the answers and gives them **Handout 10**.

Wrap up

- Family planning is the decision taken by an individual or couple based on voluntary and informed consent about when to have children, the number of children they want, and the interval between pregnancies using a contraceptive method of their choice
- It is widely accepted that integrating HIV and SHRH has many public health benefits.

Top Tips:

Essential Principles of family planning Counselling in HIV Services

- Every HIV counselling and testing (HCT), antiretroviral therapy (ART), and prevention of mother to child transmission (PMTCT) client should be assessed for family planning needs
- HCT, ART, and PMTCT clients have the right to make their own family planning choice, including safer pregnancy for HIV positive women (using risk reduction measures like ARVs and exclusive breastfeeding), if desired. Quality family planning counselling and services should reinforce clients' ability to reduce HIV transmission to HIV-negative partners and to infants.

Key Messages for family planning Counselling in HIV Services

- Generally, HIV positive clients can use most contraceptive methods, even when on ARVs. Dual method use, using condoms and a contraceptive method for protection from infection and unintended pregnancy, should be included in family planning counselling for clients with HIV.

Session Five: Integrating MNCH and HIV Services Linkages

Time: 70 minutes

Aim of Session: This session aims to present information on integration of maternal, newborn and child health (MCH) and HIV services

Learning Objectives:

By the end of the session, participants will be able to:

- Explain the continuum of care from pre-pregnancy through pregnancy, delivery and newborn and child health
- Explain the root causes and consequences of HIV infection for pregnant and postpartum women
- Describe the social, cultural, economic, gender and political factors that may increase pregnant and postpartum women's vulnerability to HIV
- Mention the advantages and disadvantages of getting counselled and tested for HIV during pregnancy and the postpartum period.

Activity 1

Discuss with the participants what 'continuum of care' in maternal, neonatal and child health means. Use the facilitator's guide and top tips below to guide the discussion.

Top Tip:

Packages of effective interventions for continuum of care in MNCH Programmes.

The continuum of care should include continuum across the life course, delivery strategies and integration across other health programmes (SHR, HIV, TB, Malaria and nutrition).

Adolescence and pre-pregnancy**:** This phase benefits from information and services on how to prevent sexually transmitted infections, HIV, unwanted pregnancies and mother to child transmission of HIV. Maternal, newborn and child health (MNCH) partnerships identifies five lifecycle phases:

a. adolescence,
b. pregnancy,
c. childbirth and the postnatal period,
d. newborn and
e. childhood.

Pregnancy**:** The thrust in interventions is on ensuring provision of skilled care during pregnancy. Quality Focused Antenatal Care (FANC) is important.

Childbirth and the postnatal period**:** The focus in this package of interventions is on ensuring skilled, professional care during childbirth. Women are encouraged to deliver at a health institution because every pregnancy is a risky one. The main causes of maternal death are:

a. Bleeding
b. Infection,
c. Unsafe abortion, and obstructed labour,
d. Convulsions,
e. HIV and
f. Malaria.

All these causes cannot be handled by traditional birth attendants but require skilled health workers. Some complications can occur even after delivery, therefore a woman should be followed-up two days, six days and six weeks after delivery.

Newborn (neonatal)**:** Essential Newborn Care is critical for the survival of the newborn. Success in this is completely dependent on the continuum of care from the time the mother became pregnant, through childbirth and facility and home based care of a newborn. The package should include:

a. wiping the baby dry immediately after birth and delaying bathing the baby even by a day,
b. breast feeding the baby within the first one hour, and
c. kangaroo care for premature and underweight babies.

Childhood**:** The package of interventions during this phase of the life cycle includes the Immunisation Plus Strategy. Communities need to understand their role in immunisation and children need to be brought for immunisations by parents, therefore it is important to explain how vaccinations can protect both individuals and communities as a whole. Integrated Management of Childhood Illness (IMCI) is the integration of simple, affordable and effective interventions for the combined management of childhood illnesses and malnutrition; nutrition promotion; hygiene and sanitation to avoid diarrhoeal diseases; and shifting focus from health institutions alone to a continuum of care that includes families and communities.

Activity 2 (30 minutes)

The root causes of health problems cannot be addressed by health workers alone, especially in relation to the factors that increase the vulnerability of women and girls. However, a good understanding of the root causes provides health workers with opportunities to understand the environments that their clients live in.

The 'Problem Tree Exercise'

Divide participants into smaller groups and introduce the exercise by telling them that they will explore the specific problem of HIV for pregnant and postpartum women by examining its root causes and consequences.

Demonstration:

- Draw a tree trunk on a flip chart **(see Handout 11)**.
- Write 'Pregnant and Postpartum Women Infected with HIV' across the trunk (this is the problem).
- Draw roots coming out of the trunk. Assign groups to brainstorm on the root causes. For each root groups can go deeper into exploring additional roots.
- Next, draw branches going upwards from the trunk, and ask the groups to brainstorm on the consequences of the problem.
- Provide each group with one of the pre-drawn problem trees, allow **20 minutes** for each group to complete their problem tree, followed by 10 minute presentations from each group to the larger group

Discussion Questions

- Which roots can be addressed in our work?
- How do you think addressing the roots would affect the consequences?

- How can we address consequences through our work?
- Does it make sense to address the consequences without dealing with the roots?

Activity 2 (20 minutes)

Discuss the questions below with participants. Ask for their ideas and opinions on each of the questions. At the end of the discussion, refer to **Handout 12** to ensure that important content is covered and that any misinformation is corrected.

- What is an HIV test?
- What is pre-test counselling?
- With an HIV test, what do voluntary, mandatory, anonymous and confidential testing really mean?
- What happens if the test results are positive?
- What happens if the test results are negative?
- Can a person be tested for HIV without his/her permission?
- What are some advantages of HCT for pregnant and postpartum women?
- What are some disadvantages of HCT for pregnant and postpartum women?
- Why should male partners of pregnant and postpartum women be encouraged to participate in HCT services?

Wrap Up

1. Pregnant and postpartum women have the right to make sexual decisions and to negotiate for safer sex with their partners
2. Pregnant and postpartum (six weeks after postpartum) women are safe to engage in sexual activities and men should not look for sexual satisfaction with other partners
3. Pregnant and post-partum women need access to appropriate information to help reduce HIV infection – for themselves, their partners or their children

4. The stigma and discrimination experienced by pregnant and postpartum women when they seek voluntary counselling and testing results in barriers in disclosure of results and adherence to prophylaxis or treatment. This also results in gender based violence and rejection by partners, families and communities
5. Following the rejection of the parents, children too can suffer poverty and ill-health if HIV positive
6. Addressing the root causes of HIV vulnerability for pregnant and postpartum women needs a multi-sectoral approach
7. Since there is still low postnatal care attendance, systems need to be put in place to ensure follow-up and confidentiality as counselling and testing are integrated into post-partum care
8. Male involvement is an important component during counselling and testing of pregnant women and those in the post-partum stage
9. The facilitator should draw points from the family planning and HIV integration session, and from the HIV and SRH linkages session; for instance, pregnant and postpartum women should be educated on the importance of condom use and the dangers of using them wrongly.

Top Tips:

1. Women should deliver in health facilities where infection prevention procedures are possible
2. Universal precautions, such as considering blood and body fluids from all persons as infected by HIV and therefore always exercising hand washing, wearing of gloves where possible and safe handling of soiled linen, biological waste and sharp instruments.

Day Three: Working for Sexual and Reproductive Health and Rights – Role of Civil Society, Decision-Makers and Influencers, and Service Providers

Session One: SRH Needs of PLHIV

Time: 1 hour 15 minutes

Aim of Session: This session aims to present information on the SRHR needs of PLHIV.

Learning Objectives:

By the end of the session, participants will:

- Understand that PLHIV are entitled to the same rights as those who are HIV negative, and that they need specific information and services to access these rights
- Appreciate the key role that stakeholders such as community based organisations (CBOs), policy makers and service providers can play in helping PLHIV to access their rights through linking and integrating SRHR into their agendas.

Facilitator's Guide

Introduce this topic by reminding participants that living with HIV now is different than it was 20 years ago. As PLHIV accessing treatment begin to live longer and healthier lives, it is important to look at their needs and desires, beyond the needs for treatment and support. This includes the desire to have children; safe pregnancy and child birth; and the need to avoid unwanted pregnancy and re-infection with HIV (dual protection). PLHIV also have the right to choice and access to SRH services.

Activity 1 (25 minutes)

Lead a brainstorming session on SRHR and what this means for PLHIV. Use **Handout 2** from Day 1 which defines SRHR to guide the discussion. For example, the right to information and education for PLHIV can include the right to information on preventing re-infection, or on PMTCT. Record the key points from the discussion on the flipchart as you go along, and then ask two or three participants to share with the group any experience they have had of barriers to PLHIV accessing these rights.

Activity 2 (10 minutes)

Ask the participants to map the stakeholders involved with MNCH, SRH and HIV linkages. Discuss which stakeholders are important and which ones are most influential. Use the matrix below to classify them:

<table>
<tr><th></th><th colspan="5">Importance of Stakeholder</th></tr>
<tr><td rowspan="5">Influence of Stakeholder</td><td></td><td>Unknown</td><td>Little or No Importance</td><td>Some Importance</td><td>Significant Importance</td></tr>
<tr><td>Significant Influence</td><td colspan="2" rowspan="2"></td><td colspan="2" rowspan="2"></td></tr>
<tr><td>Somewhat Influential</td></tr>
<tr><td>Little/No Influence</td><td colspan="2" rowspan="2"></td><td colspan="2" rowspan="2"></td></tr>
<tr><td>Unknown</td></tr>
</table>

Activity 3 (35 minutes)

Invite the participants to sit in a circle, or another setup that is comfortable and encourages easy group discussion. Refer participants to **Handout 13**, and moving around the circle, ask participants to read out the statements one at a time. After each statement is read, ask who agrees with the statement, and who disagrees with the statement. Discuss each statement with participants, using the points from the Wrap Up section as a guide.

Top Tip:

Make sure that you are very clear in your own mind about the rights and needs of PLHIV as it is possible that you might get some interesting and tough questions in this section! Note that the point of this activity is to stimulate a discussion, not to label participants as right or wrong.

Wrap Up

- We cannot know who has HIV and who does not because anyone can contract HIV and you cannot tell if a person has HIV just by looking at them, or judging by their personal circumstances
- PLHIV have the right to a safe and satisfying sex life (e.g. through using condoms for dual protection)
- Just like all people, PLHIV have the right to make their own reproductive decisions. This includes the right to decide what contraception to use, and the right not to use contraception if they do not want to
- In many southern African countries the role of women as mothers is very important, so having children is important to the majority of women. There may be conflicting pressures on women with HIV – to not infect their child, but also to become a mother. Having children may be an important part of women's social and cultural identity, and we should remember that it is within the rights of women (and men) living with HIV to have children. This is why PMTCT is so important
- It is unethical for health workers to test for HIV without the tested person's consent
- Health workers, like other workers, should not have to disclose their HIV status to be employed
- For the rights of PLHIV to be respected, health workers must be objective and should not judge their clients according to their own personal beliefs, religion or values
- It follows that stigma and discrimination experienced by PLHIV are an important reasons why they may not be able to access their rights, and access services. In the next session we will look at the impact that stigma and discrimination have on PLHIV, especially women, in terms of accessing their rights.

Session Two: Stigma and Discrimination in relation to PLHIV

Time: 1 hour 10 minutes

Aim of Session: This session will help participants better understand how stigma and discrimination can stop people from accessing their rights and accessing services.

Learning Objectives:

By the end of the session participants will:

- Be able to identify factors that fuel stigma and discrimination
- Understand how high levels of stigma and discrimination, especially by service providers, can prevent women from accessing SRH services
- Be able to list practical ways of dealing with stigma and discrimination affecting PLHIV.

Facilitator's Guide

Stigma and discrimination often stop HIV positive women and girls from accessing health services, including SRH services. Gendered factors also mean that HIV positive women and girls experience more stigma than men. They may be seen as the cause of the disease, especially where antenatal testing is the most common route for diagnosis, so women are after the first to find out about their HIV positive status and are seen as the first ones to have HIV.

Health workers can be a big source of stigma and discrimination. They may refuse certain people services and may also take a judgmental stance on women or girls with HIV or who are sexually active. After many bad experiences, women and girls might stop going to health service centres all together.

People naturally form judgments about others based on personal and cultural values and religious beliefs, among other factors. To ensure respect of the SRHR of PLHIV (and others) service providers must be open and non-judgmental with their clients. Addressing stigma and discrimination are essential ways of incorporating SRHR into HIV programming.

The underlying concept of this section is that all people have the right to correct information and services to enable them to prevent HIV infection (for HIV negative) and to prevent re-infection or transmission to children (for HIV positive).

Stigma has important implications for prevention, including:

- Many people may delay getting tested because they fear stigma
- Many people may not disclose their test results to their communities or even to their intimate partners for a long time, for fear of stigma
- Fear of stigma may stop people from accessing services that might identify them as being HIV positive, even if they are not
- Fear of stigma can cause mothers to not access PMTCT services
- Stigma impacts on the mental wellbeing of PLHIV, and difficulties in their day to day lives that can make it hard for them to live positively. A good state of mental health is needed for behaviour change that will lead to consistent condom use, preventing re-infection for themselves, or the passing on of the infection to future partners.

Activity 1 (15 minutes)

Ask participants to define first 'stigma', and then 'discrimination', and ask for examples from their experiences of each. These are two terms that are heard often by those working in the HIV field, but they have different meanings and it is important that participants understand the terms. Allow a five minute discussion around definitions of the two terms, and then get the group to come up with an agreed definition. Write these definitions in large text on the flip chart, and then display the definitions at the front of the room. Use the definitions below to guide you to make sure the group understands the concepts completely, and then discuss the difference between stigma and discrimination.

Stigma is when an individual with (or assumed to have) a certain attribute is rejected by their community or society because of that attribute. Stigma refers to the prejudice against PLHIV that can mean they are rejected by their communities, or even threatened and abused.

Discrimination is when a person is treated less favourably in a particular situation than another person would have been, because of a specific characteristic they have. In this context that characteristic would be that they are HIV positive, or it could even just be that people think that the person is HIV positive.

Activity 2 (45 minutes)

Stigma and discrimination are caused by three main factors:

a. lack of awareness in communities of stigma and discrimination and their harmful effects;
b. peoples' fear of being infected with HIV in day-to-day contact with PLHIV, and
c. the way that people in communities link HIV with 'immoral' behaviours (e.g. sex work or promiscuity).

Divide the group into **three smaller groups**; each group is to analyse one of the scenarios in **Handout 14** (**20 minutes**). A group member from each group that looked at a scenario (1, 2, or 3) should present back to the whole group. Following the presentation, participants from other groups which looked at the same scenarios can add to the discussion (**five minutes each**). Groups should then spend the last **10 minutes** discussing how stigma and discrimination could have been avoided in these scenarios.

The following questions can be used to guide discussion.

- What are the rights that are being violated for the person living with HIV?
- What needs to be in place so that HIV positive women and adolescent girls can access SRHR?
- What are the roles of CBOs in helping PLHIV to access their SRHR?

Facilitator's Guide

At the end of the group presentations, summarise the ways that CBOs can reduce stigma and discrimination (see Wrap Up below).

Wrap Up

We can reduce stigma and discrimination by:

- Empowering PLHIV to know their SRHR (**Quick Link to Community Support Kit)**
- Improving community awareness on HIV and on the problems caused by stigma and discrimination
- Setting up activities that bring together PLHIV who are advocates and can speak out in the community
- Training service providers about the false assumptions that lead to stigma, using participatory methods like interactive workshops and involving PLHIV, for example as facilitators in workshops
- Training service providers on the rights of PLHIV and the importance of providing all options and benefits for methods of family planning, avoiding STIs and treatment, and referral to SRH services as needed
- Setting up simple methods for client feedback on services so that stigma and discrimination can be monitored
- Integrating SRH and HIV services. One of the most important reasons for integrating SRH and HIV services is that the process can reduce stigma (i.e. no-one would know whether you were going to get your regular family planning information and services, or whether you were going for advice on PMTCT)
- Stigma and discrimination also affect HIV prevention, treatment, care and support services. In the next section we will look at how stigma and discrimination mean that people do not access their SRHR in prevention, treatment, care and support programmes.

Programmes can remove barriers to prevention by:

- Providing integrated services and educating communities about services provided – not only HIV services, but also family planning, STI treatment etc
- Having designated times/days for young people (and for young women) to access services
- Providing free or low cost male and female condoms
- Providing language and culturally-appropriate information, education and communication (IEC) materials on prevention of STIs and HIV
- Having convenient opening hours to support access by working people.

Session Three: Behaviour Change for SRHR and HIV

Time: 1 hour 15 minutes

Aim of Session: This session presents the need for behaviour change to target negative attitudes, beliefs and behaviours that lead to the perpetuation of stigma and discrimination.

Learning Objectives:

By the end of the session participants will be able to:

- Use the Force Field Analysis Tool to understand behaviours that prevent people from accessing SRHR
- Apply the Stages of Change Model and the Helping Skills Model to a situation where behaviour change is needed to support SRHR.

Facilitator's Guide

In previous sessions we have looked at how service providers' (and other people's) attitudes and behaviours can cause stigma and discrimination which mean that people in communities, especially women, young people and PLHIV have difficulty accessing their rights. For us to integrate SRHR into our programmes, we need to try to change the behaviours and attitudes that lead to stigma and discrimination. Other needs for behaviour change are for women to be able to negotiate for safer and satisfying sexual relationships and for men to support the SRHR of women – we can also look at activities for behaviour change in these areas in our programmes.

Highlight to participants that raising awareness of people's rights, and the damage that stigma and discrimination cause is part of this, but just because a person has the right information does not necessarily mean they will change their behaviour. Behaviour change can be a difficult process because people may have negative beliefs about themselves (e.g. I can't change) and because they might meet some resistance in trying to change (e.g. co-workers may not accept the change). People also find it difficult to change their behaviour because they do not see any 'reward' for changing their behaviour (e.g. respecting and encouraging young people to access services could just lead to more work). So trying to work for behaviour change is not a simple task! But it is an important one.

Before trying to change people's behaviour, we have to understand their current behaviours. The first activity looks at the Force Field Analysis Tool which helps participants reflect on the current behaviours they would want to change and on factors that would support or work against behaviour change. We then go on to look at 2 models that we can apply to changing behaviour to increase our chances of success.

Activity 1 (45 minutes)

Understanding Forces For and Against Behaviour Change to Impact on Stigma and Discrimination[1]

With the whole group, conduct a simple Force Field Analysis. On a flip chart draw two columns. Label the left hand column 'Forces for Change' and the right hand column 'Forces Against Change'. Explain to participants that the idea behind this exercise is that it helps us to understand what makes people more likely to change behaviour that leads to stigma and discrimination (we can work to maximise these factors) and what makes them less likely to change (we can work to minimise these factors).

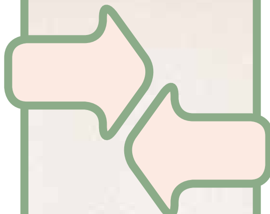
By understanding the 'pros' and 'cons' for behaviour change we can use strategies that increase the 'pros' and make it more likely that people will change their behaviour. Ask the group for ideas of Forces For and Against Change for reducing stigma and discrimination. Some examples are given below – use these to get the discussion going

1. Mind Tools, Force Field Analysis http://www.mindtools.com/pages/article/newTED_06.htm

Forces for Change

Better experiences for clients means increased job satisfaction for service providers

Senior staff members take a stand on ending stigma and discrimination



Forces against Change

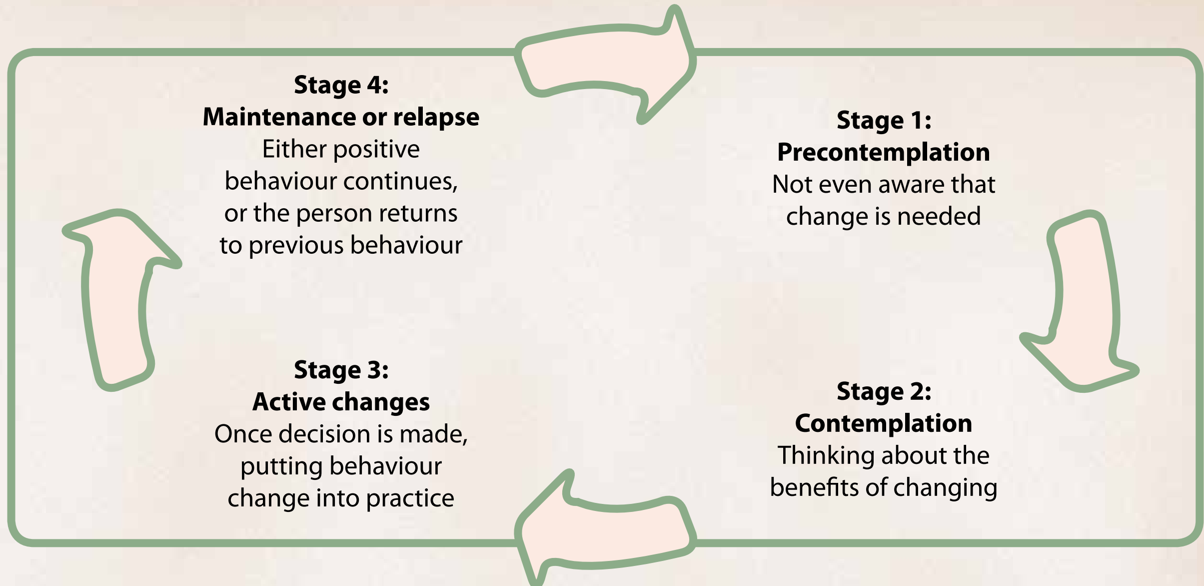
Better experiences when accessing services mean more people will come – increased workload for service providers

Service providers' attitudes reflect social and cultural norms – difficult to change

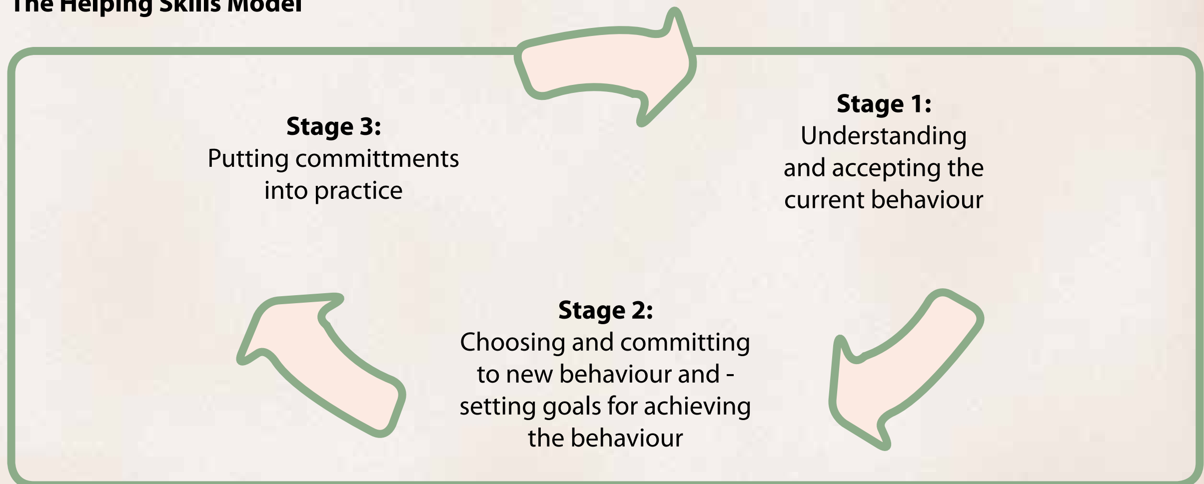
Facilitator Guide:

Once we have understood the forces for and against behaviour change, we can start to look at the strategies and activities we can use to change people's behaviour. A useful way to understand how to change behaviour is to look at models. These can be useful to help us gain a deeper understanding of a situation and what will help people to change. In this session we look at two models – the Stages of Change Model, and the Helping Skills Model. These models look at behaviour change as a continuous process or cycle, and are useful in designing activities that can get people from one stage onto the next, towards more healthy behaviour (e.g. respectful treatment of patients). You can decide on what activities to use depending on what stage in the process a person or group of people are. Explain each of the models to participants using the information below, and drawing diagrams on the flip chart **(45 minutes)**.

The Stages of Change Model[1]



The Helping Skills Model



1. Health Promotion Theory, Understanding Public Health Series, Edited by Maggie Davis and Wendy McDowall , Open University Press; 2006

Top Tip

When looking at behaviour change, highlight to participants the importance of 'self efficacy'. This means that a person believes they have the power to change their behaviour, and that making a change will have a positive impact on their lives. So in all our behaviour change activities, we want to support people in developing self efficacy.

Activity 2 (30 minutes)

Divide the participants into **groups of three**. Explain to the groups that they should apply one of the behaviour change models to a scenario to come up with ways that they could try to get service providers to change their behaviour. Participants should analyse the different situations according to the following questions:

- Who needs to change their behaviour here?
- What changes would be needed?
- What would be the best ways to support behaviour change according to the chosen model?

Thefacilitator should then assign each of the groups one of the scenarios below to discuss.

Prevention

- A service provider who will not refer an HIV positive woman for SRH services as he or she believes the woman should not be sexually active.

Treatment

- A young HIV positive woman who has been told by her family and friends that ARVs and PMTCT do not work, and that they are too expensive, so she does not want to use them.

Support and Care

- A community where young people who are HIV positive are excluded from support groups and not supported in continuing their education.

After **20 minutes** get feedback from the group **(10 minutes)** on what they discussed as ways of supporting behaviour change, and record key points on the flip chart.

Wrap Up

- Behaviour change is important at different levels – for policy makers, service providers, programme managers, PLHIV and young people. It relates to everyone
- The concept of self efficacy, belief that change can happen and that there will be a benefit of change, is particularly important for women accessing SRHR and for countering the defeatist attitudes about HIV that are sometimes present in communities
- The different levels of change; individual, community and environment, mean that each service provider and organisation must recognise their strengths and understand their roles and have an understanding of where they can form partnerships to have impact at different levels (**Quick Link to Advocacy Section**).

Session Four: Let's Integrate SRHR - The SRHR Tool

Time: 1 hour 45 minutes

Aim of Session: This session introduces the SRHR tools which will enable participants to outline activities to integrate SRHR into their programmes.

Learning Objectives:

Through the session participants will:

- Work through a case study aiming to integrate SRH into an HIV programme and to change the attitudes and practices of communities and service providers to reduce stigma and discrimination.

Facilitator's Guide

Introduce the SRHR tool (**Handout 15.1**) as a planning tool that will enable participants to break down the challenges faced in addressing stigma and discrimination, and integrating or linking with SRH services. This tool ensures a rights-based approach by providing a systematic way to address the rights involved in different services provided (Column 1), finding ways to increase the participation of key stakeholders (Column 2) and considering gender factors that may impact on whether people access their SRHR or not (Column 3). Make sure you spend enough time explaining this tool to participants so that everyone understands. It might be helpful to show how you could use it – referring to the example in **Handout 15.2**. Invite questions on this tool and discuss until everyone in the group is clear on how they could use it.

Activity 1 (70 minutes)

Divide participants into **five groups** (this can be according to organisation, or organisations with similar functions, so that participants are grouped with those with the most similar interests and experience). Explain to the groups that they will remain in these groups until the end of Day 4, and that the activities that follow are all building on the knowledge of SRHR that has been gained during Days 1, 2 and 3 up to this point.

Participants should read carefully the **case study in Handout 16**. In their groups, participants spend **45 minutes** discussing and filling out the SRHR tool format on a flip chart. They should keep as this flipchart they will use it on Day 4 in action planning. Participants should focus on the 'Main challenges' outlined in the case study, and how they can address these challenges. Also, remind groups that it is not possible for one organisation to address everything – for the sake of time in the activity they can focus on one area of HIV programming shown in the tool (either prevention, treatment, care and support, or young people).

After the groups have had 45 minutes to work on this activity, ask the groups for feedback on the points they have discussed on ensuring participation, integration of SRH and focusing on gender **(five minutes each for the five groups).** Record some of the key points from each section on the flipchart as they come up. At this stage also ask participants if they are clear on how to use the SRHR tool, and what the benefits of using this tool are.

Wrap up

The SRHR tool supports a rights based approach to integrating SRHR by helping us to consider these factors;
Sexual and reproductive health rights to support

- Right to information
- Right to be treated with respect and dignity
- Right to privacy
- Right to decide when to have children
- Right to a safe sex life.

Participation of PLHIV, young people, minority and vulnerable groups and other stakeholders:

- In decision making and planning for activities
- In advocacy and communication campaigns
- In peer education
- As staff or consultants
- As trainers
- In research, monitoring and evaluation.

Gender considerations:

- Providing information for women on their rights
- Ensuring that women can access information and interventions without parental or spousal consent
- Increasing community and service provider awareness of gender factors and the effects of stigma and discrimination.

Top Tip:

Remind participants that providing SRH services can attract new clients and this means service providers have a chance to make a positive impact on a wider population.

This session will have given participants ideas of ways in which they can go out to integrate SRHR into their programmes and communities. It will also have highlighted the fact that there are deep social and cultural reasons why people are not always able to access their rights. CBOs also have a role in trying to work on these root causes, and the most important way to do this is to incorporate advocacy initiatives. The next session looks at advocacy for SRHR for CBOs.

Session Five: Working on Root Causes - Advocacy

Time: 45 minutes

Aim of Session: This session emphasises the need for CBOs to address the root causes of the HIV epidemic to create an environment that enables people (especially women and young girls) to access SRHR.

Learning Objectives:

By the end of the session participants will:

- Understand the role of advocacy in creating an enabling environment for SRHR.

Facilitator's Guide

Due to the nature of sexuality and gender, and how they are influenced by society and culture, it is impossible for individuals to change their behaviour to access SRHR, or to support others in accessing SRHR, if their environment doesn't support them in this (e.g. if there is still a 'culture' of stigma and discrimination against PLHIV) **(Quick Link to Gendered Epidemic Section)**. Many of the strategies that participants will have come up with using the SRHR tool will have an impact on the individual and community levels. Advocacy allows CBOs to make a wider impact at societal level by influencing key opinion leaders, policy makers and traditional and religious leaders to support SRHR.

Activity 1 (45 minutes)

'Opening the Door for Advocacy'

Ask four volunteers to come to the front of the room for this activity. The rest of the participants should stay in their seats. Explain that in this activity, the four volunteers are 'advocates' who are working to ensure access to safe medical abortion and post-abortion care in the HIV programme in the Hearts and Minds case study – to support the rights of women in the area even though abortion is illegal. There is opposition to this from the government and religious groups, as well as from service providers and community members.

Top Tip:

It is important that you know the legal and policy context of abortion in your country. Explain this to participants so they are all aware of the context: they should use this context for working on the Hearts and Minds Case Study.

Ask the volunteers the questions below, and then invite the rest of the participants to add to the answers given by the volunteers.

Volunteer 1

1. The door is locked, no one wants to talk to you on this issue – what can you do?

Some ideas:

- Map the people who have influence in the area (e.g. department of health, district health managers etc.)
- Highlight who are the most important influences and target your advocacy activities at these individuals and groups
- Find opportunities to speak to these people to show them how this issue is important to them.

Volunteer 2

2. The door is slightly open; you have only a few people who will talk to you about this - what can you do?

Some ideas:

- Create partnerships with other organisations to strengthen your message
- Involve women, young people, minorities, PLHIV, and community and religious leaders and local celebrities who support the cause.

Volunteer 3

3. The door is open, you have people listening, but you do not get the reaction you were expecting - what can you do?

Some ideas:

- Meet with policy makers, and gain public commitments from them
- Work with the media to put forward your messages and publicise the issue.

Volunteer 4

4. The door opens, and closes. No one is taking action after hearing you - what can you do?

Some ideas

- Raise awareness in communities and set up petitions on the issue.

Wrap Up

Working on advocacy for SRHR means we:

- Work for respect for diversity (equal rights for minority groups)
- Work against gender-based violence
- Work for the rights of sexual minorities
- Work for the rights of PLHIV, women and young people
- Work to hold government health systems accountable for providing and ensuring equal access and treatment.

Session Six: Introduction to the SAfAIDS Cascade Model

Time: 1 hour

Aim of Session: Following on the previous sessions which present information on SRHR, this session introduces the SAfAIDS Cascade Model which shows participants how they can go on to share this knowledge.

Learning Objectives:

By the end of the session participants will:

- Understand their role in cascading information, and how this process aims to support community members in accessing their SRHR.

Facilitator's Guide

Communities and individuals, especially young women, may have even less knowledge of their rights than service providers. As well as integrating SRHR into their programmes, CBOs have a role to play in increasing their clients' awareness of their rights. Introduce the SAfAIDS Cascade Model as a model used by SAfAIDS and partners to share information from national and district level trainings, right down to the level of individuals in communities.

In this model, the Community Support Kit will be helpful in sharing information in community group trainings and door-to-door activities. The Community Support Kit will be covered during Day 4. Refer participants to the visual representation of the **SAfAIDS Cascade Model** (see below). Go through each step and explain the importance of each to participants.

Activity 1 'Raising Awareness in the Community'

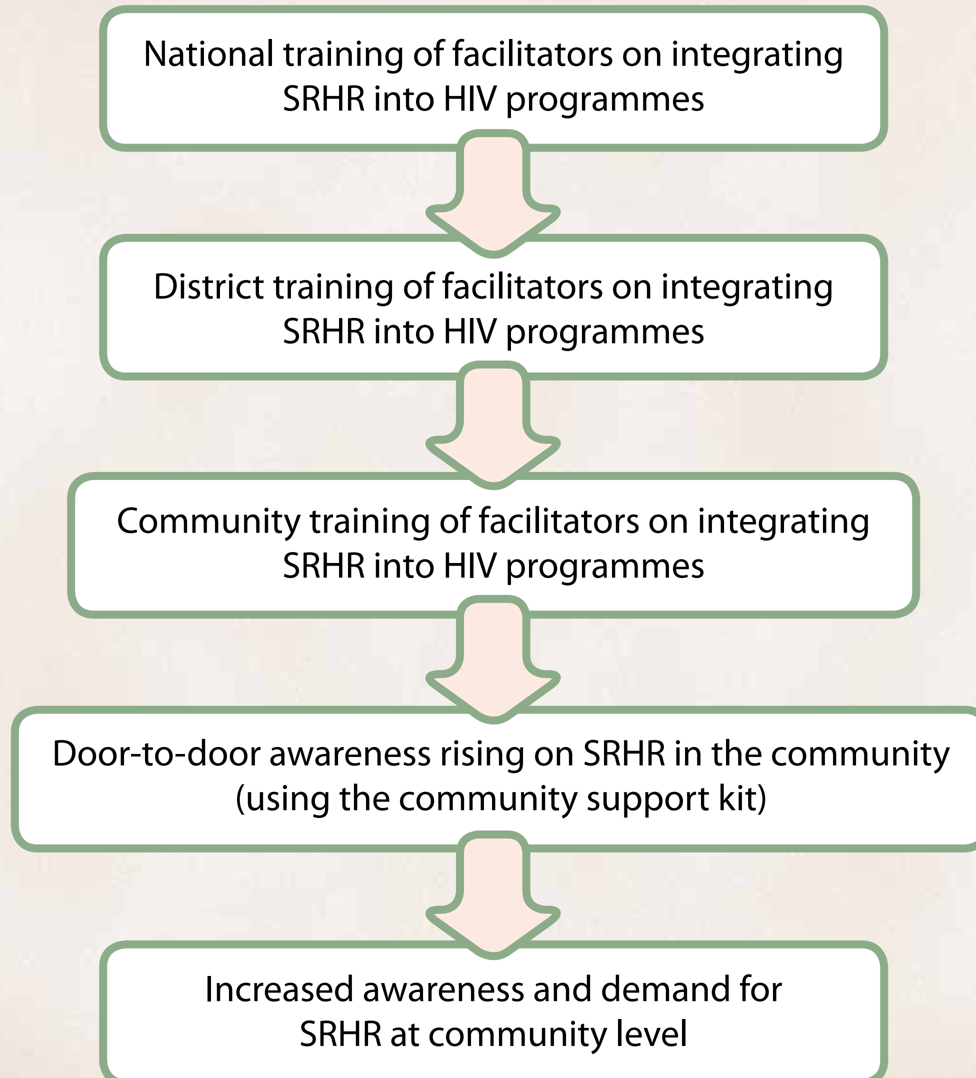
Groups are tasked with spending **15 minutes** designing and drawing a 'Community Awareness' poster, on a flip chart. This activity is to get the groups thinking about what is most important to present to community members – they should incorporate messages and information on SRHR and SRH services that they think are most important for their communities. Two members of each group then present their posters to the rest of the participants, highlighting the key messages.

Wrap Up

- The cascade approach is an effective and cost effective way of ensuring that information on SRHR filters down to the community level
- It is important to ensure that information is cascaded correctly to all levels, so that the final recipients, community members, can benefit

In Day 3 we have covered behaviour change models for understanding how to support people to access their rights, and the role of advocacy in creating an enabling environment for rights. This leads us on to Day 4 where we will look at the practical aspects of planning and implementing these activities for integrating SRHR, and how we can increase awareness of SRHR in communities.

The SAfAIDS Cascade Model



Day Four: Way Forward - Action Planning

Recap Day Three: 15 minutes

Ask the participants to consider the most important thing that they learned during training on Day 3. Invite participants to share with the group what this was and also share with the group what the most important learning point they are taking away from the training is.

Session One: The Planning Cycle

Time: 30 minutes

Aim of Session: This session introduces the planning cycle as a way of ensuring planning, implementation and monitoring for effective programmes.

Learning Objectives:

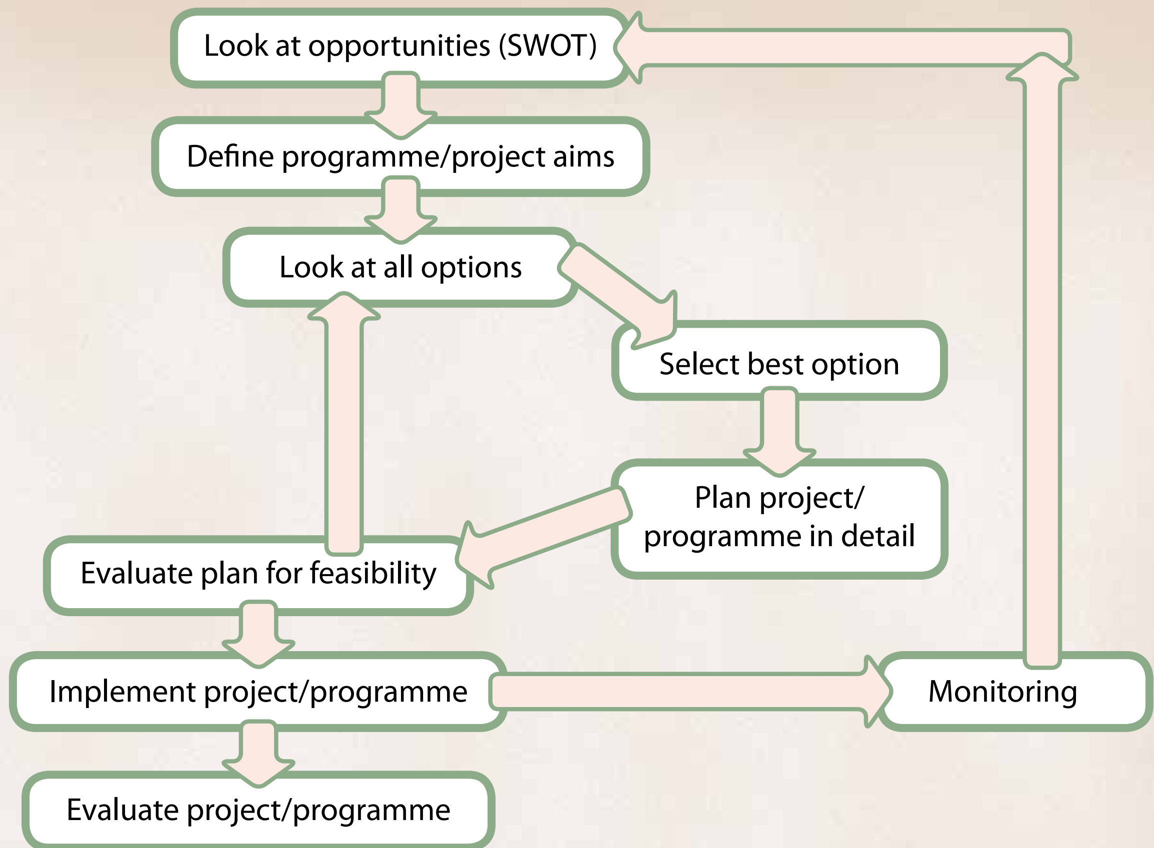
By the end of the session participants will:

- Understand the need to plan effectively for integrating SRHR into their programmes.
- Know and understand the components of the planning cycle.

Facilitator’s Guide

Draw the diagram of the planning cycle on your flip chart. As you draw each component, explain to participants what this component involves.

1. Looking at opportunities allows managers to find areas where they can make or achieve the most impact, taking into account the situations they are working in
2. Defining aims allows managers to think about what is feasible with the time and budget available
3. Looking at all options allows creativity and innovation in looking at problems
4. Selecting the best option makes the best of managers’ experience of the context for a project/ programme that is more likely to be successful
5. Detailed planning allows managers to know what resources will be needed, the timing of activities, and who will be involved
6. Implementation of the plan is carrying out activities towards the overall goal
7. Monitoring indicators allows managers to know that progress is being made towards the overall goals, and to make changes if needed
8. Evaluation at the end of implementation shows how far the project/programme achieved its aims and what the overall impact was.



The Planning Cycle

Wrap Up

- This planning process is an important tool for effective programmes, and for gaining information that can be used to support funding proposals and reporting to donors
- The process is dynamic, so feedback from monitoring is one of the most important parts of the cycle – it enables managers to make changes as soon as they see that things might not be working the way they hoped
- The first step in the planning process is to conduct a SWOT Analysis

Session Two: SWOT Analysis

Time: 45 minutes

Aim of Session: This session aims to introduce SWOT Analysis as the first step in planning.

Learning Objectives:

By the end of the session participants will:

- Have gained experience in conducting a SWOT Analysis.

Facilitator Guide:

Ask participants to define 'SWOT Analysis' then draw a SWOT Analysis table on a flipchart (see example below) invite the group to share their ideas on what information can go in each section. Discuss why each factor is a Strength, Weakness, Opportunity or Threat and fill in the SWOT Analysis grid. A guide as to how you could do this is presented below.

Strengths	Weaknesses
• Experienced and motivated management staff • Good potential budget from international donor	• Discriminatory attitudes of service providers • Long distance to access SRH services • Lack of education and information on importance of SRH services in community
Opportunities	**Threats**
• Work with community and religious leaders who have strong influence • Community centre available for dedicated youth services once a week	• Significant incidence of stigma in the community • Threat of GBV for women accessing services

Top Tip:

Make sure participants are clear on the difference between weaknesses (something internal that the organisation has control over) and threats (an external factor that the organisation has no control over).

Activity 1 'SWOT Analysis for Hearts and Minds'

The same groups from Day 3 should come together again and conduct a **20 minute** SWOT Analysis for the proposed integration of SRHR into the Hearts and Minds Programme (this is a continuation of the activities from Day 3). It might be helpful for participants to read through the information on the situation in the Handout again. After 20 minutes ask for one group to present their analysis, and invite additional comments or questions from the other participants.

Top Tip:

The SWOT Analysis can include opportunities for forming links with other stakeholders. Let participants know that in their real-life situations, it could be useful to do a simple mapping exercise of all the NGOs or other stakeholders in their area who they could partner or collaborate with.

Wrap Up

- SWOT Analysis is a useful tool for getting us to think about all the factors that could make our programmes successful, or unsuccessful.
- This SWOT Analysis, along with the SRHR matrices from Day 3, will be the key tools that the groups will use in action planning in the next session.
- The log frame is an important tool in the development field for planning and monitoring activities; it is covered in the next session.

Session Three: The Log Frame – A Tool for Action Planning and Monitoring

Time: 1 hour 45 minutes

Aim of Session: This session introduces a simple log frame approach to planning and monitoring programmes.

Learning Objectives:

By the end of the session participants will:

- Be able to use the log frame format to plan activities for the Hearts and Minds Programme.
- Have a good understanding of how this tool could be used in their own programme.

Facilitator's Guide

Introduce the Log Frame as a tool which is widely used in the development field which allows for systematic planning and monitoring of projects/programmes. Log Frames are usually set up at the planning stage of a project/programme, but they are dynamic and evolving documents. The first step in using the Log Frame will be setting objectives. Here you can introduce the concept of SMART objectives. For good planning, objectives should be:

S – Specific – state exactly what you plan to achieve

M – Measurable – so that you can measure your progress towards achieving objectives

A – Achievable – within the scope of your organisation to achieve this objective

R – Realistic – so you do not aim to do something that you cannot possibly achieve

T – Time-bound – you need to specify the time by when you will achieve the objective

Activity 1 'Using the Log Frame'

In their groups, participants should conduct a planning exercise, using the Log Frame in **Handout 17**. Give the participants the following context:

> *'If you receive US$50,000 to design and implement a project to integrate SRHR into the Hearts and Minds Programme, what would you do?'*

The groups should start the activity by deciding on their objectives, ensuring that these are SMART. For the sake of time in the training session, participants should focus on just two objectives (**15 minutes**).

Facilitator's Guide

Next, introduce participants to some of the reasons we monitor programmes - to measure our progress towards meeting our objectives and to allow us to change things if they are not working as we had hoped. In a rights-based approach, monitoring is also very important for finding out whether rights violations are happening, for example, monitoring for stigma and discrimination. Indicators are the tools that allow us to monitor programmes. To explain the characteristics of a good indicator, draw up the following on the flip chart:

The Three 'E's and the Two 'R's' for good indicators

- Provide an **E**arly warning of potential problems.
- **E**asy to understand.
- **E**asy to monitor regularly.
- **R**elevant to programme management needs.
- Feed into **R**eporting obligations of the CBO.

In the next part of the activity groups should design indicators to measure how they are progressing towards achieving each of their objectives. They should also discuss how the information for the indicators will be gathered (e.g. survey, patient exit interview, report etc).

Encourage participants to check the suitability of their indicators by asking themselves:

- Does the indicator measure something important to the programme and the community?
- Will the indicator lead to action, improving access to SRHR?
- Is the indicator easily measurable?

Groups should then go on to complete the rest of the planning using the Log Frame. The emphasis should be on these plans being realistic and feasible. Once these action plans are completed, the groups select two members to present back to the rest of the participants in group during the next session.

Facilitator's Guide

Participants will have different objectives, indicators and activities. Below are some suggestions that you can use to help focus group discussions.

Objective: Offer STI treatment at the same centre where VCT and ARVs are provided.

Indicator: Number of VCT and ARV clients being diagnosed and treated for STIs per month (information obtained from service records).

Activities:

1. Provide training on STI diagnosis and treatment.
2. Recruit additional staff member(s) to cover additional tasks.
3. Set up supply chains for STI treatments (antibiotics etc.).

Top Tip:

This is the most important activity of the training, where the participants integrate all of the knowledge from the previous days.

Session Four: Presentation of Action Plans

Time: 1 hour

Aim of Session: This session affords participants the opportunity to present their plans for integration of SRHR and obtain feedback, drawing on the varied experiences of participants in the room.

Learning Objectives:

By the end of the session participants will:

- Have consolidated their understanding of the Log Frame.

Activity 1

Invite two members from each group to present to the whole group for about **15 minutes per group** (**depending on the number of groups**). The presenters should go through their two objectives, the indicators they have set out (explaining why they are good indicators and how they will be measured). They can also explain the activities they have planned. After each group has presented, the facilitator and the rest of the participants can give feedback to presenters and ask questions on the plans presented.

Wrap Up

- The log frame approach is a valuable tool for planning. The document should be shared with all involved in the programme, and seen as a dynamic, evolving document.
- The main roles of CBOs in integrating SRHR are:
    - Ensuring provision of key SRH services (family planning, prevention and management of GBV and STIs),
    - Improving referrals to SRH services,
    - Service provider training, and
    - Ensuring client involvement.

At the end of this session, participants will have consolidated their knowledge on integrating SRHR. To help participants to cascade information to their communities SAfAIDS has produced a Community Support Kit which can be used for this. The next session seeks to assist participants to understand how they can use the different elements in this kit to effectively cascade information on SRHR down to their communities.

Session Five: Introduction to the SAfAIDS Community Support Kit

Time: 1 hour

Aim of Session: This session introduces participants to the materials in the SAfAIDS Community Support Kit which aims to raise awareness and knowledge of sexual and reproductive health and rights and HIV.

Learning Objectives:

By the end of the session participants will:

- Understand how the community support booklet, sticker and poster can be used to improve knowledge and awareness of SRHR in their communities.

Facilitator's Guide

The SAfAIDS Community Support Kit has been specially designed to provide information on SRHR for communities in a simple, easy to understand format. In particular, the kit provides information for PLHIV and for women.

1. Community Awareness Sticker
The sticker aims to put the issue of sexual and reproductive health and rights in the open, creating the awareness that is needed before people can be empowered to access their rights. The information that can be presented on a sticker is limited, but it is enough to make people start thinking about SRHR.

2. Community Awareness Poster
The poster provides more specific information on SRHR than can be obtained from the sticker. It makes the link between not accessing rights and HIV; and aims to share information on how accessing rights can improve peoples' quality of life.

3. Community Awareness Booklet
This booklet is designed to provide relevant, but easy to understand information for community members (particularly women and young girls, and PLHIV) on SRHR and linkages to HIV. The booklet can be used by community members on their own, for individual learning, or in group activities such as community meetings.

The importance and strength of these materials is that they all reinforce one key message to communities - that it is important to know their rights.

Activity 1

Hand out copies of the community support booklet, poster and sticker to the groups (participants can stay in the same groups they were in during the last activity). The groups **have 30 minutes** to read and discuss these materials. At the end of this time, each group will share their ideas on:

- The three things they like about the sticker, the poster, and the booklet.
- The three possible negatives about the sticker, the poster, and the booklet.
- How CBOs could make use of each of the different materials?.

Record key points for each of the three elements on the flipchart as the groups present their ideas. Also record participants' ideas about how they could use these materials in their work – this information will be valuable for the group as the participants will have experience working in different community settings.

Wrap Up

The end of this session is the end of the content of the training. Participants will have covered information and knowledge on the links between SRHR and HIV, focusing on how stigma and discrimination prevent people from accessing sexual and reproduce health services and enjoying their rights. They will also have gained skills in understanding behaviour and planning for activities aimed at reducing stigma and discrimination and integrating SRH into HIV programmes during the four days of training.

The final session, session six, is set up to ensure that participants leave the training with a commitment to taking action on integrating SRHR into their programmes and to share the knowledge they have gained with others.

Session Six: Commitment to Action and Closure of Training

Time: 20 minutes

Aim of Session: This session closes the training, ensuring that participants leave with a strong commitment to action.

Activity 1

Invite participants to sit in a in a circle and ask them one by one to share with the group one concrete action that they are committed to taking following this training. For example someone might say they are committed to providing training for their service providers on the impact of stigma and discrimination on health-seeking behaviour.

Once participants have finished this exercise, close the training by thanking them for their participation, attention and energy during the training. Encourage them to go back to their programmes and implement the type of plans that they have come up with during the training. Thank them for their commitment and remind them that by taking action in this way, it is possible for them to make a positive impact on many lives.

Annexes

Handouts

Handout 1: Human Rights Instruments and Declarations

1. Universal Declaration of Human Rights[1]

- All human beings are born free and equal.
- Everyone is entitled to all the rights and freedoms in the declaration, without discrimination.
- Men and women over 18 have the right to marry and to found a family.
- Motherhood and childhood are entitled to special care and assistance.

2. Covenant on Economic, Social and Cultural Rights

- Everyone has the right to 'the enjoyment of the highest attainable standard of physical and mental health… the right to control one's own health and body (including reproduction), and be free from interference such as torture or medical experimentation'.

3. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[2]

- Countries should eliminate discrimination against women in the field of health care in order to ensure access to health care services, including those related to family planning,
- Ensure women have appropriate services in connection with pregnancy, and
- Take action to modify social and cultural patterns to eliminate prejudices and practices based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

4. The African Charter on Human and Peoples' Rights (The Banjul Charter)[3]

- Every individual shall have the right to enjoy the best attainable state of physical and mental health.
- Countries should ensure the elimination of discrimination against women and ensure protection of the rights of the woman and the child.

5. Protocol on the Rights of Women in Africa

The southern African countries that have signed on are Lesotho, Malawi, Mozambique, Namibia, South Africa and Zambia. The protocol:

- Provides broad protections for women's rights, including sexual and reproductive rights.
- Is the first international instrument to state women's right to abortion when pregnancy results from sexual assault, rape or incest.
- Calls for prohibition of harmful practices such as female circumcision/female genital mutilation

1. http://en.wikipedia.org/wiki/International_Covenant_on_Civil_and_Political_Rights#Convention_provisions
2. http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm
3. http://www.hrcr.org/docs/Banjul/afrhr2.html

Handout 2: Defining Sexual and Reproductive Health Rights[1]

1. Everyone has the right to life and this should not be put at risk by pregnancy and childbirth.
2. Everyone has the right and freedom to control their own sexual and reproductive lives.
3. No one should be discriminated against on the basis of race, poverty, sex or sexual orientation, marital status or religious or political opinion. This means everyone has the right to access SRH services.
4. Everyone has the right to privately and confidentially make their own decisions about their sexual and reproductive life, and to have these decisions respected.
5. Everyone has the right to access information and education on SRHR and this includes the right to know about the benefits and availability of SRH services.
6. Everyone has the right to choose when and whether they want to marry and have children. This covers the right to choose which type of contraception you want to use, and the right to choose whether you will breastfeed your child or not.
7. Each person has the right to decide on the number, timing and spacing of their children, if they choose to have children.
8. Everyone has the right to attain the highest possible standards of sexual and reproductive health. This includes avoiding unwanted pregnancies, STIs, and sexual violence.
9. Everyone has the right to access new technologies that have the potential to improve health.
10. Any individual or organisation has the right to advocate for SRHR issues.
11. Everyone has the right to be free from degrading treatment, including to be treated with respect and consideration when accessing health services.
12. Everyone has the right to have a satisfying, safe and pleasurable sex life.

1. IPPF Guide to SRHR

1. **The Right to Life**
    - The right to life has been used to campaign for the rights of foetuses (anti-abortion), but this could also relate to the rights of women whose lives are put at risk because of dangerous pregnancies. This also means that it is an infringement of someone's right to life if a partner exposes them to infection with HIV.

2. **The Right to Freedom and Safety**
    - This right covers the right of men, women and children to be protected from sexual abuse and sexual exploitation, including sexual slavery.
    - It also means making it necessary for spousal or parental consent to obtain contraception is a violation of this right, as is forced pregnancy and forced abortion.

3. **The Right to Equality, and to be Free from all Forms of Discrimination**
    - Issues in this area would include discrimination in accessing services, for example, wives requiring the consent of their husbands to access sexual and reproductive health services; young people requiring paternal consent; or services only being accessible to married women.

4. **The Right to Privacy**
    - Infringements of this right would be where inadequate facilities at health services make it difficult for consultations to be private or if private health information (e.g. HIV status) is made public by service providers without consent. This is especially relevant to SRH services for young people, where confidentiality may be breached.

5. **The Right to Freedom of Thought**
    - Examples of infringements of this right could be cases where religious beliefs mean that access to SRH information and services is restricted (e.g. to married women only).

6. **The Right to Information and Education**
    - This is an important area of rights for youth so they can access SRHR information.

7. **The Right to Choose Whether or Not to Marry and to Plan a Family**
    - Violations of this right would include child marriage and betrothal without the consent of both partners.
    - This right supports access to family planning.

8. **The Right to Decide Whether or When to Have Children**
    - This right again relates to having access to information and services for safe motherhood and the various methods of contraception. A key message is that each man or woman is free to choose a method to protect against unwanted pregnancy.
    - Violation of this right would include the requirement of parental or spousal consent for contraception.

9. **The Right to Health Care and Health Protection**
    - This right encompasses the right to a full range of services – prevention of unwanted pregnancy, safe abortion and diagnosis and treatment of STIs (including HIV). This also means people have the right to SRH services that are financially and geographically accessible, private and confidential, and respectful and comfortable.

10. **The Right to the Benefits of Scientific Progress**
    - This right supports access to newer methods of contraception and abortion – as appropriate to the context.

11. **The Right to Freedom of Assembly and Political Participation**
    - This right is important for those working in the SRH and HIV field; it means that anyone has the right to engage in advocacy in the field of sexual and reproductive health and rights.

12. **The Right to be Free from Torture and Ill Treatment**
    - This means that all people have the right not to experience rape, sexual assault, sexual abuse, sexual harassment and violence.

Handout 3: Scenarios for SRHR

Scenario 1

Mutinta and Busiku are a young married couple living in the Southern Province of Zambia. Mutinta became pregnant and visited the antenatal care unit where the health worker offered her an HIV test, which she consented to. She later received a positive result, which she was not expecting at all, because she had never had sex with anyone before she was married. Mutinta did not blame Busiku; rather she just wanted to do the best for her family. When she told Busiku she was HIV positive he was very angry with her. He refused to let her go back to the health centre, even though she tried to explain that it was very important that she should do this so that she could do everything she could to stop the baby from being infected. Busiku refused to let her go to the hospital to deliver the baby.

Scenario 2

Suwilanji lives in a small village in the Northern Province of Zambia. She has a husband, Tupilwe and they have six healthy children, but when the last child was born Suwilanji very nearly died in the birth. She has heard that there are easy methods she can use to stop another pregnancy, but when she brought this up with Tupilwe he told her that having children is decided by God. Suwilanji visited a health worker who told her about options for family planning like the pill or condoms. Suwilanji said Tupilwe would never use condoms, and she was worried that he might find her pills if she kept them at their home. The health worker then told her that she could have an operation called voluntary sterilisation which would mean that she did not have to worry about contraception. When Suwilanji thought about this she decided she did not like the idea of doing something permanent to her body, but when she told the health worker about her decision, he became angry and shouted at her.

Scenario 3

Towela is a 14 year old girl living in Lusaka. She lost both her parents to HIV when she was 12, and since that time she has been living with her father's brother, her Uncle Mabvuto, and his wife Manyando. About one year after she moved in with them, Mabvuto came to Towela while Manyando was at the market and asked her if she knew about sex. He then unbuttoned his trousers, and forced her to have sex with him. He has threatened to stop paying her school fees and to throw her out of his house if she tells anyone. Towela is very worried about getting pregnant but the nurse at the health centre said she was too young to need condoms. Towela feels lonely and depressed when she thinks about the fact that she might get pregnant.

Handout 4: Important Congresses and Conventions for SRHR

1. International Conference on Population and Development (1994, Cairo)

Programme for action included:

1. Empowerment of women and eliminating all forms of exploitation, abuse, and violence against women, adolescents and girls.
2. Eliminating all forms of discrimination against the girl child (education etc.).
3. Ensuring care for women and young people, including family planning counselling; education and services for prenatal care, safe delivery and post-natal care, especially breastfeeding and infant and women's health care; prevention and treatment of infertility; treatment of reproductive tract infections and STIs and other reproductive health conditions; and information, education and counselling on human sexuality, reproductive health and responsible parenthood.

2. Fourth World Conference on Women (1995, Beijing)

Declaration included:

Ensuring equal access to and equal treatment of women and men in education and health care and enhancing women's sexual and reproductive health education.

3. SADC Gender and Development Declaration (1997)

Commitments included:

1. Making good reproductive and other health services more accessible to women and men.
2. Promoting the reproductive and sexual rights of women and the girl child.
3. Taking urgent measures to prevent violence against women and children.
4. Encouraging mass media to present information on the human rights of women and children.

4. The SADC Health Protocol (1999)

Commitments:

- Harmonise regional strategies for prevention and management of HIV and AIDS and STIs.
- Provide trans-border populations with services for HIV and AIDS and STIs.
- Empower men and women and communities to have access to safe, effective and affordable contraception.
- Develop regional strategies to encourage adolescents to delay early sexual activity.

5. United Nations General Assembly Special Session on HIV and AIDS (2001, New York)

Commitments focus on:

1. Reducing HIV prevalence among young people aged 15 to 24 years.
2. Providing all women and adolescent girls with sexual and reproductive health services.

6. SADC Declaration on HIV/AIDS (2003, Maseru)

1. Prevention activities and social mobilisation for strengthening family units and encouraging positive behaviour change in cultural values.
2. Making female and male condoms easily accessible to young men and women.
3. Strengthening provision of health services to women and girls to enable them to protect themselves from HIV.

7. Maputo Declaration (2004)

Commitments:

1. Promote maternal health and reduce maternal mortality through sharing best practices and information.
2. Mobilise resources to work towards attaining the rights of women and children.

Handout 5: HIV as a Gendered Epidemic

In Zambia, the prevalence of HIV in women of reproductive age is 16.1 percent, compared to 12.3 percent in men of the same age group[1].

Factors increasing vulnerability of women to HIV[8]

Biological

- It is much easier for a woman to contract HIV during heterosexual intercourse as they are exposed to more fluids (semen).
- Haemorrhage in pregnancy can expose women to increased risk of receiving infected blood or blood products.

Gender

- Early marriage of young girls, often to much older men, can expose them to contracting HIV at a young age.
- Gender norms discourage young women from accessing information and services related to HIV, as doing this leads them to being labelled as sexually active or promiscuous.
- Women may be affected more by stigma for being HIV positive because of general lack of acceptance of women as sexual beings.

Culture

- Social norms that accept and tolerate extra-marital sexual relationships for men put married women at risk of being infected by their husbands.
- Cultural beliefs and norms reduce the decision-making power of women in intimate relationships, affecting their ability to negotiate condom use.

Social

- Poverty and lack of education may force women into transactional sexual activity.
- Women may be targeted as being the 'cause' of HIV, especially as they are often the first to find out their status through antenatal testing.
- Women in households and communities bear the brunt of caring for those infected and affected by HIV.

Violence

- Coerced sex or rape may be faced by women, increasing their risk. Young girls may be sexually abused by their guardians and caregivers.
- Physical or emotional abuse may be encountered when women try to negotiate condom use.

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1. WHO http://www.who.int/gender/documents/en/HIV_AIDS.pdf

Handout 6: Role Plays for SRHR

Role Play 1

Lubabo is a 25 year old woman living in a rural district called Kasempa. She attends church regularly with her husband Bibusa. Bisuba works on a local farm, and has a second job working in a convenience store over the weekends. He never visits sex workers or bars, but he has one female friend who he has sex with, only very occasionally when he feels especially stressed. Lubabo is not aware of this, but Bibusa feels that he is not doing anything wrong as he does not love this woman and as Lubabo has seemed to lose interest in sex as she has gotten older. One participant should play Lubabo, trying to get Bibusa to use a condom when they are going to have sex, even though she does not believe that her husband is being unfaithful to her, but because neither of them has ever been tested for HIV. The other participant should play Bibusa who does not see any reason for using condoms because he has only one other partner. He also believes that he will not be able to enjoy sex if he uses condoms.

Role Play 2

Lusale and Muyalwa are both sixteen, they have been dating for six months and are in the same class at school. Lusale wanted to have sex and although they were both virgins, Muyalwa eventually agreed to have sex with him when he threatened to break up with her. They had sex once after school in the classroom. They both had a lot of information on HIV, but they were both not worried because neither of them had had sex with anyone else before, and they thought Muyalwa could not get pregnant if it was her first time. Three months later, Muyalwa is very worried that she is pregnant as she has missed three periods. Two participants should role play the discussion between Lusale and Muyalwa as Lusale tries to convince her to have an abortion, and Muyalwa tries to convince him of their other options and of her rights.

Handout 7: Human Rights, Sexual and Reproductive Health and HIV – the Links

Basic human right	Link to sexual and reproductive health	Link to HIV and AIDS (prevention, treatment and support)
Right to freedom from discrimination	Service providers discriminate against unmarried women and young women for being sexually active. Women are prevented from accessing contraception, safe abortion, and STI treatment by husbands, partners, families or service providers. Young women do not access SRH services because of fear of being labelled as 'sexually active' – which is unacceptable in the community. All of these can lead to unplanned pregnancy or STIs.	Women stigmatised in the community, labelled 'promiscuous' if they access HIV services; seen as the 'cause' of HIV. PLHIV discriminated against when trying to access SRH services (e.g. family planning or treatment for STIs). They are not accepted as being sexually active. Service providers prioritise some people over others for ARV treatment if they view them as more 'deserving'.
Right to life and personal security	Gender power imbalance, men make all decisions relating to sexual and reproductive health, leading to unsafe delivery, lack of treatment of STIs, which can lead to infertility, and stigma against women and girls. Women experience sexual violence, which increases their risk of unwanted pregnancy and STIs. Cultural practices such as female genital mutilation violate women's rights to a satisfying sex life.	PLHIV may not access ARV treatment because of government policies, high cost, and inaccessibility. Women experience sexual violence, increasing risk of HIV. Cultural practices, such as female genital mutilation, put women at increased risk of HIV infection through re-use of instruments and increased risk of tearing during intercourse and childbirth.
Right to privacy	Service providers may share the confidential information of young people with their parents.	PLHIV who do not have their privacy respected may face discrimination and fail to access treatment and supportive services.
Right to full consent to marriage and equal rights within marriage	Unequal rights in marriage (after payment of lobola) in contexts where divorce is culturally unacceptable. Women stay in unsafe relationships and experience sexual violence. They cannot negotiate condom use or say no to sex, increasing risk of unwanted pregnancy and STIs. Women are unable to negotiate family planning and child spacing. Women cannot challenge husbands about affairs due to the threat of violence, increasing their STI risk. Sex is not discussed in marriage. When sexually unsatisfied, women and men seek sex elsewhere, increasing both their risk of contracting STIs. Young age at marriage means that young people; young women in particular, are exposed to STIs from a young age.	Unequal rights in marriage (after payment of lobola) in contexts where divorce is culturally unacceptable. Women stay in unsafe relationships and experience sexual violence. They cannot negotiate condom use or say no to sex, increasing their risk of contracting HIV. Women cannot challenge husbands about affairs due to the threat of violence, increasing their risk of contracting HIV. Women and men, when unsatisfied sexually in their marriages or relationships, seek sex elsewhere, increasing their risk of contracting HIV. Young age at marriage means that young people; young women in particular are exposed to HIV from a young age.

Handout 8.1: Service Integration

SRHR Providers' Responsibilities

- HIV prevention information and services, including for people living with HIV;
- Information to prevent unintended pregnancies and HIV and STIs (dual protection) through correct and consistent condom use; and provision of male and female condoms;
- Non-directive, non-judgmental and confidential counselling on SRH for people living with HIV;
- HIV counselling and testing and provision of ART as indicated;
- Services to address the SRH needs of key populations
- Strengthened maternal and child health services which include elements of prevention of mother-to-child transmission services; and
    - Integrated HIV counselling and testing into SRH services;
    - Provision of high quality SRH for women living with HIV;
    - Integration of SRH into ART centres, or strengthened referrals;
    - Provision of family planning counselling and services during antenatal and post-partum care; and
    - Screening and treatment for syphilis and other STIs.

Service providers also bear the responsibility to develop appropriate guidelines, tools and competencies for SRH for people living with HIV in the context of PMTCT.

HIV Providers' Responsibilities

- Addressing the sexual and reproductive health information and service needs of people living with HIV;
- Preventing, diagnosing and treating sexually transmitted infections other than HIV;
- Referring women for prenatal care and high quality obstetrical services;
- Providing counselling on fertility desires and providing related services and commodities;
- Better understanding and response to the SRH needs of key populations.

Researchers' Responsibilities

- Designing rigorous studies to evaluate integrated SRH and HIV services, particularly comparative assessments of integrated delivery of services versus non-integrated delivery of the same services.
- Evaluating key outcomes, such as:
    - Health, stigma reduction, cost-effectiveness
    - Trends in access to services
- Direct research toward areas that are under-studied, for example comprehensive SRH services for people living with HIV and gender-based violence prevention.

Handout 8.2: Checklist for Youth Friendly Services

1. Were young people involved in planning the services?
2. Were young people with HIV involved in planning the services?
3. Are there outreach services that go to youth centres or other places where young people gather?
4. Are services affordable for young people?
5. Have the providers been trained in communication, counselling and providing information and services to young people?
6. Are services completely confidential?
7. Is the physical environment of the services clean, friendly and comfortable for young people?
8. Are there designated times when young women and young men can access services?
9. Do young people have to travel to another location to access SRH services (e.g. family planning) when they are referred?

Handout 9: Family Planning

Family Planning

The definition of family planning is the decision taken by an individual or couple based on voluntary and informed consent about when to have children, the number of children they want, and the interval between pregnancies using a contraceptive method of their choice.

Family Planning Counselling and Services

Family planning counselling and services are important for the health and wellbeing of all young people and adults because they address the possibility of pregnancy and prevention of unintended pregnancies.

Benefits of Family Planning

- Contraception protects against unintended pregnancies.
- Family planning supports the healthy timing and spacing of pregnancies, which helps women's health by allowing their bodies to begin childbearing when they are at a healthy age, and allows them to recover fully between pregnancies. (**Note:** Pregnancies are safer for the mother and baby if a woman waits until age 18 to become pregnant, has two years spacing between childbirth and her next pregnancy, and has six months between a miscarriage or abortion and her next pregnancy). Family planning saves the lives of children by helping women to space births and have healthy pregnancies.
- Some contraceptive methods provide additional health benefits, such as protection against some forms of cancer.
- Condoms prevent the spread of HIV, sexually transmitted infections (STIs) and unintended pregnancy.
- Having knowledge about contraception helps adolescents make responsible choices and may help men to share responsibility for reproductive health and child rearing.
- Family planning helps men and women to provide a better life for their families by improving health and economic well-being.
- Family planning helps promote national development by allowing families to concentrate their resources on raising a smaller number of children.

Similarities of Family Planning and HIV Services

- Behavioural risk assessment for HIV, STIs, and unintended pregnancy;
- Identification of options for reducing risk (HIV, STIs, and unintended pregnancy);
- Enabling clients to make their own decisions about safer sex practices; and
- Support for initiation and maintenance of positive behavioural changes.

Handout 10: HIV Positive Clients and Pregnancy

HIV Positive Clients and Pregnancy – Things to Consider:

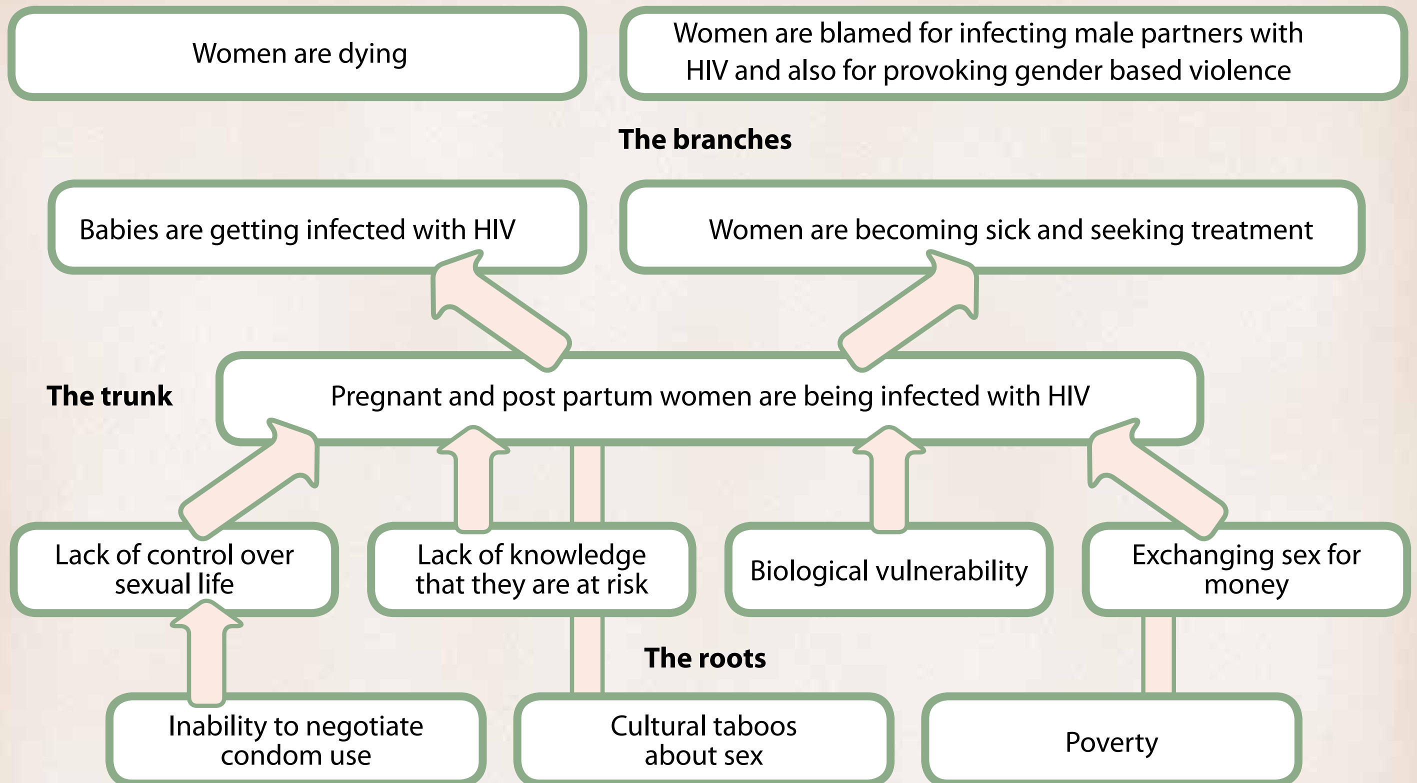
- HIV and STI transmission to their partner(s) (HIV positive clients can transmit HIV to uninfected partners, and can acquire STIs or new strains of HIV that make their disease advance more quickly, and more resistant to treatment with their current ARV medication).
- The risk of HIV transmission from a pregnant woman to her baby (in the absence of medical intervention to reduce the risk of HIV transmission from mother-to child) is about 35 percent. This means that about one out of every three HIV positive women passes the virus to the baby if she cannot or does not access medicine. With medical intervention - ART - for the mother during pregnancy or ARVs for prevention, transmission can be lower than five percent. HIV positive clients with active symptoms may consider starting ART to lower viral load and improve health before getting pregnant.

HIV positive clients desiring a pregnancy should

1. Reduce the risk of HIV transmission to their partner by:
    a. Ensuring that both partners have been tested for HIV and have disclosed their status to each other.
    b. Getting appropriate care and treatment.
    c. Avoiding sex without a condom, except during the fertile days of the woman's menstrual cycle (for a woman with a 28 day cycle the most fertile day is the 13th day of her cycle).
2. Reduce the risk of mother-to-child transmission by:
    a. Making sure that the HIV positive woman's viral load is not high and that the CD4 count is not low (CD4 count more than 350 recommended).
    b. Having the HIV positive pregnant woman attend regular ANC and PMTCT visits, especially to make sure she takes ARVs for PMTCT and that she gets counselling about exclusive breastfeeding and alternative feeding.
3. Reduce the risk of birth defects in the baby by:
    a. Making sure an HIV-infected woman desiring a pregnancy is not taking Efavirenz (EFV) (commonly used in some ART regimens).

Remember: Providers counselling HIV positive clients should support clients who desire a pregnancy. We know that HIV positive clients may desire a pregnancy, especially those women and couples who are young, have no or few children, and who have access to ART. We also know that pregnancy does not accelerate progression of HIV; ART improves health and longevity of adults and is becoming widely available; and that PMTCT drugs are more effective (including new recommendations about ART initiation during pregnancy). Finally, in some places artificial insemination may be available to help discordant couples reduce or eliminate the risk of transmission (though this may be costly).

Handout 11: The Problem Tree



Handout 12: HIV Testing

- *What is an HIV test*: an HIV test is used to determine whether a person is infected with HIV, the virus which causes AIDS. Tests look for antibodies which develop in response to HIV, the HIV organism itself or its antigens (HIV viral proteins).
- *What is pre-test counselling:* Pre-test counselling provides an opportunity for clients and their counsellors to talk about the HIV testing process; the meaning of positive and negative results; the client's potential HIV risks; how to reduce the risks and the client's intended course of action once he/she gets his/her results, whatever the outcome.
- *Advantages of HCT:* Reassurance and prevention counselling if results are negative; freer mind upon knowing status, knowing status helps people to take precautions to protect loved ones; helps people to make key and informed lifestyle changes for longevity of life; heightened concern for a pregnant partner may enhance couple counselling; negative result may provide relief from worry and provide motivation towards commitment to remain negative.
- *Disadvantages of HCT:* Positive result may carry with it stigma and discrimination; being classified as HIV positive may result in isolation; potential for violence and abandonment as well as blame for introducing HIV into the family.

Handout 13: Rights of PLHIV

Do you agree or disagree with these statements?

1. Patients who are HIV positive should be treated the same as other patients, with respect and care.
2. If you know a patient in your community who is HIV positive, you should tell his or her spouse and close relatives so that they can support them.
3. Health workers who are HIV positive should tell their employers and patients their status so that other people can be protected.
4. Health workers who are HIV positive should not be allowed to care for patients directly.
5. If people get HIV through promiscuous sexual behaviour, they are to blame for their own circumstances.
6. HIV positive women should not have children because they will pass the infection to their babies.
7. If a woman test HIV positive, and she already has a large family, she should be sterilised so that there is no chance of her passing the infection to any other children.
8. If a health worker is afraid of getting HIV from a patient, he or she should have the option not to see that patient.
9. Health workers have the right to refuse to provide services if they are not able to take precautions to protect themselves from infection.
10. Health workers have the right to test their clients for HIV even if they do not want to be tested, so that they can protect themselves.

Handout 14: Stigma and Discrimination Scenarios

The paragraphs below provides three scenarios where a person is experiencing stigma or discrimination.

1. A 35 year old woman was advised by nurses at her local health centre not to have any more children as she was HIV positive. A year later she became pregnant again and the nurses shouted at her for not taking their advice. They also did not give her information on PMTCT and told her not to come to the health centre again as she was wasting their time.

2. An HIV positive woman migrant was told by a service provider in Johannesburg that she could not get treatment because she did not have the right documents. The service provider told her to go back to her country and that it was people like her who were bringing these diseases into his country.

3. A 25 year old man who had trained as a community health worker applied to work in an area next to his home village. Leaders in the community used their influence to block his application as they did not want a health worker working in their community who was HIV positive.

Discuss these scenarios based on these questions:

- What are the rights that are being violated for the person living with HIV?
- What needs to be in place so that HIV positive women and adolescent girls can access SRHR?
- What are the roles of CBOs in helping PLHIV to access their SRHR?

Handout 15.1: The SRHR Tool

		1. Which rights do we need to support?	2. How do we ensure participation?	3. How do we take account of gender factors?
Prevention	**Prevention activities:**			
	IEC (individual, community, public)			
	Diagnosis and treatment of STIs			
	VCT			
	Contraception, PMTCT			
	Capacity building of providers			
Treatment and care	**Treatment and care activities:**			
	ARV provision services			
	Treatment of opportunistic infections			
	Capacity building of providers			
Support	**Support activities:**			
	Individual counselling			
	Support groups			
	Capacity building of providers			
Young people	**Activities for young people**			
	Information on sexual and reproductive health and HIV			
	Access to contraception (and emergency contraception)			
	Access to dual protection			

Handout 15.2: Completed SRHR Tool – An Example

	Integrated SRH and HIV services	1.Integrating SRHR	2. Ensuring Participation	3. Gender Lens
Prevention	**Prevention activities:**			
	IEC (individual, community, public)	Right to information	Survey of gaps in current knowledge levels on prevention Involve community leaders, PLHIV, young people in design and testing of IEC materials	Provide women and girls with information on their rights in an appropriate format
	Information, diagnosis and treatment of STIs	Right to protect health	Involve community and PLHIV in awareness raising for SRH services offered in addition to HIV services (through community dialogue, peer educators, IEC) Set up referral links to SRH services if diagnosis and treatment cannot be provided in-house	Ensure service providers do not require partner consent for treating women Identify financial barriers for treatment experienced by women and address these
	VCT	Right to protect health	Research community awareness of VCT Involve community and PLHIV in awareness raising for VCT (e.g. peer educators, prominent community members publicly testing)	Put in place systems to ensure service providers avoid disclosure without consent for women
	Secondary prevention/ Dual protection	Right to protect health	Involve community members and PLHIV in awareness raising for secondary prevention (community dialogue, peer educators)	Ensure PLHIV, especially women know benefits of negotiating condom use Ensure services available for women who experience violence

	Integrated SRH and HIV services	1.Integrating SRHR	2. Ensuring Participation	3. Gender Lens
	Contraception, PMTCT	Right to decide when to have a child, child spacing. Right to protect health (for child)	Involve WLHIV in the community as advocates/ peer educators supporting PMTCT Set up referral links to SRH services if contraceptive services (other than condoms) cannot be provided in-house	Ensure contraceptive services available to women without partner consent
	Capacity building of service providers	Right to be treated with respect, non-discrimination	Involve PLHIV in training workshops for service providers Involve organisations working with GBV in training	Ensure training or refresher training on gender and gender-based violence Training for service providers to offer all contraceptive services and sexual and reproductive rights of PLHIV Set up ways of getting feedback from clients to monitor stigma and discrimination
Treatment and care	**Treatment and care activities:**			
	ARV provision services	Right to protect health	Involve PLHIV in planning for ARV provision services	Ensure equal access for men and women as per national guidelines Integrate other SRH services to reduce stigma when accessing ARVs
	Adherence support	Right to protect health	Involve PLHIV as peer educators for adherence support	Provide women with information and support for adherence in day-to-day life (e.g. SAfAIDS women's Treatment Literacy Kit)

	Integrated SRH and HIV services	1.Integrating SRHR	2. Ensuring Participation	3. Gender Lens
	Treatment of opportunistic infections	Right to protect health	Involve PLHIV as peer educators for services treating opportunistic infections	Ensure equal access to treatment for women, without requirement of partner consent Identify financial treatment barriers for women
	Capacity building of providers	Right to be treated with respect, non-discrimination	Involve WLHIV	Training on gender issues to reduce stigma towards women on ARVs as 'cause' of disease Set up ways of getting feedback from clients to monitor stigma and discrimination
Support	**Support activities:**			
	Individual counselling	Right to protect health	Involve PLHIV, especially women in planning counselling services Ensure availability of male and female counsellors so clients can chose their preference	Ensure equal access to counselling for women Ensure counsellors cover sexual and reproductive rights, pregnancy planning in depth
	Support groups	Right to protect health	Involve community leaders, PLHIV in support groups	Ensure counsellors cover sexual and reproductive rights and pregnancy planning in depth Increase awareness in communities to reduce stigma of women going to support groups
	Nutritional counselling	Right to protect health	Survey counselling needs Involve PLHIV in planning counselling services	Ensure equal access to women as per national guidelines

	Integrated SRH and HIV services	1.Integrating SRHR	2. Ensuring Participation	3. Gender Lens
	Income generating activities	Right to make own decisions	Involve community leaders, and all PLHIV in activities	Give particular support to WLHIV for income generation
	Capacity building of service providers	Right to be treated with respect, non-discrimination	Involve PLHIV, especially WLHIV in training for service providers	Training for sexual and reproductive rights and pregnancy planning for PLHIV to reduce stigma and discrimination Set up ways of getting feedback from clients to monitor stigma and discrimination
Young people	**Activities for young people**			
	Information on sexual/ reproductive health and HIV	Right to information	Survey young people's knowledge on SRH and HIV Involve young people in design and testing of information activities/ interventions	Provide information to boys and girls Ensure young girls have information on their rights
	Access to dual protection, contraception (and emergency contraception)	Right to protect health	Involve young people in increasing awareness on contraception and emergency contraception (peer educators)	Ensure access for young girls without parental or partner consent Services set up so young girls can access them (appropriate time and place)
	Capacity building of providers	Right to be treated with respect, non-discrimination	Involve young people, including young people living with HIV, in designing and training for service providers	Training for service providers on rights of young people, especially girls Training for service providers on providing youth-friendly services

Handout 16: Case Study for SRHR Tool

Hearts and Minds is a CBO working in HIV prevention, treatment and support for the past five years in the fictional town of Muranza.

Geographical Context
Muranza area is fairly remote. The district hospital is located in a large town which is 75 kilometres away. A large number of the men in the town have left their families to go and find work in the capital city.

HIV Situation
This region has high HIV prevalence, with prevalence at over 15 percent. Although data are scarce, the nurses at Hearts and Minds say they are witnessing more and more young women under the age of 25 who are testing HIV positive.

Socio-cultural Context
Muranza is a traditional community. Most people attend a Christian church and the leaders of this church have influence in the community. Service providers at Hearts and Minds also say they are seeing many more unwanted pregnancies in the last year and they think this is because young women are more promiscuous when their husbands are away working. Polygamy and wife inheritance are accepted practices in the community.

ARVs
The location of this area and the fact that Hearts and Minds does not have a permanent supply manager means there are sometimes stock-outs of ARVs. There is low uptake of PMTCT in the area, and although Hearts and Minds does try to promote it, there is a strong belief in the community that it is not effective.

Donors
Hearts and Minds funders are willing to increase funding to the Hearts and Minds programme on condition that SRHR is integrated into the current programme and efforts are made to reduce stigma and discrimination against PLHIV, especially women.

You are tasked with addressing the challenges below to meet your donor requirements. Use the SRHR tool to begin the process of understanding the problems faced and preparing for Action Planning on Day 4. Refer to Day 1 for ways to effectively integrate sexual and reproductive health and HIV.

Remember, the main ways of integrating SRH services into HIV programmes are:

- Providing information on dual protection and access to condoms.
- Diagnosing and treating STIs.
- Family planning counselling and interventions.

Main challenges to be addressed in integrating SRHR

- Members of staff do not refer PLHIV for SRH services.
- SRH services are far away, at the district hospital.
- Members of staff are not experienced in providing services for SRH and GBV.
- Members of staff are not aware of the rights of women and PLHIV, leading to stigma and discrimination.
- Young people are starting to come for services less and less because of the judgmental attitudes of service providers.
- Community members are not aware of their SRHR.
- Low uptake of PMTCT.

Handout 17: The Log Frame

Activity	Objective	Staff	Date	Place	Resources Required	Indicator
	Objective1:					
	Objective 2:					

Further Reading

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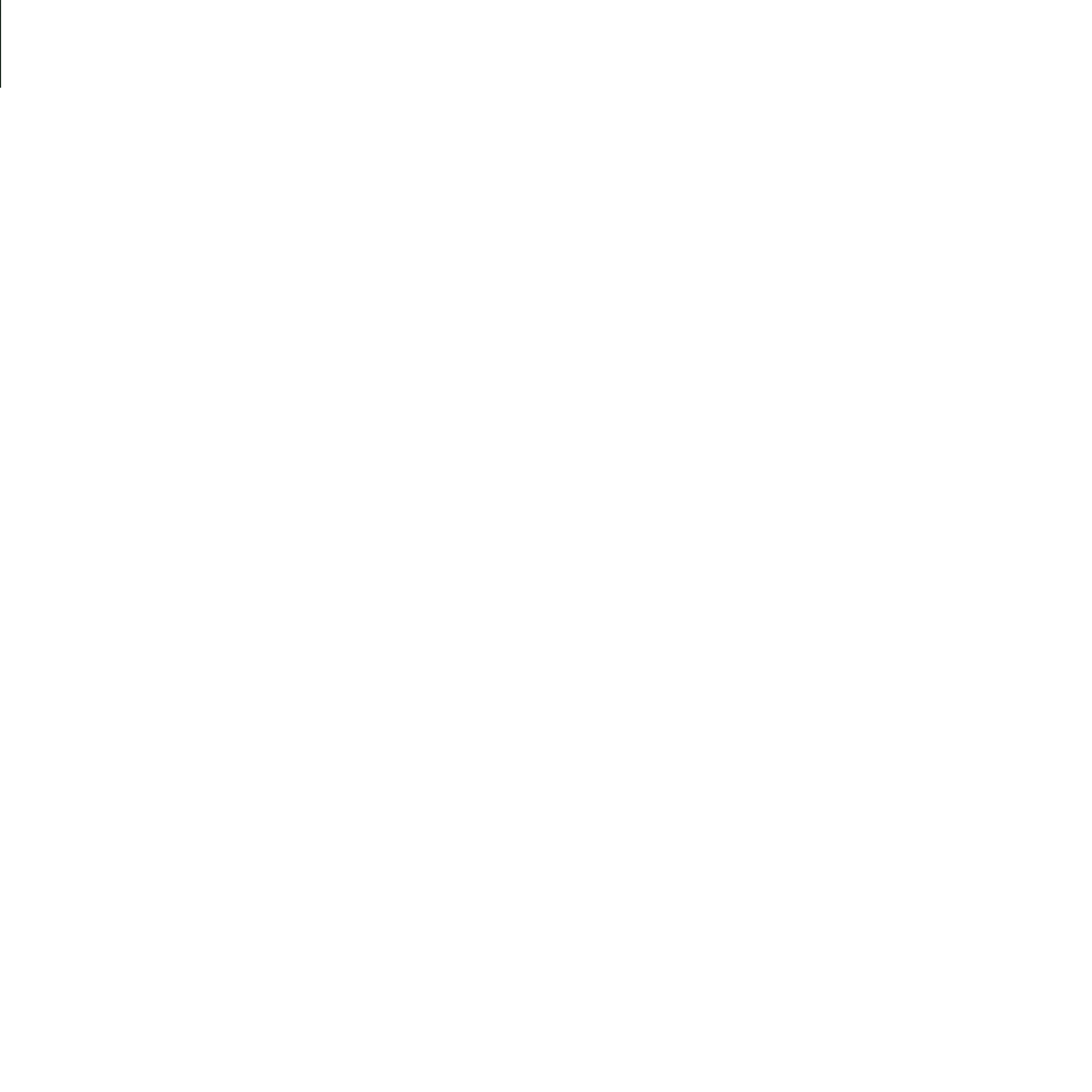

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