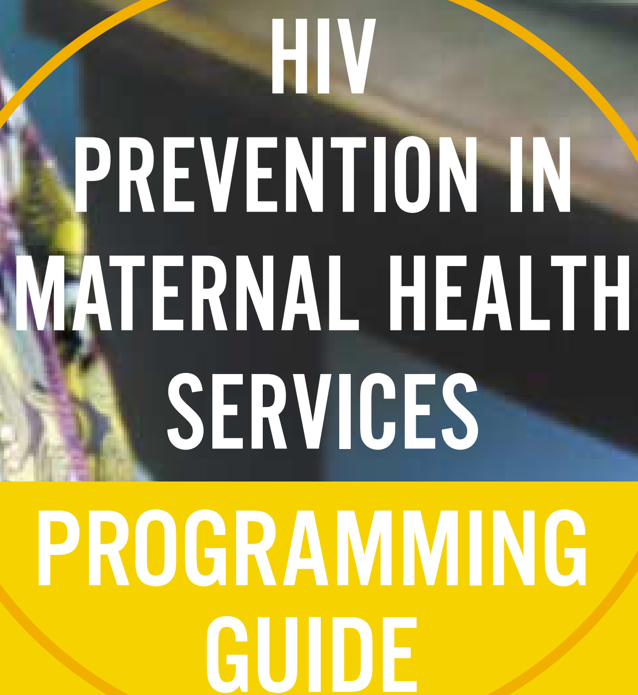
PREVENTING HIV, PROMOTING REPRODUCTIVE HEALTH



HIV PREVENTION IN MATERNAL HEALTH SERVICES

PROGRAMMING GUIDE

UNFPA

ENGENDERHEALTH
Improving Women's Health Worldwide

HIV Prevention in Maternal Health Services: Programming Guide

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INTRODUCTION

INTRODUCTION

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Why Was This Guide Developed?

Each year, an estimated 200 million women in the world become pregnant, and approximately 2.5 million of these women are HIV-positive (UNAIDS, 2002). Infection rates are alarmingly high among pregnant women in some countries, especially in Sub-Saharan Africa,[1] but the majority of pregnant women in the world are HIV-negative. This fact presents the world with the major challenge of enabling the nearly 99% of women who become pregnant each year and who have not acquired the virus to remain HIV-negative.

This guide, then, has a two-fold purpose:

- To address programming gaps in the prevention of HIV and other sexually transmitted infections (STIs) in maternal health services
- To increase the capacity of maternal health providers and community-based providers (e.g., traditional birth attendants, midwives, and community health workers) through training and facilitative supervision to provide pregnant and postpartum women with HIV and STI prevention services and referrals

The biological, social, cultural, economic, and gender-based factors that contribute to women's vulnerability to HIV/AIDS and other STIs are well documented (UNAIDS, 2003; UNFPA, 2002; WHO & UNAIDS, 1999). In addition, a growing body of knowledge suggests that preventing HIV infection in women of reproductive age is more effective and less costly than is intervening after a woman is already infected:

- In some countries, culturally prescribed periods of sexual abstinence or decreased sexual activity between a couple during pregnancy and postpartum can lead men to seek out extramarital relations, and these may increase a woman's risk of infection once a couple resumes sexual relations (either during pregnancy or after childbirth) (Leroy et al., 1994; Mbizvo et al., 2001; Zondi et al., 2002).
- Biologically, women are at elevated risk of becoming infected with HIV/AIDS and other STIs during pregnancy, for several reasons. First, vulvar and vaginal tissues are richer in blood vessels and blood supply during pregnancy, and are more likely to rupture as a result of trauma, potentially giving HIV and other STIs access to the bloodstream. Additionally, as a result of labour and delivery,

[1] In some countries of Sub-Saharan Africa, HIV prevalence rates among pregnant and postpartum women can be as high as 35% or more.

the tissues are more fragile postnatally and women may experience cuts or abrasions that provide easier entry for HIV/AIDS or other STIs (WHO & UNAIDS, 1999; UNFPA, 2002; UNAIDS, 2003).

- A young girl is particularly vulnerable because her cervix is less fully developed and because she produces less vaginal mucus, which presents less of a barrier to HIV and can lead to more tears and abrasions during sexual relations (UNAIDS, 2003).
- The presence of STIs, which often are asymptomatic in women, increases the risk of HIV infection (WHO & UNAIDS, 1999; Silva et al., 2002; Taha & Gray, 2000).
- Women in high-fertility settings spend a varying but significant proportion of their reproductive lifetime pregnant and breastfeeding.
- There is no known cure for HIV, and in many places treatment is still not available.
- During pregnancy and the postpartum period, both parents are motivated to protect the infant, and their health awareness and risk perception may be higher, leading to an increased likelihood of behaviour change.

Preventing HIV infection in pregnant women simultaneously benefits the women themselves, their partners, and their children. The benefits of HIV prevention counselling and services provided during pregnancy can carry over into the postpartum period, when HIV risk is high, and throughout the client's lifetime.

Given that many women access health services only during pregnancy, maternal health services represent a pragmatic entry point for providing HIV interventions tailored to the needs of pregnant and postpartum women. Yet few efforts currently address the HIV prevention concerns of pregnant and postpartum women, especially those who are HIV-negative. This need is particularly important in light of the equally pressing need to prevent vertical transmission and to provide treatment, care, and support for HIV-positive mothers and their families.

Maternal health services are critically positioned to help address the prevention needs of pregnant and postpartum women who are HIV-negative or whose HIV status is unknown. UNFPA and EngenderHealth developed this guide to ensure that prevention among pregnant and postpartum women remains a critical strategy of HIV/AIDS and maternal health programmes, and that women are provided with the skills and resources they need to remain HIV-negative.

This programming guide recognizes that inequalities between women and men (reflected in different norms for women's and for men's sexual behavior) increase women's vulnerability to HIV/STIs and can affect how empowered women are to protect themselves and their offspring from HIV. Effective HIV prevention interventions address the empowerment of women within a rights-based framework and the promotion of male involvement in protecting the health of their partner and their children. Eliminating stigma and discrimination within the community can help build a supportive environment in which women can become more empowered to exercise their sexual and reproductive rights, regardless of their HIV status.

What Is Covered in This Guide?

While this guide primarily addresses HIV prevention, it also makes the link to other STIs, since these can increase a pregnant woman's susceptibility to HIV infection and since both HIV/AIDS and other STIs can be transmitted to the foetus or newborn child.

While preventing HIV infection in pregnant women is a critical element in preventing HIV transmission to the child (vertical transmission), this guide does not attempt to duplicate the many training aides and programme guides that already address prevention of vertical transmission.

Prevention of mother-to-child transmission (PMTCT) is more than the provision of antiretroviral drugs to prevent transmission of HIV from an HIV-positive woman to her infant. A comprehensive programme to prevent HIV transmission to pregnant women, mothers, and their children, which has been endorsed by the United Nations (UN) system, includes four elements known as PMTCT, defined as:

1. Prevention of HIV, especially among young people and pregnant women
2. Prevention of unintended pregnancies among HIV-infected women
3. Prevention of HIV transmission from HIV-infected women to their infants
4. Provision of treatment, care, and support to HIV-infected women and their families

This guide focusses primarily on the first of the four elements—prevention of HIV infection among women, particularly among pregnant and postpartum women—to

fill the gap in existing programming or training guidelines that currently address PMTCT. While this guide primarily focusses on the first of the four elements, it also covers a number of other interventions that fall under the other elements, including safer delivery practises, counselling on infant feeding, universal precautions, etc.

Throughout this guide, planners, programme developers, and trainers are encouraged to seek opportunities for addressing gender inequities (which can be critical for successful HIV prevention interventions) by:

- Finding effective ways to increase men's participation
- Helping women to negotiate safer sex, especially condom use
- Eliminating gender-based violence
- Advocating with policymakers to change discriminatory legislation
- Working with community leaders to raise awareness about harmful traditional practises

How Was This Guide Developed?

This guide is based on the findings of a literature review and the recommendations of a needs assessment conducted by EngenderHealth and UNFPA in Ethiopia and Cambodia. It also draws upon various programming and training approaches, best practises, and current planning and training guides in the field.

The draft guide was extensively field-tested in Cambodia, Ethiopia, Ghana, and Malawi, in collaboration with UNFPA and with Ministry of Health staff in each of these countries. This version reflects those field experiences and has benefitted from input from planners, programme managers, trainers, and staff.

Who Is This Guide For?

The primary audience of the guide includes:

- Ministry of Health and UNFPA country office planners and policymakers
- District-level or site-level programme managers and trainers
- International and local nongovernmental organisations

While the guide focusses primarily on district-level or site-level activities, it assumes HIV/AIDS and STI programmes are also being coordinated at the national and regional levels in many countries, including:

- Provision of an overall vision
- Strategic plans to address policy and infrastructure issues
- National policies
- Procedures and minimum standards for service delivery
- A detailed implementation plan and mechanisms for monitoring progress towards national HIV and STI goals.

In countries where this is not the case, district- or site-level officials may need to engage national and regional officials in national-level and regional-level planning activities, to promote consensus among stakeholders and implementers on the above programming issues.

The secondary audience consists of health care providers who attend training courses associated with integration of HIV and STI interventions with maternal health services. They include both facility-based staff (e.g., care providers, counsellors, behaviour-change communication and information, education, and communication staff, reception staff, etc.) and community-based providers (e.g., traditional birth attendants, community health workers, and other outreach workers) who have contact with pregnant and postpartum women.

The client population addressed in this guide is principally pregnant and postpartum women.

How Can This Guide Be Used?

District-level or site-level planners, programmers, and trainers using this guide will, according to their needs, be able to:

1. Plan for integrating HIV and STI prevention interventions into maternal health services
2. Determine the most appropriate and feasible HIV and STI interventions for clients in their setting, by considering factors that determine the size and scope of HIV and STI interventions for pregnant and postpartum women
3. Design and implement gender-sensitive HIV prevention interventions
4. Train staff in technical areas to ensure they have the capacity to deliver HIV and STI prevention interventions for pregnant and postpartum women
5. Monitor and evaluate HIV and STI prevention interventions for pregnant and postpartum women

How Is This Guide Organised?

Following this introduction, the guide is divided into three chapters. Chapter 1 covers the key steps and activities in planning HIV and STI interventions. Chapter 2 provides a brief description of various HIV and STI interventions that programme planners and managers can consider in programme design. Chapter 3 offers an overview of important training topics that programme managers and trainers can consider in training staff about HIV and STI interventions. The appendices provide significant supplementary material. In particular, Appendix A includes a number of exercises (and related worksheets) that sites can use to discover more fully what their needs are and how these can be met in the planning process.

Accompanying this guide are some additional resources. One is a stand-alone laminated card showing 10 key prevention messages for pregnant and postpartum women. Another is a training curriculum for providing a basic orientation to HIV and STI prevention in maternal health services. Finally, at the end of each chapter

of this guide, there is a section listing many excellent resources on programme planning, HIV and STI interventions, and HIV and STI training.

It is recommended that you read the entire guide before commencing any of the programme planning activities in Chapter 1. Familiarising yourself with all three chapters will help you better understand the programme planning steps and activities, as well as the specific HIV and STI interventions and the types of training that you can integrate into your programme design.

Some of the activities in Appendix A will require you to refer to Chapters 2 and 3, to prioritise and choose your HIV and STI interventions, as well as to decide what kinds of training you need to offer your staff to ensure they have the necessary skills and capacity to implement the interventions.

The Key Messages Card can provide direction on what prevention messages you can adapt and integrate into various HIV and STI interventions in your setting. Health providers can also use it as a job aide, to prompt them regarding the essential information to impart to pregnant and postpartum women during each client-provider interaction.

HIV Prevention in Maternal Health Services: Training Guide is a curriculum for training the staff at a particular site. It can be used in its entirety, or it can be adapted to suit the needs of your setting. There are also a couple of exercises in the training guide about how to use the Key Messages Card and adapt the messages for use in information, education, and communication activities, group education sessions, prevention counselling (including condom use for dual protection), infant feeding counselling, and voluntary counselling and testing.

CHAPTER 1

CHAPTER 1

PROGRAMME PLANNING

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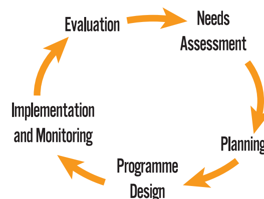
This chapter will assist programme managers and planners in determining the most appropriate HIV and STI prevention interventions for pregnant and postpartum women to implement in their setting by:

- Providing planning activities that a facility can adapt for collecting relevant baseline information, organising and synthesising the information, developing relevant plans, and making sound programming decisions
- Presenting options and considerations that must be taken into account in tailoring HIV and STI interventions for pregnant and postpartum women to best fit their setting

Planning Process

Sequential and participatory planning processes, whether at the national, regional, district, or site level, involve the following steps (Synergy Project, 2002):



Each of these steps is discussed in greater detail below. The steps will vary from facility to facility, based on resources, the number of staff, and the staff's capacity in terms of their knowledge, skills, and attitudes. A discussion of each step includes an overview of the basic activities that district- or facility-level officials can consider when planning HIV and STI interventions in maternal health services. In discussing the planning steps, we assume that most sites will have two or more staff participating in the planning activities that are outlined. Managers of service-delivery sites with only one staff member can also complete some or all of the planning activities in this chapter and should feel free to choose and adapt the planning activities and steps that best meet their needs.

The process outlined below is not labour-intensive and can facilitate the timely implementation of small-scale HIV and STI interventions (e.g., simple interventions with a single objective targetting pregnant and postpartum women in the immediate setting, such as counselling clients on condom use). If a district or facility is considering a large-scale programme (e.g., complex interventions with multiple objectives targetting pregnant and postpartum women at the district or national levels, such as establishing a voluntary counselling and testing programme) and has additional resources and sufficient time, programme planners and managers should consider using more in-depth and comprehensive planning resources and tools (see resources and tools listed at the end of this chapter).

While programme planning is a sequential process, remember that is also cyclical, and some of the steps overlap. It may require completing several iterations of some steps and activities to ensure that a programme is the best fit for a facility, given available resources, the level of service utilisation, and local HIV prevalence. It is also possible to enter into the planning cycle at any point, depending on your needs, and to be engaged in multiple planning activities simultaneously. For example, if a facility already has completed a needs assessment and has a strategic plan, it may be possible to enter into programme planning at the design step. Also, the design, monitoring, and evaluation activities occur at the same time. Regardless of which step you are undertaking, it is important to link the various steps and activities in the planning process, to prevent duplication of effort and to ensure ongoing sharing of relevant information for future programme planning.

STEP 1 Needs Assessment

A needs assessment answers the question, “What is the nature of the HIV/AIDS problem for pregnant and postpartum women within your setting?” Assessment is the process used to better understand the status of the HIV/AIDS epidemic and the programme responses to it in a specific time and place (Synergy Project, 2002).

A needs assessment should produce the following results:

- A better understanding of HIV prevalence among pregnant and postpartum women in your setting and a clearer identification of the vulnerable subpopulations of pregnant and postpartum women affected by HIV/AIDS and other

STIs—including adolescents, sex workers, women with a history of STIs, female injecting drug users, partners of men with STIs, female partners of male injecting drug users, and partners of men involved in work that requires travel away from home for extended periods of time

- A better recognition of existing HIV and STI prevention activities and services for pregnant and postpartum women (including those already existing in maternal health services) within your region, the level of utilisation of these services, and new opportunities for HIV and STI interventions among pregnant and postpartum women
- An understanding of the critical gaps in information about the problem and how to gather additional information to address these gaps
- Identification of how gender inequalities increase pregnant and postpartum women's vulnerability and ability to take action to protect themselves

Data collected as part of an assessment can contribute to creating a baseline that is used for midpoint and final evaluations. Data (disaggregated by sex) can also add to the general knowledge about the HIV and AIDS situation in an area and can ultimately help with a variety of evaluation activities. The assessment process is also an opportunity to achieve buy-in from decision makers by involving key stakeholders and partners early in the programming cycle. One way to ensure that stakeholders' concerns have been addressed is to include them as team members or resource persons or as sources of information during the assessment. Key stakeholders and partners may include:

- Staff from all levels of the health district and the implementing agency
- Clients
- Implementation partners (local and international nongovernmental organisations, private-sector agencies, and public-sector agencies)
- National health officials
- Members of donor organisations
- Officials from UN organisations

Programme managers can use the checklist on page 16 to guide them through the assessment step.

In addition to raising awareness about the current HIV situation in your setting, the final activity in the checklist will help to build support for developing and implementing your HIV and STI interventions and move the process along to the next step—planning.

ASSESSMENT CHECKLIST	✔
Assemble an assessment team and identify a team leader to conduct the assessment(s). Determine the role of the district or regional health management teams and the National HIV/AIDS Coordinating Committee, if applicable.	
Compile and distribute existing data and information, including country-specific policies and strategic plans on HIV/AIDS and other STIs, country-specific HIV and STI prevalence rates, and other national surveys or studies pertinent to pregnant and postpartum women's health, such as antenatal HIV prevalence rates.	
Conduct a half-day planning and briefing meeting with the assessment team to define roles and responsibilities and to agree on a work plan and a timeline for completing the assessments.	
Conduct a situational analysis[2] by using rapid-assessment methods. Beginning with a rapid assessment of clients' needs, including the impact of stigma on current HIV/STI efforts and on gender dynamics, complete Activity A1 (Appendix A, pages 92–96).	
Conduct a rapid assessment of existing services in the community, including existing referral mechanisms, by completing Activity A2 (Appendix A, pages 97–102).	
Conduct a rapid assessment of staff training needs by completing Activity A3 (Appendix A, pages 103–108). (Refer to Chapter 3 for an overview of the various types of training while completing this assessment.)	
Analyse the data that you have gathered from Activities A1, A2, and A3 to identify key programming areas and the key needs within each area. (See the resources at the end of this chapter, which can assist you in data analysis.)	
Write a report of the key findings from the assessment.	
Seek feedback from stakeholders and partners before finalising the report.	
Disseminate the results of the assessment to facility staff, planners, government officials, potential donors and partners, etc.	

[2] A situational analysis is an assessment of the magnitude and dynamics of the situation regarding HIV and AIDS in a particular country, province, district, or community. It helps recognise important needs and, in the strategic planning step of the planning process, identify actions that will be required to meet those needs.

STEP 2 Planning

Planning answers the question, "What objectives should you pursue to address HIV prevention among pregnant and postpartum women?" It builds on the assessment process and examines the data that you collected in your assessment, to define priority objectives and strategies for effective HIV and STI interventions. Planning involves thinking about what goes into a programme's design at its start or at any other point in its cycle where you have an opportunity to assess how you can improve its overall effectiveness (RHRC, 2003).

The various components of a planning framework can be arranged in a number of different ways, according to the needs and usual planning processes of the facility. The design, monitoring, and evaluation decisions inherent in planning should take place as early as possible.

Programme managers can use the following checklist to guide them through the planning step:

PLANNING CHECKLIST	✔
Establish a planning team that includes key stakeholders and that will be responsible for developing a strategic plan.	
Review the assessment findings from the assessment step.	
Make a strategic plan by completing Activity A4 (Appendix A, pages 109–115).	
Based on the strategic plan, determine how your planning efforts contribute to a national HIV/AIDS plan and what implementation mechanisms are in place at the national level to support your efforts.	
Determine the kinds of skills and expertise required to implement the plan, by reviewing the results of the staff-training assessment completed in Activity A2.	
Determine the materials and tools required for implementing your plan. Activity A5 (Appendix A, pages 116–122) introduces another worksheet and discussion guide to assist in this process.	

STEP 3 Programme Design

Programme design answers the question, "How do you design HIV and STI prevention interventions for pregnant and postpartum women that will efficiently accomplish the key objectives in your strategic plan?" By the time you get to programme design, you have already begun to identify key elements of the programme under development. In Step 1, you gained a better understanding of the local situation regarding HIV/AIDS among pregnant and postpartum women and of gender dynamics, and you identified important gaps in the current responses. In Step 2, you defined and prioritised the objectives your facility will pursue.

In this planning step, you will become more specific about the resources and interventions needed to accomplish your objectives, and you will organise them into a design that is a good fit with the other services you are providing. Remember that programme design is an ongoing process. Even excellently designed programmes require refinement based on information gathered from ongoing assessments. Gathering and reviewing information about a project's performance is an essential part of programme design and is linked with monitoring and evaluation.

Programme managers can use the checklist on page 19 to guide them through the design step.

Programme Indicators

As programme designers, you have been focussing on what you want to accomplish and on how you are going to do it. Your objectives determine the strategy or how your programme responds. As the design team develops the project or programme, team members responsible for monitoring and evaluation should begin to envision how they will monitor and evaluate the project or programme. Working together, the team should review the programme objectives identified in the planning phase, to ensure that they are specific enough to guide the programme plan and inform the monitoring and evaluation steps of the planning process.

Remember, objectives are discrete points of accomplishment on the way towards achieving your goal. They also help you to monitor your movement towards the goal. Hence, programme design, monitoring, and evaluation are closely linked. It is the responsibility of both programme managers and the person(s) responsible for evaluation to ensure that there is a close (and logical) link between programme objectives and monitoring and evaluation tools.

PROGRAMME DESIGN CHECKLIST	✔
Review the programmatic vision, goals, and objectives decided upon in Activity A5, and finalise the mandate, purpose, and intended uses of the HIV/AIDS programme that you are considering.	
Assemble and brief a design team.	
Involve stakeholders and partners throughout the design process.	
Review the programme descriptions in Chapter 2 to better understand the various HIV and STI interventions, as well as their programmatic requirements.	
Review the training topics in Chapter 3 to better understand the important training topics to address in building your staff's capacity to undertake HIV and STI interventions.	
Prioritise and choose your key interventions by completing Activity A6 (Appendix A, pages 123–130).	
Refine the logical frameworks that you made in Step 2 (Activity A4) to ensure that they capture all of the needed information, based on your design decisions.	
Consider how to monitor your programme and develop indicators for each of your prioritised interventions. Sample programme indicators are listed in Figure 1 (pages 20–21).	

You can track progress towards achieving your objectives, even those specific to a single HIV or AIDS objective, by monitoring changes in specific variables or indicators. If indicators are moving in the expected direction at the expected rate of change, then your programme will reach its objective by the end of the projected period. The process of identifying indicators offers programme managers a way to clarify the logic of the intervention design.

An indicator is a characteristic or dimension used to measure an intended change towards an objective. Indicators should:

- Be precisely defined
- Measure what they are supposed to (known as validity)
- Measure with minimal error (known as reliability)
- Allow comparability across different groups (including by gender) and delivery approaches

Figure 1. Sample programme indicators

Objective	Process indicators	Outcome indicators
Provide quality HIV/STI prevention interventions integrated with maternal health services by the end of the five-year programme.	■ No. of clients screened for STIs ■ No. of clients receiving voluntary counselling and testing services ■ No. of HIV tests administered ■ No. of clients served ■ No. of pregnant and postpartum women screened for syphilis ■ No. of norms and protocols developed that address integration ■ Percentage of providers trained to offer integrated HIV and STI services ■ Percentage of clients receiving HIV prevention counselling during their antenatal visit ■ Percentage of clients returning for follow-up visits (with repeat STIs or postpartum) ■ Percentage of clients screened for risk or exposure to violence ■ Percentage of interventions addressing STI screening and treatment ■ No. of clients receiving condoms ■ No. of condoms distributed ■ No. of information, education, and communication (IEC) materials incorporating key messages that were produced or distributed ■ No. of providers using key messages with pregnant and postpartum clients ■ No. of clients reporting that they remembered key messages ■ No. of clients reporting a change in knowledge, attitudes, and practises ■ Percentage of antenatal care visits/deliveries/postpartum visits in which the partner is present ■ Percentage of budget allocated to HIV/STI programme integration and activities ■ Percentage of action plan items implemented	■ No. of clients reporting increased satisfaction with HIV and STI services ■ No. of clients reporting satisfaction with voluntary counselling and testing process ■ No. of new infection control practises ■ No. of clients reporting increased knowledge of risk factors for HIV/AIDS and other STIs ■ Percentage of women attended in clinics who report having discussed condom use and/or risk prevention with partners ■ Percentage of women using condoms during their last sexual intercourse or in the previous month ■ No. of providers who consistently apply universal precautions correctly *(continued)*

Figure 1. Sample programme indicators *(continued)*

Objective	Process indicators	Outcome indicators
Increase the number of HIV/STI prevention interventions linked with treatment, care, and support services by the end of the five-year programme.	■ No. of functioning links created (between private/NGO- and public-sector services) ■ No. of referrals to and from other prevention, care, treatment, and support services	■ Percentage of clients who successfully follow up on HIV/STI referrals ■ No. of clients with comprehensive HIV/STI case management
Increase community awareness about HIV prevention in pregnancy and the postpartum period, about gender inequalities, and about HIV/AIDS-related stigma and discrimination by the end of the five-year programme.	■ No. of IEC materials produced or distributed in the community ■ Percentage of community members who have seen IEC materials ■ No. of outreach activities in the community ■ No. of community leaders trained	■ No. of clients reporting accurate knowledge of HIV and STI risk factors for pregnant and postpartum women ■ No. of community members reporting accurate knowledge of HIV and STI risk factors for pregnant and postpartum women ■ No. of clients reporting fewer incidents of HIV- or AIDS-related stigma and discrimination ■ No. of community members reporting fewer incidents of HIV- or AIDS-related stigma and discrimination ■ No. of clients reporting fewer incidents of gender-related violence and discrimination ■ No. of women in the community reporting fewer incidents of gender-related violence and discrimination

- Be readily available from existing data sources or obtainable on a regular basis at low cost
- Be measured in relative terms (e.g., as a percentage or rate) and without directionality (e.g., not state the need for an increase or decrease)

There are three types of indicators:

- Process indicators (related to inputs, activities, and outputs)
- Outcome indicators (related to the objectives)
- Impact indicators (related to the long-term goals of the programme)

Many indicators related to HIV/AIDS have already been designed and tested for these criteria and have been endorsed by the U.S. Agency for International Development and UNAIDS. Figure 1 shows some sample indicators for programme objectives that integrate HIV and STI interventions with maternal health services.

STEP 4 Implementation and Monitoring

Implementation is the process of putting a plan into action by taking into account the necessary activities, tasks, resources, and time. Monitoring answers the question, “How do you know that the HIV or STI interventions for pregnant and postpartum women that you chose are taking place according to your design?” Monitoring is the process of periodically checking the status of a programme. It requires routine data gathering and periodic analysis and reporting of the results. Incorporating monitoring at the beginning of programme design will ensure that the goals and objectives are clear, measurable, and relevant and that the project or programme being implemented is the same as the one you planned.

You have already developed your programme indicators in Step 3. The checklist on page 23 can help guide programme managers through the other activities involved in implementation and monitoring. Remember that these activities are ongoing and overlap with the design and evaluation activities of the planning process.

IMPLEMENTATION AND MONITORING CHECKLIST	✔
Assemble and brief an implementation and monitoring team.	
Assess available resources to determine if they are sufficient to implement monitoring activities.	
Determine the presence or absence of national policies and protocols on HIV/AIDS and other STIs, as well as on gender.	
Review your site's policies to see how relevant they are to HIV and STI programming and if they complement national policies and guidelines. Some examples of the types of HIV and STI policies to consider are listed in Figure 2, page 24.	
Review your facility's HIV and STI protocols and develop relevant new protocols, as necessary. General HIV and STI protocols will vary, depending on the approach to service delivery and types of HIV and STI interventions. Some sample HIV/STI protocols to consider are listed in Figure 3, page 24.	
Make an implementation plan (a work plan). A sample work plan is illustrated in Figure 4 (page 25).	
Make a monitoring plan to track the progress of the work plan. A sample monitoring plan is illustrated in Figure 5 (page 26). (For help in determining data needs and in choosing the most appropriate methods for collecting your data, see Appendix D.)	
Ensure your monitoring plan is consistent with district-level and national-level implementation plans (e.g., the data collected and used for monitoring purposes at the local level will be summarised and passed on to the district level, and then passed on to the national level).	
Prepare the site through renovation and furnishings, if required.	
Pilot-test modified working hours, if required, to determine their impact on accessibility.	
Develop or adopt ongoing quality assurance measures to include HIV and STI services.	
Develop local, gender-sensitive promotional strategies for HIV and STI services that complement the national strategy (if one exists).	
Choose one person or a couple of people who will be responsible for monitoring the workplan's progress, for recommending changes or improvements to the workplan, and for ensuring that all adhere to agreed-upon monitoring and quality assurance procedures. Define the relationship of this monitoring mechanism to the district-level or site-level management body.	
Provide ongoing facilitative supervision support and monitoring of staff performance.	

Figure 2. Examples of types of policies on HIV and other STIs

Types of policies
■ Confidentiality policy outlining how to share information about clients, including their HIV status, within a facility and with referral agencies ■ Testing policy outlining who can conduct HIV counselling and testing, age of consent for HIV testing, partner or parental notification and disclosure of test results, existing mandatory practises of testing specific groups, and distinction between anonymous and confidential testing ■ HIV and AIDS policy outlining clients' right to nondiscriminatory services, as well as providers' right to nondiscriminatory employment, related to HIV status ■ Health and safety policy outlining clients' and providers' rights to safe health practises, as well as the procedures to follow for an accident or injury ■ Policy outlining clients' right to nondiscriminatory services, as well as providers' right to nondiscriminatory employment, based on their gender, sexual orientation, religion, ethnic and cultural origin, etc.

Figure 3. Examples of HIV/STI protocols

Examples
■ Local adaptation of national guidelines, including counselling, syndromic management, infant feeding, infection control, etc. ■ Minimum staffing requirements for counselling, STI management, etc. ■ Minimum spacing requirements ■ Blood-taking and testing protocols ■ Informed consent procedures ■ Confidentiality protocols ■ Referral protocols ■ Quality assurance protocols

Work Plan

Earlier in the planning process, you reviewed HIV and STI interventions related to the priority objectives in your strategic plan. You and your colleagues also identified measurable indicators for monitoring the progress of your interventions. You are now ready to draft an implementation plan that will ensure your HIV and STI interventions are implemented according to the plan. It is also a logical framework and is formed around the factors that allow you to implement the plan, such as activity, task, responsible party, resources needed, costs, and timetable.

Some programme planners use different factor headings to correspond to their task requirements, such as recommendations, contact person, funding constraints, etc. Others may order activities under corresponding objectives and create a table that focusses only on beginning and ending time assignments.

Regardless of the format, the relationships connecting each of the enabling factors to the other should be logical and sequential and should relate directly to the objective or activity they address.

Figure 4. Sample work plan

Objective: Provide quality HIV/STI prevention interventions integrated with maternal health services				
Type of HIV/STI intervention/strategy: Condom programming (male and female)				
Activities	**Tasks required to implement the intervention**	**Person responsible**	**Resources required**	**Completion date**
Counsel women on condom use. Distribute condoms to each client.	Conduct training on condom use (including impact of women's empowerment).	Ministry of Health training officer	Staff time	September 2005
	Purchase penis and pelvic models.	Programme manager	Cost of penis and pelvic models	October 2005
	Purchase condoms.	Commodities manager	Cost of condoms	October 2005
	Develop inventory systems for condoms.	Commodities manager	Staff time	October 2005

Monitoring Plan

The best approach for monitoring and evaluating a project or programme is to do so as part of the process of programme design. When monitoring and evaluation considerations are incorporated into the programme design, it helps to ensure that the project's or programme's objectives are clearly defined and articulated and that they can be objectively measured and verified with appropriate data collection methods.

A monitoring plan assists in tracking the progress of your HIV and STI interventions at regular intervals. It describes the information to be collected pertaining to each objective in the strategic plan, so that by following the plan, different people at different times and places can collect the same type of data. This ensures that programs in different areas can be compared, as can the progress of the same programs over time. One way of making a monitoring plan is to summarise this information in a logical framework, identifying who will collect the information for each strategic objective and how often the information will be collected.

Figure 5. Sample monitoring plan

Objective: Provide quality HIV/STI prevention interventions integrated with maternal health services				
Type of HIV/STI intervention/strategy: Condom programming				
Indicators	**Information source**	**People responsible for data collection**	**Method of collecting data**	**Frequency of data collection**
No. of clients receiving condoms	Providers	Providers	Clinic service statistics	Monthly
No. of condoms distributed	Providers	Providers	Clinic service statistics	Monthly
Percentage of women attended in clinics who report having discussed condom use with partners	Clients	Programme managers, outside evaluator	Client interviews	Quarterly
Percentage of women using condoms during their last sexual intercourse or in the previous month	Clients	Programme managers, outside evaluator	Client interviews	Quarterly

STEP 5 Evaluation

Evaluation anwers the question, “How do you know that your HIV and STI interventions for pregnant and postpartum women are working?” Preparing for evaluation should ideally overlap with the design and monitoring steps, because it helps you to think through the links between your goals, objectives, outputs, activities, and inputs.

There are a number of important reasons for evaluating your programme:

- To demonstrate the programme's effectiveness and sustainability
- To strengthen and improve the programme
- To influence donors and policymakers
- To contribute to the body of knowledge of what works and what does not, with regard to HIV prevention strategies for pregnant and postpartum women
- To mobilise the community in efforts to prevent HIV/AIDS and other STIs among pregnant and postpartum women

Evaluation is a broad term that encompasses many different approaches (Synergy Project, 2002). The following are three examples of different types of evaluations.

- A **process evaluation** involves assessing the programme's content, scope or coverage, and quality of implementation. Process evaluation assesses the extent to which a programme is unfolding as planned and whether it is effectively reaching its target population.
- An **outcome evaluation** measures changes in knowledge, attitudes, and practises or changes in the quality of and access to services, and attributes these changes directly to a programme. The strongest outcome evaluation is one that appropriately demonstrates causal linkages between the outcome indicators and effectiveness of the programme.
- An **impact evaluation** is able to attribute long-term changes (say, in HIV infection rates among pregnant women) to a specific programme. Most on-the-ground programmes contribute to impact, which can be measured through population-based surveys. Measuring changes attributable to a particular programme, however, is usually very difficult or impossible.

This guide assumes that users will be evaluating at the programme level and will be undertaking an evaluation of the process and outcomes. You have already gathered baseline data in Step 1, developed measureable programme indicators in Step 3, and made a monitoring plan in Step 4. The following checklist (page 28) will guide programme managers through the activities that the evaluation step entails. Remember that these activities are ongoing and overlap with the design and implementation and monitoring activities of the planning process.

EVALUATION CHECKLIST	✔
Assess resources to determine the supplies and staff needed or available for conducting the evaluation.	
Assemble and brief an evaluation team with clear terms of reference, to ensure that the evaluation is conducted effectively and efficiently.	
Make an evaluation plan. A sample outline for an evaluation plan is provided in Figure 6 (page 29).	
Compile existing baseline and programme monitoring data, identify gaps in existing data, and collect new data. Refer to Appendix D for help in determining additional data needs and in choosing the most appropriate methods for collecting new data.	
Organise and analyse the data collected. There are various resources at the end of this chapter that can help you with analysing your evaluation data.	
Present a summary of the data to programme staff, stakeholders, donors, and other audiences, to ensure that the results are discussed, compared, and validated with personal perspectives and experiences.	
Apply the findings by reviewing the evaluation results, modifying the programme based on the results, and linking the results to future evaluation and strategic planning.	
Write an evaluation report, summarising and analysing the data collected, at regular intervals throughout the programme cycle. The frequency will depend on donor requirements as well as on your own needs.	
Disseminate results by sharing the evaluation report with facility staff, planners, government officials, and potential donors and partners, among others.	

Evaluation Plan

All of the information and decisions covered during the preparatory evaluation activities should be summarised in one document—an evaluation plan. This plan will serve as a framework for an evaluation consultant or the staff conducting the evaluation and as a reference for program partners and donors. A sample evaluation plan outline is provided in Figure 6.

Figure 6. Sample evaluation plan outline

Key questions to address	Content
What is the purpose of the evaluation?	■ Scope of the evaluation ■ Goals and objectives of the programme ■ Conceptual framework that maps the linkages between inputs, processes, outputs, and outcomes (strategic plan and monitoring plan developed in Steps 2 and 3) ■ Objectives of the evaluation
How will the evaluation be conducted?	■ Study design, including evaluation approach, evaluation needs, and evaluation questions ■ Evaluation indicators ■ Data sources
Who will conduct the evaluation?	■ Individuals and institutions responsible for different parts of the evaluation
When will the evaluation be conducted?	■ Timetable for specific activities
With what funds will the evaluation be conducted?	■ Budget
Why is the evaluation being conducted?	■ Audiences to which the results will be disseminated and that will utilise the results ■ Format and content of the reporting of the results

Adapted from: Synergy Project, 2002.

You have now completed the steps in the programme planning cycle. As mentioned at the beginning of this chapter, planning is an ongoing process. You will need to complete some of the monitoring and evaluation steps prior to moving forward with implementing your HIV/STI interventions, as well as at regular intervals during the programme cycle. If you plan additional interventions, you will also need to revisit the assessment, planning, and design steps as well. As you do, please remember to use and adapt all or part of this guide according to the needs of your service-delivery site.

Planning Resources

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———. 1996. Using direct observation techniques. *Performance Monitoring and Evaluation Tips,* No. 4. Washington, DC. www.dec.org/pdf_docs/pnaby208.pdf.

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USAID Center for Population Health and Nutrition, HIV/AIDS Division. 1997. *The Universal Framework of Objectives (UFO) for HIV/AIDS.* Arlington, VA. www.iaen.org/library/usaidtech.pdf.

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CHAPTER 2

CHAPTER 2

PROGRAMME DESCRIPTIONS

From *HIV Prevention in Maternal Health Services: Programming Guide*
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This chapter describes a variety of HIV and STI interventions relevant to the discussion of programme design in Chapter 1 (and mentioned in Table A4, as part of Activity A2); the description of each intervention includes its definition, why it is important in preventing HIV and STIs among pregnant and postpartum women, and the key elements or steps required for implementing it. In considering these interventions, each maternal health setting should gauge its capacity for implementing these interventions and what additional technical assistance it will need and where to get it. Consider contacting the district or regional office of the Ministry of Health or any nongovernmental agencies in your district or region for help in designing and implementing these interventions. It is important to bear in mind that gender dimensions should be considered when HIV/STI interventions are being designed.

Information, Education, and Communication

Definition

Information, education, and communication (IEC) refers to the development and dissemination of various types of media—from posters and brochures to broad communication campaigns—for conveying clear and correct information about HIV and STI transmission, prevention, treatment, care, and support. This information can be used to reinforce positive individual behaviours associated with HIV/AIDS and other STIs and raise awareness about HIV- and AIDS-related stigma and discrimination in the community and about gender inequities.

Rationale

IEC materials can raise pregnant and postpartum women's awareness about how to prevent HIV/AIDS and other STIs and can correct misconceptions about proper condom use, the advantages of HIV counselling and testing, and benefits of various infant feeding options. Additionally, they can raise public awareness about the prevention of HIV/AIDS during pregnancy and encourage broad public debate about HIV/AIDS and other STIs, sexuality, and gender issues, based on accurate information.

Steps in developing IEC materials include:

- Defining target populations and involving them in developing materials
- Identifying priority messages, issues, and services for pregnant and postpartum women (See the Key Messages Card for important information to incorporate into materials.)
- Field-testing your messages with the target population
- Using multiple channels (including pamphlets, posters, electronic media, and mass media) to communicate and reinforce messages
- Increasing the use of mass electronic media, especially radio, to reach illiterate populations
- Creating interest in services offered at a facility by disseminating the materials

Group Education Strategies

Definition

This intervention brings a group of individuals together to learn about HIV and STI risk and risk reduction (including how to use condoms and how to negotiate their use with partners) by participating in educational activities based on interactive approaches that draw on the participants' real-life experiences in discussing safer sex activities.

Rationale

Because many pregnant women and their partners only access health services during pregnancy or the postpartum period, health providers should use this opportunity to educate these clients while they attend the health facility. Information presented and discussed during group sessions ideally complements the other services offered at the facility or in the community, including voluntary counselling and testing (VCT), STI management, prevention of mother-to-child transmission (PMTCT), and family planning.

Elements of group education include:

- Training staff who will conduct group education sessions
- Coordinating staff duties to ensure coverage of both individual counselling sessions and group sessions
- Creating a safe and friendly environment through the placement of posters and other IEC materials
- Engaging clients in the waiting room of maternal health services, family planning services, and/or HIV and STI counselling services
- Facilitating interactive group discussions that encourage participants to learn from one another
- Presenting basic information on transmission and prevention of HIV/AIDS
- Promoting and demonstrating condom use
- Using audiovisual aids such as videos to spark interest
- Ensuring sufficient supplies of condoms and educational materials
- Referring clients for VCT, STI management, and PMTCT services within your facility or at other facilities

Prevention Counselling

Definition

Prevention counselling is an interactive, confidential process during which health care providers help a client perceive his or her risk of HIV/AIDS and other STIs and explore with that client how he or she can eliminate or reduce the risk of infection (or reinfection). The provider engages the client in a two-way conversation about the client's needs, interpersonal relationships, sexual practises, and other risk factors in the client's social context, such as cultural traditions and taboos about sexuality, gender-related power imbalances in relationships, and stigma and discrimination.

Rationale

Prevention counselling offered during antenatal and postpartum visits provides a good opportunity for women and their partners to seek counselling without the fear of the stigma associated with an HIV or STI service and have their HIV/STI and pregnancy needs met at the same time. Pregnant and postpartum women are at increased risk for HIV infection, and it is imperative that providers use every opportunity to help women and their partners better understand how to reduce their risk for HIV and STI infection.

The main elements of prevention counselling include the following:

- Providers are trained in core counselling skills, in how to complete a risk assessment, in individual and couples counselling strategies, in counselling on dual protection, and in counselling on safer infant feeding options.
- Counsellor(s) complete a risk assessment to explore a client's individual circumstances, risks, and needs, using a behaviour checklist to identify the client's perception of risk for infection with HIV or STIs.
- Counsellor(s) provide information about HIV and STI transmission and risk and relate these to the client's individual situation.
- Clients are counselled to make realistic decisions about risk-reduction strategies, including using condoms, practising dual protection, negotiating with partners, and other options for women at risk who cannot negotiate with their partners, such as using the female condom.
- Role-playing is used to help clients communicate better with their partners.
- Couples counselling is promoted for mutual support in reinforcing risk-reduction behaviours.
- Appropriate referrals for support and complementary services such as VCT, STI management, and PMTCT are made available.
- Through follow-up counselling, providers support clients' maintenance of new behaviors.
- Counsellors demonstrate how to use condoms and promote their use.

Counselling on Safer Infant Feeding

Definition

Counselling on safer infant feeding includes discussing with each HIV-positive woman the risks and benefits of various infant feeding options with regard to acceptability, feasibility, affordability, sustainability, and safety, as well as providing her the necessary support to maintain her infant feeding decision. HIV-negative women and women who do not know their HIV status need to be counselled to exclusively breastfeed and consider HIV testing.

Rationale

Counselling on infant feeding can help reduce both mother-to-child transmission of HIV and infant mortality. Given that many women may be under a great deal of pressure to follow the culturally accepted method of infant feeding, it is critical that all HIV-positive pregnant and postpartum women be counselled to understand the risks of HIV infection associated with different infant feeding options. Infant feeding counselling for HIV-negative women and for women who do not know their HIV status reinforces the benefits of breastfeeding.

Principal elements of an infant feeding counselling programme include:

- Understanding and ensuring compliance with national infant feeding guidelines and the international code of marketing of breast-milk substitutes
- Assessing the local situation inside and outside of health facilities, including the local acceptability, feasibility, affordability, sustainability, and safety of infant feeding options for women
- Ensuring baby-friendly practises in maternal health facilities
- Developing mechanisms for procuring and distributing supplies and for monitoring their use
- Providing information to pregnant women and their partners about HIV transmission in general, about transmission of HIV infection to infants and young children, and about how risk is increased if a mother becomes infected with HIV at the end of pregnancy or during breastfeeding

(continued)

- Providing information about infant feeding in general, including (in particular) the benefits of breastfeeding and the risks of artificial feeding, and referring HIV-positive women to trained infant feeding counsellors who can speak with women in more depth on infant feeding options in the context of HIV and provide adequate support and follow-up
- Training and supporting counsellors on all aspects of infant and young-child feeding
- Counselling women about improving their nutrition
- Counselling HIV-negative mothers to exclusively breastfeed for the first six months of life to help the child achieve optimal growth, development, and health, and recommending introduction of nutritionally adequate and safe complementary foods at six months, while breastfeeding continues for up to two years of age or beyond
- Counselling mothers whose HIV status is unknown to seek VCT and, if replacement feeding is not feasible, promoting breastfeeding as safer than replacement feeding
- Counselling HIV-positive mothers to avoid breastfeeding when replacement feeding is acceptable, feasible, affordable, sustainable, and safe, and when replacement feeding is not feasible, recommending exclusive breastfeeding for the first few months of the infant's life or until it is feasible to discontinue breastfeeding (This would normally imply the same conditions as for replacement feeding from birth—that is, being acceptable, feasible, affordable, sustainable, and safe.)
- Supporting treatment of HIV-positive women with antiretroviral drugs as needed to treat their illness and to prevent vertical transmission
- Counselling women on the implications of replacement feeding (including possible stigma) or of exclusive breastfeeding, for both her and her child
- Supporting all breastfeeding mothers in the prevention, diagnosis, and early treatment of breast problems
- Providing adequate follow-up and support for infant feeding decisions
- Providing counselling on family planning, including child spacing and access to contraceptives within first six weeks of delivery
- Ensuring the development and implementation of a communication strategy to protect, promote, and support appropriate infant feeding practises at the community level
- Engaging community members to support breastfeeding and address stigma related to infant feeding

Condom Programming (Male and Female)

Definition

Comprehensive condom programming addresses demand and supply of male and female condoms and the related support for men and women, youth, and adults to enable them to protect themselves from HIV/STIs and from unintended pregnancy. It should explicitly address gender perspectives and power dynamics in the use of condoms, considering the particular vulnerabilities of youth (especially girls) and reaching out to boys to help shape gender roles to include responsible and healthy behaviour.

Rationale

Consistent and correct use of condoms can significantly reduce the transmission of HIV/AIDS and other STIs. Given that men rather than women tend to be sexually active with more than one partner during pregnancy and postpartum, it is very important to encourage men and women to use condoms consistently with all of their partners. It is also important to encourage pregnant and postpartum women to use condoms following a period of abstinence or decreased sexual activity.

Main elements of condom programming include:

- Assessing and meeting diverse user needs
- Overcoming barriers to access and use, including individuals' perceptions and fears, often through behaviour change communication
- Promoting consistent and correct use
- Creating a supportive political and socio-cultural environment
- Ensuring product acceptability, availability, affordability, and quality
- Forecasting, financing, and procuring condoms according to internationally accepted standards and specifications
- Establishing distribution systems, including logistics management, information systems, transport, and storage
- Making distribution channels appropriate to users' needs
- Monitoring the impact of programming on condom use, and ultimately on prevention

Linkages and Referral Systems

Definition

Establishing functional links and referral systems means identifying relevant services to which pregnant and postpartum clients can be referred, within a health facility and between health facilities and/or services, both in the public and private sectors; developing ongoing working relationships with these services; and establishing a system for making referrals between facilities and/or services.

Rationale

The HIV and STI needs of pregnant and postpartum women determine the types of referral to other services, from basic HIV and STI interventions (such as prevention counselling, infant feeding counselling, and condom programming) to progressively more specialised and complementary HIV and STI services (such as VCT, STI management, and PMTCT), including treatment, care, and support for HIV-positive women and their children and families.

Establishing functional links and referral systems includes:

- Completing an assessment of existing HIV/AIDS services (see Appendix A, Table A3, page 99)
- Creating standardised discharge summaries and referral forms
- Creating a resource directory of appropriate referrals with relevant information about the types and location of the services
- Identifying and addressing access issues, such as transportation and cost of services, before making referrals
- Providing incentives for referrals and follow-up, such as no-wait appointments
- Arranging for representatives from referral agencies to orient staff about their services

Building the Capacity of Traditional Birth Attendants, Midwives, and Community Health Workers

Definition

This intervention entails creating strong linkages between staff at local maternal health facilities and community health workers, midwives, and traditional birth attendants, as well as providing opportunities for collaborative training and programming. This may entail negotiating formal agreements, or simply cultivating informal partnerships with these individuals or their professional associations.

Rationale

Traditional birth attendants, midwives, and community health workers are strategically placed to influence behaviours and practises in communities and to reach pregnant and postpartum women who are not readily accessing services. Creating strong links to these community resources is also critical for building community support for HIV and STI services and for reducing stigma related to HIV and AIDS. The ability of maternal health services to meet all of the community's needs is limited, and partnerships with traditional birth attendants, midwives, and community health workers can help increase the coverage of HIV and STI services.

Building the capacity of traditional birth attendants, midwives, and community health workers includes:

- Establishing strong relationships with traditional birth attendants, midwives, and community health workers in your setting, if they are not already linked with your facility
- Enlisting the help of midwives, traditional birth attendants, and community health workers in delivering HIV and STI services both at the facility and in the community
- Establishing a referral mechanism for clients being referred to the facility by midwives, traditional birth attendants, or community health workers
- Providing training in HIV prevention and home-based care and support to midwives, traditional birth attendants, and community health workers
- Supporting networks for midwives, traditional birth attendants, and community health workers at all levels

Community Outreach Strategies

Definition

This intervention entails enlisting the help of outreach workers, or training your own outreach workers, to educate pregnant and postpartum clients about HIV and STI prevention, and to facilitate clients' access to HIV and STI services. Community outreach can be conducted one-on-one in any kind of venue in which the woman is comfortable or with a group of women in venues that women frequent, such as clinics, shops, factories, bars, brothels, and truck stops. Outreach workers can also partner with relevant community groups and organisations to raise awareness about stigma and discrimination related to HIV/AIDS and other STIs, as well as about gender inequality, and mobilise the community to support and promote HIV and STI services for pregnant and postpartum women.

Rationale

Stigma and HIV- and AIDS-related discrimination, cultural and linguistic biases, racial and gender discrimination, and poverty all profoundly affect pregnant and postpartum women's access to health care. Sometimes engaging pregnant women on their own terms in community settings, either one-on-one or in groups, is the only way to reach them.

Community outreach includes:

- Training and supporting outreach workers, including peers, such as young women, sex workers, women with a history of drug use, etc.
- Guarding the safety of outreach workers during outreach activities
- Engaging women in face-to-face, small-group, and large-group discussions on issues most relevant to them, including child support, food security, harm reduction, and abusive partners, among others
- Building a trusting relationship with clients and helping them reduce their risk for infection, as well as helping them access HIV and STI services and other health services
- Providing practical information on methods that reduce the risk of acquiring HIV and other STIs and distributing appropriate IEC materials (i.e., information on obtaining affordable maternal health care and other related services, condom use, bleach kits, etc.)

(continued)

- Demonstrating proper condom use and promoting condoms
- Demonstrating safer injection practises, including how to correctly clean and reuse needles, clean and prevent abscesses, etc.
- Building relationships with community partners, such as schools, community groups, churches, businesses, business associations, brothels, health facilities, etc.
- Helping raise community awareness of HIV and AIDS issues and assisting in mobilising community members to use HIV and STI services, such as VCT, STI, and PMTCT services
- Respecting the operating conditions and contributing to the spirit of the venue where outreach activities are taking place

Voluntary Counselling and Testing Services

Definition

VCT for HIV entails confidential counselling with clients that helps them make informed decisions related to HIV testing and risk-reduction. VCT consists of pretest, posttest, and follow-up counselling. In pretest counselling, individuals, couples, or groups are provided with information about HIV/AIDS and about the HIV test and are supported to understand the advantages and disadvantages of getting tested and the strategies for preventing HIV. Posttest counselling and follow-up is conducted with individuals or couples, given the confidential nature of the counselling process.

Rationale

VCT can be the entry point for a comprehensive package of HIV and STI services, including STI management, PMTCT, and treatment, care, and support services. Pregnant and postpartum women who test positive for HIV can be supported in posttest counselling and follow-up to come to terms with their test result; address partner notification issues; discuss risk-reduction strategies to prevent infection of their children and partner; and access treatment, care, and support services. Women who test negative for HIV can be supported to maintain risk-reduction strategies so as to remain negative, including maintaining proper condom use and encouraging their partner to be tested.

VCT services include:

- Ensuring that the facility has adequate space and equipment, including laboratory and counselling room(s)
- Guaranteeing voluntary services
- Guaranteeing confidentiality and privacy for counselling
- Guaranteeing HIV testing with informed consent
- Promising clients not to disclose their HIV status to anyone without their informed consent
- Establishing an appropriate testing strategy and deciding on a parallel[3] or serial[4] testing protocol
- Procuring testing kits and condoms and ensuring a readily available supply
- Providing information on HIV/AIDS and other STIs
- Providing complete pretest counselling, including information about HIV transmission and prevention, testing, and confidentiality; explaining the benefits and disadvantages of an HIV test and the implications of the results; discussing ethical and legal responsibilities associated with HIV testing; and presenting advantages and risks of HIV disclosure and partner notification
- Supporting assessment of risk and development of a risk-reduction plan, and sustaining safer sexual practises
- Providing posttest counselling for women who test HIV-negative, including prevention of future infections and infant feeding options
- Providing posttest counselling for women who test HIV-positive, including information about the natural history of HIV infection, about care and support options, about mother-to-child transmission, about infant feeding options, and about preventing the infection of others

(continued)

[3] A parallel testing protocol in VCT for HIV is when two different HIV tests are used for each client. If the two initial test results agree (as either HIV-positive or HIV-negative), the result is reported to the client. If the initial results disagree, a third test is used as a tiebreaker (Family Health International, 2003, page 12).
[4] A serial testing protocol in VCT for HIV is when one screening test is first used on each client and is then followed by a different test for all samples that initially tested HIV-positive. If the results of the first and second tests disagree, a third is used as a tiebreaker (Family Health International, 2003, page 12).

- Establishing a partner notification counselling protocol that is sensitive to the needs of women who face the prospect of domestic violence, abandonment, etc., when notifying a partner
- Counselling women on partner notification options and supporting women who choose to notify their own partner(s)
- Promoting and distributing condoms
- Offering the opportunity to bring men for counselling
- Assessing women's risk for gender-based violence
- Referring clients to other relevant STI management, PMTCT, and treatment, care, and support services, and providing follow-up on referrals
- Supporting maintenance of new behaviours through follow-up counselling
- Ensuring regular quality control of rapid tests and laboratory tests

Syndromic Management of Sexually Transmitted Infections

Definition

In the syndromic approach to STI management, the health care provider classifies and treats STIs and reproductive tract infections (RTIs) based on the symptoms and signs noticed or discussed with the client during an examination. This approach offers no definitive diagnosis, as the client is treated for all infections that could possibly have caused the syndrome. Because vaginal discharge is a poor indicator of cervical infection, syndromic management has a limited ability to correctly identify and treat gonococcal and chlamydial infections in pregnant women, and referral to a facility that can perform laboratory tests may be warranted.

Rationale

Through the syndromic approach, maternal health services with no laboratory equipment can still play a role in managing STIs among pregnant and postpartum women. Given that untreated STIs can result in complications for the mother and her infant and can facilitate the transmission of HIV, it is critical that providers screen pregnant and postpartum women for STIs.

The principal elements of STI management using the syndromic approach include:

- Establishing protocols or algorithms for syndromic management, based on the local prevalence of STIs and on drug supplies
- Developing and maintaining a reliable drug supply for treatment of STI syndromes (depending on affordability, availability, how well clients tolerate drugs, and local antimicrobial resistance patterns)
- Training and supporting providers in syndromic management protocols and algorithms
- Applying syndromic management protocols and algorithms, conducting proper clinical examinations, identifying STI symptoms, prescribing the correct drugs, and counselling clients on the importance of adhering to treatment
- Collecting client histories, including ascertaining STI history, assessing risks in partners, and asking about number of partners, client's age, and client's marital status
- Establishing a partner notification counselling protocol that is sensitive to the needs of women who face the prospect of domestic violence when notifying a partner, particularly given the possibility of misdiagnosis of STIs among women with vaginal discharge
- Counselling women on the advantages and risks of different options for notifying partners and supporting women who choose to notify their own partner(s)
- Providing STI education and counselling to clients, including demonstrating and promoting condom use and preventing future infections or reinfections
- Scheduling a follow-up visit with a client to determine if an STI has been cured and providing ongoing support, as necessary, for behaviour change intended to prevent reinfection or future infection

Aetiologic Management of Sexually Transmitted Infections

Definition

Aetiologic management of STIs and RTIs involves using laboratory tests to identify the infectious organism causing an STI or RTI, which then determines the course of treatment. Aetiologic STI management is the "gold standard" for clinical diagnosis, but it is expensive and relatively slow for diagnosing STIs and RTIs. Active case-finding refers to routine STI/RTI testing of individuals who present for health services. Syphilis screening among pregnant women is highly cost-effective, is inexpensive, and is feasible, as it costs less than US $0.50 to diagnose and cure syphilis. Given its cost-effectiveness, syphilis screening and treatment is now considered a routine service at many maternal health facilities.

Rationale

Syndromic management cannot address the widespread problem of infections in which clients experience no symptoms at all. The benefit of routinely screening pregnant women for STIs, such as syphilis, is that such asymptomatic infections can be identified and treated and that serious complications for both mother and child resulting from untreated infections can be prevented. In this case, aetiologic management is the preferred approach.

The principal elements of STI management using aetiologic management include:

- Ensuring that the facility has adequate space and equipment for completing tests
- Establishing protocols for aetiologic management, based on the local prevalence of STIs and on drug supplies
- Developing and maintaining a reliable drug supply for treatment of STIs (taking into account affordability, availability, how well clients tolerate drugs, and local antimicrobial resistance patterns)
- Training and supporting providers in aetiologic management protocols

(continued)

- Applying aetiologic management protocols, including conducting laboratory tests, interpreting laboratory results, prescribing the correct drugs, and counselling clients on the importance of adhering to treatment
- Ensuring that syphilis screening is routinely conducted early in pregnancy
- Collecting client histories, including ascertaining STI history, assessing risks in partners, and asking about number of partners, client's age, and client's marital status
- Establishing a partner notification counselling protocol that is sensitive to the needs of women who face the prospect of domestic violence when notifying a partner
- Counselling women on the advantages and risks of different options for notifying partners and supporting women who choose to notify their own partner(s)
- Providing STI education and counselling to clients, including demonstrating and promoting condom use
- Scheduling a follow-up visit with a client to determine if an STI has been cured, and providing ongoing support, as necessary, for behaviour change intended to prevent reinfection or future infection
- Ensuring regular quality control of laboratory tests
- Where a laboratory is not available on site, exploring accessible, reliable, and quality-assured resources for syphilis testing (including developing a transport and feedback system for carrying specimens and obtaining test results)

Screening for Tuberculosis

Definition

Measures for controlling the spread of tuberculosis include active tuberculosis case-finding through routine screening and treatment of latent tuberculosis infection among pregnant and postpartum women. Directly Observed Treatment, Short Course (known as DOTS) is a programme for effectively treating clients with

tuberculosis. Pregnant and postpartum women in high-risk groups and women from areas with a high prevalence of both HIV infection and tuberculosis should be routinely asked about contact with infectious tuberculosis patients, and tuberculin skin testing should always be considered for these women, along with VCT for HIV.

Rationale

Although both tuberculosis and HIV are considered life-threatening, the interaction between tuberculosis and HIV can accelerate the progression of both diseases if it is undiagnosed or left untreated. Tuberculosis-related symptoms can mimic the physiological changes that occur during pregnancy (i.e., increased respiratory rate and fatigue). Furthermore, tuberculosis is the greatest single infectious cause of death in young women worldwide. Given that many women access health services only during pregnancy and postpartum and that tuberculosis is one of the first opportunistic infections to appear in someone who is HIV-positive, routine tuberculosis screening combined with VCT provides an opportunity for early tuberculosis and HIV interventions.

Screening for tuberculosis includes:

- Ensuring that the facility has adequate space and equipment for completing tuberculosis tests
- Developing and maintaining a reliable drug supply for treatment of tuberculosis for both HIV-negative and HIV-positive clients (taking into account affordability and availability)
- Establishing an appropriate testing strategy and deciding on skin test, X-ray, and sputum analysis protocols
- Procuring tuberculosis-testing reagents and ensuring a regular supply
- Creating a system for identifying, managing, and referring clients with active tuberculosis
- Training staff on how to conduct tuberculosis tests, on case management of active tuberculosis clients, and on infection control practises
- Ensuring routine tuberculosis screening of all pregnant women in countries with high HIV prevalence and targeted tuberculosis screening of pregnant women from groups vulnerable to HIV in countries with low HIV prevalence

(continued)

- Ensuring completion of treatment of active cases through establishing a DOTS programme or some other strategy for follow-up with clients
- Establishing linkages between DOTS programmes at clinics or hospitals and home or community care of clients with active tuberculosis
- Establishing a partner-notification counselling protocol
- Counselling women on their options for notifying partners and supporting women who choose to notify their own partner(s)
- Providing HIV and STI education and counselling for clients, including demonstrating and promoting condom use
- Ensuring regular quality control of tuberculosis tests

Providing Male-Friendly Services

Definition

Male-friendly services are those that are welcoming and accessible for men, especially for male partners of maternal health clients. Ways of ensuring that services are male-friendly include improving the physical environment of a facility (e.g., adding signage, posters, and brochures that include men) and offering services that are sensitive to men's sexual health needs. This may also include providing new services specifically tailored to attract men, such as male sexual and reproductive health services, mental health services, STI services, and services for prostate and testicular cancer.

Rationale

Pregnant and postpartum women are at an increased risk of HIV and STI infection because men are more likely to have other sex partners during pregnancy, while women are more likely to be faithful and to abstain or to decrease their sexual activity during pregnancy. Men may be more receptive to HIV and STI prevention during their wife's pregnancy because they are concerned for the health of their wife and future child. Maternal health services can take advantage of this opportunity to improve men's awareness and support for their partner's reproductive health choices and to encourage greater personal responsibility for both HIV and STI prevention and family planning.

Male-friendly services include:

- Providing training to ensure that staff are knowledgeable about and comfortable with talking to men about HIV and STI prevention, male sexual and reproductive health, and family planning, including sensitive topics such as violence, sexual dysfunction, etc.
- Integrating male services into existing female-oriented services (if appropriate)
- Providing stand-alone services for men (if feasible)
- Designing male-focused IEC activities to improve men's knowledge about HIV/AIDS and STI prevention, family planning, and other aspects of reproductive health
- Giving information on HIV prevention to men directly, not only via their female partners
- Revising hospital regulations that restrict men's access to obstetric and gynaecological departments and other areas in ways that do not compromise the modesty of the women in the wards
- Setting clinic hours that accommodate both women's and men's work schedules
- Helping service providers remove facility and staff biases (through training) that may be an obstacle to providing services to men
- Considering the interests of men when planning couples counselling (e.g., including topics of relevance to men, such as sex during pregnancy)
- Ensuring that existing services are well-linked and culturally appropriate (e.g., some mosques having health education facilities and a school, which can be important venues for education aimed at men)

Improving Access for Young Pregnant Women

Definition

Youth-friendly health services are welcoming, confidential, accessible, and affordable. HIV and STI services for young pregnant women can be part of freestanding clinics for youth or can be attached to existing clinics or recreational facilities. Besides HIV and STI services, such services often include a full range of health services and information for young women, including sexual, reproductive health, and family planning services, life-skills counselling, and drug and alcohol counselling.

Rationale

Young women are hard to reach, particularly those who are not in school. They also are less likely to have money, have limited access to the information they need to protect themselves, are often in relationships where they have little power over their sexual and reproductive health, and may face stigma and discrimination at home, in their communities, at school, and within the health care system. Many young women also find themselves pregnant without ever having received reproductive health or family planning services, often for social and economic reasons. Improving access for young pregnant women can help address their HIV/STI prevention needs, as well as providing an opportunity for sexual and reproductive health counselling.

Improving access for young pregnant women includes:

- Providing training to ensure that staff are knowledgeable about and comfortable with talking to young women about HIV and STI prevention, adolescent sexual and reproductive health, and family planning, including sensitive topics such as drug and alcohol use, gender-based violence, etc.
- Involving youth in all aspects of programme planning
- Ensuring privacy and confidentiality
- If appropriate, integrating specific services for young pregnant women into existing female-oriented services
- If feasible, providing stand-alone services for young women
- Using peer educators and counsellors

(continued)

- Providing basic information on issues such as adolescent sexuality, family planning, reproductive health, and HIV/AIDS and other STIs
- Completing a risk assessment and providing prevention counselling on HIV/STI risk-reduction strategies, on negotiating with partners, and on dual protection
- Demonstrating proper condom use and promoting the use of both male and female condoms
- Developing IEC materials that address specific needs of young pregnant women, including life skills, stigma, etc.
- Increasing male support and involvement (Some young pregnant women may be more likely to accompany their partners to HIV and STI services than to attend on their own.)
- Building and strengthening partnerships with groups and organisations working with youth (e.g., most schools having health education programmes, or youth groups having radio programmes or youth magazines)

Making Services Friendlier for Stigmatised Populations

Definition

Stigmatised populations of pregnant and postpartum women may include sex workers, women who exchange sex for goods or services, single pregnant women, women with a history of mental illness, women with a history of STIs, injecting drug users or partners of injecting drug users, partners of men with STIs, refugees, or members of other migratory groups. Making services more friendly to such individuals involves building a sense of trust and respect between the client and service provider, by ensuring that providers have a good understanding of the needs of diverse groups of women. This understanding should be reflected both through the physical environment of the facility (e.g., that providers are friendly and welcoming, and that service hours accommodate the needs of the women) and through the specific services offered to these women (e.g., mobile HIV and STI management services in the community, outreach services, life-skills counselling, drug and alcohol counselling, and income generation, among others).

Rationale

Some pregnant and postpartum women are stigmatised in communities and at health care facilities because of the perception that their sexual and drug-use practises are morally wrong, that the particular socioeconomic predicament they find themselves in is their own fault, or that they are just different. As a result, they often do not receive equal treatment or care from health care workers. Stigma and discrimination are key factors contributing to vulnerability to HIV among women from diverse groups. To prevent HIV and STI infection among pregnant and postpartum women, it is imperative to address the needs of stigmatised populations of women while reducing stigma and discrimination within the health care system.

Making services friendlier to stigmatised populations includes:

- Providing training to ensure that staff are knowledgeable about and comfortable with talking to diverse groups of women about HIV and STI prevention, female sexual and reproductive health, and family planning
- Modifying hours and fee scales to accommodate clients' needs
- If feasible, providing stand-alone services for stigmatised populations or considering mobile services for hard-to-reach populations
- Using peer educators and counsellors from stigmatised populations, such as sex workers and women with a history of drug use, among others
- Providing regular screening, diagnosis, treatment, or referral for HIV and STI management services
- Promoting services such as VCT and PMTCT
- Providing culturally appropriate IEC materials
- Providing emergency contraception
- Completing a risk assessment and providing prevention counselling on HIV/STI risk-reduction strategies, on negotiating with partners, and on dual protection
- Demonstrating proper condom use and promoting the use of both male and female condoms
- Strengthening community outreach activities and collaborations with community health care workers to reach some of these diverse groups

Universal Precautions

Definition

The term "universal precautions" refers to simple standards of infection control that are to be used in the care of all patients at all times to reduce the risk of transmission of bloodbourne infections (WHO, 2000).

Rationale

HIV and other bloodbourne infections (such as hepatitis B) may be transmitted in the health care setting from patient to health care worker, from patient to patient, or from health care worker to patient (WHO, 2000). The occupational risk of becoming infected with HIV from patients in health care settings is low (approximately 0.3%), in most cases is associated with needle-stick injuries, and is dependent upon consistent and correct application of universal precautions (WHO, 2000). The consistent and correct application of universal precautions in community and home-based care settings is also important for protecting health workers, clients, and family members from becoming infected with HIV and other STIs. Universal precautions are important not only to protect all health workers and patients, but also to create a climate of safety in which providers feel they can give proper care without stigmatising patients based on their perceived HIV status and in which pregnant and postpartum clients feel they can seek care without risking their health or being discriminated against.

Applying universal precautions in health facilities includes:

- Regularly reviewing and updating infection control protocols
- Ensuring an adequate and reliable supply of infection control commodities
- Providing training to all staff on universal precautions, including health providers, cleaners, orderlies, etc.
- Ensuring that staff practise universal precautions consistently and correctly, including careful handling and disposal of needles and other "sharps," hand-washing before and after procedures, use of protective barriers such as gloves, gowns, aprons, masks, and goggles during direct contact with blood and other body fluids, safe disposal of contaminated waste, proper disinfection of instruments and other contaminated equipment, and proper handling of soiled linen
- Addressing postexposure care, including postexposure prophylaxis

Applying universal precautions in the community and the home includes:

- Providing IEC materials on universal precautions to traditional birth attendants, midwives, and family members
- Applying universal precautions in all situations where care is being provided in the community or the home
- Supporting midwifery associations in developing a peer-training module on universal precautions for midwives and traditional birth attendants
- Raising awareness in the community about the HIV risks associated with unsafe injections and cutting practises in the community (e.g., scarification and genital cutting, unsafe injections from lay health professionals, etc.)

Safer Delivery Practises

Definition

This intervention refers to reducing HIV transmission from an HIV-positive woman to her infant by adopting practises that minimise the infant's exposure to maternal blood during labour and delivery, as well as to reducing HIV transmission to an HIV-negative mother and the newborn by using proper infection control practises, including ensuring a safe blood supply. Safer delivery practises include avoiding unnecessary episiotomies, foetal scalp monitoring, prolonged labour, prolonged rupture of the membranes, routine artificial rupture of the membranes, and other trauma (e.g., unnecessary use of forceps), and ensuring adherence to universal precautions (such as sterility of instruments and injecting equipment and proper waste disposal). Many women deliver at home and rely on traditional birth attendants to assist them. Clean home delivery kits are now available to make home births safer.

Rationale

Given the potential risk for mother-to-child transmission of HIV during labour and delivery and the potential exposure of the mother to infected blood from failure to adhere to universal precautions, safer delivery practises (in combination with effective infection control practises) should be introduced as a routine part of the man-

agement of labour and delivery for all women, regardless of their known or supposed HIV status.

Applying safer delivery practises includes:

- Counselling pregnant women on birth preparedness
- Training providers to ensure skilled attendance at delivery
- Providing adequate labour and delivery supplies
- Ensuring that staff practise safer delivery practises at the health facility and in the home, including avoidance of unnecessary episiotomy, foetal scalp monitoring, prolonged labour, prolonged rupture of the membranes, routine artificial rupture of the membranes, and other trauma (e.g., unnecessary use of forceps)
- Ensuring that staff practise universal precautions during labour and delivery at the health facility and in the home
- Providing clean home delivery kits (if available)
- Providing elective caesarean section to reduce HIV transmission (if appropriate, safe, and feasible)
- Ensuring an available supply of safe blood for use in transfusion
- Providing comprehensive management of delivery complications
- Offering community education for women and their families regarding safer delivery practises, prevention of HIV transmission, and use of clean home delivery kits

Staff Training

Definition

Offering general and specialised HIV and STI training is an essential strategy for integrating HIV and AIDS prevention in maternal health services. Staff training entails sensitising all existing staff, through whole-site training, to ensure they have the same baseline knowledge about HIV/AIDS and other STIs and have positive

attitudes towards supporting HIV and STI prevention interventions at the facility, including interventions on gender sensitivity. It also involves providing more in-depth in-service training for staff members who will be providing more specialised HIV and STI services, such as counsellors, midwives, nurses, and doctors. In some cases, however, hiring extra staff will be necessary, and ensuring that they are adequately trained is also a part of an overall training strategy.

Rationale

Service providers must be confident of their ability to provide quality, gender-sensitive HIV/STI prevention services to pregnant and postpartum women. Service provision will be adversely affected if clients' trust in service providers is eroded by misinformation, stigma, and discrimination. Maternal health services already suffer shortages of trained staff. Whole-site, specialised in-service, and preservice training can help address these shortages.

Staff training includes:

- Assessing the general and specialised HIV and STI training needs of staff (Activity A3, pages 103–108, will help you assess the training needs of your staff. You can also refer to Chapter 3 for an overview of the various training topics pertinent to providing HIV and STI interventions.)
- Identifying training priorities and formulating a training implementation plan
- Identifying the level at which training will be conducted (centralised, regional, or on the job)
- Developing training objectives and a training curriculum (It is also possible to adapt already existing training curricula. The curriculum outlined in the Training Guide can be used in its entirety or adapted as needed.)
- Identifying competent trainers at the facility or district level who can help deliver the training
- Providing job aids to assist providers in following the training (Providers can use the Key Messages Card to remind themselves of the essential information to convey to pregnant and postpartum women during client-provider interactions or to incorporate in IEC materials.)
- Employing professional counsellors to support and mentor newly trained counsellors
- Following up with trainees and monitoring their attitudes and skills

Facilitative Supervision

Definition

Facilitative supervision is an approach to supervision that emphasises the supervisor's role in facilitating a process of ongoing quality improvement that is shared by both managers and staff. It emphasises mentoring, joint problem-solving, and two-way communication between a supervisor and those being supervised.

Rationale

Staff may feel initially overwhelmed by HIV and STI issues that are beyond the scope of what they can accomplish within current HIV and STI services or by referring clients to other HIV and STI services. Facilitative supervision aims to reinforce staff's positive skills and determine what additional skills they need to work with pregnant women and their partners in the area of HIV and STI prevention. Health care staff function best—and so meet the needs of their clients best—in a supportive work environment in which supervisors and managers value and encourage quality improvement and provide staff with the support needed to enable them to perform their tasks well.

Key elements for facilitative supervision include:

- Creating an environment of teamwork in which change and improvement in the quality of HIV and STI prevention services can flourish
- Facilitating joint problem-solving, with full staff participation and the use of simple, practical tools to foster the quality improvement process
- Coaching and mentoring staff
- Providing whole-site, in-service, and preservice training opportunities to meet staff needs for information, training, and development
- Meeting staff needs for supplies, equipment, and infrastructure

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CHAPTER 3

TRAINING TOPICS

From *HIV Prevention in Maternal Health Services: Programming Guide*
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This chapter describes different types of training that you can consider for your staff, including whole-site training and in-service training, to ensure they have the capacity to deliver the HIV and STI interventions that you will include in your programme design. The description of each training topic includes a definition, why it is important in the context of HIV and STI service delivery for pregnant and postpartum women, and the key issues to cover in training, including gender sensitivity.

In considering these training topics, each service-delivery setting should evaluate its capacity for undertaking training initiatives and what additional technical assistance will be needed and where it can be obtained. Think about contacting the district or regional office of your Ministry of Health or nongovernmental agencies in your district or region to see what training assistance and resources already exist or are offered.

Basic HIV and STI Orientation

Definition

For HIV and STI prevention services to be effectively integrated into maternal health services, the whole health delivery site needs to be involved in training about HIV and STIs. A basic orientation on HIV/AIDS and other STIs should provide staff with the same baseline knowledge, skills, and attitudes about HIV and STI prevention, HIV and STI services, and awareness of sexuality and gender issues.

Rationale

All staff at a site, from counsellors to cleaning attendants, can play an important role in HIV prevention. They should feel comfortable working with both HIV-negative and HIV-positive clients, as well as with clients of unknown status. This will help ensure that clients are provided with clear and correct information on available HIV and STI services, as well as create a warm and welcoming atmosphere for clients, free of stigma and discrimination.

Key issues to cover in a basic orientation on HIV and STIs include:

- Clarifying general values, beliefs, and attitudes about sexuality, pregnancy, and gender dynamics
- Understanding how HIV is transmitted during pregnancy and what the key prevention messages are
- Understanding women's HIV risk during pregnancy
- Understanding the underlying biological, social, gender-related, political, legal, and economic factors contributing to women's HIV vulnerability during pregnancy
- Understanding the advantages and disadvantages of voluntary counselling and testing (VCT)
- Understanding the importance of prevention of mother-to-child transmission (PMTCT) of HIV
- Understanding the risks and benefits of various infant feeding options
- Demonstrating the use of both male and female condoms
- Understanding the importance of promoting condoms and of counselling women on condom use in the postpartum period
- Understanding dual protection and how to counsel women on dual protection
- Understanding how to make services more friendly to men
- Understanding and applying standard infection control practises
- Practising applying key prevention messages for pregnant and postpartum women

Group Education Strategies

Definition

Training on group education includes helping providers develop group facilitation skills, instructing them on how to use educational aids such as posters, videos, etc.,

and explaining how to impart basic HIV and AIDS information in a clear and concise manner. In some settings, it may also include training providers on conducting pretest counselling with groups of women and men in reception or waiting areas or in maternal health services. Providers will also need training on how to undertake group education sessions with men, such as on tailoring key messages, selecting appropriate media for communicating messages, creating appealing spaces for men to learn in (regardless of their age or marital status), and helping men learn to communicate with their partners.

Rationale

Through training on group education, providers can take advantage of multiple opportunities to reinforce prevention and risk-reduction behaviours such as condom use, including dual protection. Providers can also better understand that by engaging women and their male partners during antenatal and postpartum family planning and well-baby clinic visits, they can refer and support clients to use other HIV/STI services, such as prevention counselling, VCT, STI management, and PMTCT.

Key issues to cover in training on group education strategies include:

- Integrating prevention messages (outlined on the Key Messages Card) in group education activities and materials
- Practising group facilitation skills for imparting clear and correct information on HIV and STI prevention
- Demonstrating the correct use of the male and female condoms and promoting their use
- Developing coordination skills in planning, conducting, and evaluating creative health education sessions aimed at HIV and STI prevention, promotion of VCT and STI services, and condom use
- Practising counselling skills for supporting clients to maintain effective risk-reduction strategies and communication with partners
- Practising mentoring skills for engaging men to influence their peers and stimulate changes in social norms within their communities

Core Counselling Skills

Definition

Training on core counselling skills involves developing the provider's counselling and communication skills so that he or she is able to both provide information to clients and elicit it from clients in an effective way, as part of a client-centred, two-way dialogue.

Rationale

Communicating effectively by feeling comfortable with discussing and addressing issues associated with sexuality, gender, and HIV/AIDS and other STIs is critical to counselling pregnant and postpartum women about HIV/STIs. Receiving training on core counselling skills will help providers feel at ease and help them put their clients at ease, in supporting clients to discuss specific risks and preventive actions in detail. It should also help providers overcome personal and professional biases that may impede a nonjudgemental and enabling counselling process. This training should be provided before any other counselling training is undertaken.

Key issues to cover in training on core counselling skills include:

- Creating a comfortable atmosphere for the client
- Developing good communication skills, including listening, paraphrasing, and asking open-ended questions
- Developing an awareness of personal values and biases and being respectful and nonjudgemental
- Developing a comfort level with sexuality and with discussing it
- Eliciting information effectively by demonstrating empathy and encouragement
- Presenting information accurately and clearly
- Effectively communicating prevention messages (outlined on the Key Messages Card) in all interactions with clients

Individual Counselling Strategies

Definition

HIV prevention counselling is typically an individual, one-on-one process. Training providers on individual counselling strategies for HIV prevention builds on their core counselling skills to enable them to:

- Explore the pregnant woman's perception of her risk of becoming infected
- Explore prevention strategies that she feels she will be able to carry out
- Provide information about the risk to herself and her baby of acquiring the infection during her pregnancy, labour, and delivery and in the postpartum period
- Demonstrate proper condom use and support the woman in developing communication skills to negotiate condom use with her partner

Rationale

Training on individual counselling strategies is critical in preparing providers to help pregnant and postpartum women perceive their risk of HIV/AIDS and other STIs, make decisions about what risk behaviours they can change, and identify appropriate risk-reduction strategies, given the women's particular social and personal context. Training should also help providers understand the behaviour change process and strategies for maintaining healthy behaviours.

Key issues to cover in training on individual counselling strategies include:

- Using a risk-assessment tool
- Developing counselling skills for asking sensitive questions in a nonjudgemental manner and framing follow-up questions to facilitate information-sharing by the client
- Creating a safe and comfortable environment for discussing sexuality, gender, and HIV/AIDS and other STIs
- Screening for gender-based partner violence
- Learning about community-based support for women experiencing violence

(continued)

- Practising counselling skills for helping clients explore their risk for HIV, STIs, and unintended pregnancy
- Developing counselling skills to promote realistic and achievable outcomes
- Helping clients understand their misconceptions about HIV and STI risk
- Encouraging male involvement
- Practising counselling skills for helping women communicate with their partner about risk reduction, including condom use
- Helping women think through the consequences of any actions they take with respect to risk reduction
- Helping women maintain healthy behaviours through ongoing follow-up and support
- Promoting support networks and support groups among women and couples
- Demonstrating correct condom use and promoting condoms

Couples-Counselling Strategies

Definition

Training on couples counselling aims to enhance the providers' counselling skills so they can confidently and objectively support a couple through difficult issues pertaining to HIV/AIDS and other STIs, different perceptions of HIV risk within the couple, the risks and benefits of getting tested for HIV, preparation for receiving the test results, disclosure of the test results, and facilitation of joint planning for risk reduction. Providers engaged in couples counselling should receive training on individual counselling and should gain some experience with this before undertaking work with couples.

Rationale

Given that some women lack power within their relationship, a woman's ability to initiate communication related to sex, to negotiate sexual behaviour that would protect her from infection, or to share her HIV status with sexual partners may be

limited. For these reasons, providers should be prepared to support couples in addressing these issues. Couples counselling is an effective strategy both in the VCT process and in prevention counselling, in the absence of VCT services.

Key issues to cover in training on couples counselling include:

- Understanding power dynamics
- Developing counselling skills to address HIV status with couples
- Helping couples understand the risks and benefits of disclosing HIV status to other family members or to members of the community
- Developing counselling skills to reinforce current risk-reduction strategies among couples and to identify new ones

Counselling on Dual Protection

Definition

Counselling on dual protection[5] follows basic core counselling principles and can be a part of both individual and couples counselling. Training providers to counsel clients on dual protection prepares them to help clients simultaneously perceive their risks both of infection with HIV and other STIs and of pregnancy and take appropriate actions to reduce these risks. Pregnant women should receive counselling about their need for dual protection before they resume sexual activity after a period of abstinence or reduced sexual activity. Ideally, such counselling should take place during the antenatal period, rather than wait until the postpartum period.

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[5] Dual protection can be defined as a strategy to prevent both transmission of HIV/STIs and unintended pregnancy through the use of condoms alone, through the use of condoms combined with other contraceptive methods (dual method use), or through the avoidance of unsafe sex. Options for avoiding unsafe sex include abstinence, avoidance of all types of unprotected penetrative sex, mutual monogamy between uninfected partners combined with a contraceptive method (for those wishing to avoid pregnancy), and delayed sexual debut (for young people).

Rationale

As a component of prevention counselling for pregnant and postpartum women, dual protection helps women understand their risk of infection and unwanted pregnancy and offers another means with which to protect themselves from unwanted pregnancies. It also provides women an opportunity to address condom use with their partners for preventing pregnancy, as opposed to preventing HIV/STIs. This is a particularly important risk-reduction strategy for women who are at increased risk for gender-based violence.

Key issues to cover in training on dual-protection counselling include:

- Developing and practising counselling skills to support women's ability to discuss dual-protection options and condom use with their partners
- Providing counselling on child spacing and access to contraceptives within the first six weeks of delivery
- Discussing the most appropriate contraceptive methods in the context of reducing risk of HIV infection
- Helping clients make decisions about pregnancy prevention and HIV and STI risk reduction
- Demonstrating proper condom use and promoting condoms

Counselling on Infant Feeding

Definition

Providers with core counselling skills can be trained to counsel HIV-positive pregnant and postpartum women on safer infant feeding options. They first need to understand mother-to-child transmission and how to prevent infection in the foetus or newborn child. They should also be familiar with the recommended infant feeding guidelines and with locally appropriate infant feeding options, so as to be able to counsel women on different options and support them in addressing barriers to maintaining their infant feeding decision.

Rationale

To make an informed decision about infant feeding, HIV-positive pregnant and postpartum women need to understand the risks and benefits of the most relevant options in the context of HIV. HIV-negative women and those who do not know their HIV status should be encouraged to breastfeed. Due to misinformation about replacement feeding, they might avoid breastfeeding without fully understanding its benefits for their infants and children.

Key issues to cover in training on infant feeding counselling include:

- Understanding infant feeding in the context of HIV
- Understanding the locally appropriate infant feeding options and being able to counsel and support women adequately on their infant feeding decision
- Practising counselling skills (e.g., listening, building confidence, giving support, and providing information) to discuss risks and benefits of different infant feeding options in the context of HIV, including nutritional requirements, replacement feeding versus breastfeeding, exclusive breastfeeding, bacterial infection, cost implications, family planning/child spacing, psychological stimulation, social and cultural factors, and breast problems
- Providing information to pregnant women and their partners about how HIV is transmitted in general, how it is transmitted to infants and young children, including through breastfeeding, and how risk is increased if a mother becomes infected with HIV at the end of pregnancy or during breastfeeding (as viral load is initially higher when one is newly infected)
- Understanding the five major criteria for determining if replacement feeding is appropriate for HIV-positive women, including acceptability, feasibility, affordability, sustainability, and safety[6]
- Practising counselling skills to support a woman's ability to discuss with her partner(s) the implications of mother-to-child transmission and of her infant feeding decision for the health of the child
- Understanding a range of contraceptive options to enable a timely postpartum decision without stress, especially in the case of nonbreastfeeding mothers, with an emphasis on dual protection against HIV/STIs and pregnancies afforded by condoms

(continued)

[6] For a more detailed explanation of infant feeding in the context of HIV, see page 48 in the accompanying training guide.

- Demonstrating the correct way to breastfeed
- Understanding the most common challenges and solutions associated with sustaining exclusive breastfeeding during the first six months
- Understanding the importance of providing counselling and support on infant feeding at various points in the provision of maternal health care[7]

Voluntary Counselling and Testing

Definition

In addition to being trained on core counselling skills and prevention-counselling skills, providers undertaking VCT also need training to help them understand the importance of building client trust so as to obtain the client's informed consent for HIV testing. Such training should also prepare the provider to understand how to conduct pretest and posttest counselling in a way that respects and protects the client's confidentiality, including emotional support techniques. In addition to counselling skills, providers also need to understand the different testing strategies and protocols.

Rationale

Given that VCT is the entry point for many other services for both HIV-negative and HIV-positive pregnant and postpartum clients, it is extremely important that providers receive adequate training so as to be able to offer VCT in a nonjudgemental and confidential manner. Quality VCT services can help widen access to other HIV/STI services, by maximizing the number of pregnant and postpartum women who return for their test results.

[7] An HIV-positive pregnant woman should be counselled one or more times during pregnancy after her test results are known, immediately after she gives birth, and within 10 days of birth, to make sure she is able to practise the option she selected.

Key issues to cover in training on VCT include:

- Understanding relevant national HIV testing policies and guidelines
- Understanding different HIV testing strategies and protocols, including the importance of quality control of testing technologies
- Understanding the advantages and disadvantages of different VCT models
- Understanding confidentiality
- Understanding informed consent
- Developing good communication skills (if not addressed in previous training)
- Helping clients understand the risks and benefits of VCT
- Practising applying pretesting and posttesting guidelines
- Practising emotional support techniques
- Helping clients understand the risks and benefits of various options for disclosing their HIV status to partners and other family members
- Using role plays to help clients communicate with their partners about using condoms, getting tested, and disclosing HIV test results
- Helping clients involve their partners in the VCT process
- Understanding how to screen for risk of HIV, depression, suicide, gender-based violence, and abandonment, among others
- Helping clients develop a risk-reduction plan, communicate to partners about their plan, and maintain positive new behaviours

Management of Sexually Transmitted Infections

Definition

Training on STI management can help providers understand the links between HIV infection and other STIs. It should also help them understand the advantages and disadvantages of both the syndromic and aetiologic approaches to managing STIs, including STI syndromic protocols in their setting and the importance of HIV and syphilis screening in pregnant women. Since syndromic management relies on people's ability to recognise symptoms and present themselves for treatment, it is very important for providers to receive training on imparting information about the symptoms of STI syndromes to clients during counselling and health education ses-

sions. Many of the skills discussed under prevention counselling are directly relevant to training providers in managing STIs.

Rationale

Training providers on STI management is an integral part of HIV and STI prevention, because it supports pregnant and postpartum women in reducing their STI risk, as well as preventing transmission of STIs to their children and their partners. Training providers on routine syphilis screening will also help to minimise the consequences of untreated syphilis during pregnancy, which can infect babies and can cause neurological impairment, seizures, deafness, bone deformities, and death.

Key issues to cover in training on STI management include:

- Understanding the different STIs or syndromes and treatment protocols
- Understanding treatment options and how to enhance the effect of medication(s) in treating STIs
- Developing counselling skills to support clients in adhering to drug regimens
- Understanding a client's right to informed decision making
- Practising counselling skills to discuss with clients STIs, including the link between STIs and increased risk for HIV infection
- Helping clients understand their misconceptions about risks of HIV/AIDS and other STIs
- Practising counselling skills for helping women explore their risk for HIV, STIs, and unintended pregnancy
- Developing counselling skills for promoting realistic and achievable goals for reducing their risk
- Practising counselling skills to help women communicate with their partner about risk reduction, including condom use
- Encouraging male involvement
- Demonstrating condom use and promoting condoms
- Helping clients understand the risks and benefits of various options for notifying partners
- Communicating prevention messages (outlined in the Key Messages Card) in all interactions with clients

Providing Male-Friendly Services

Definition

Providers should receive sensitisation training about men's desire to be involved in reproductive health and family planning services and the services they require that will respond to these needs. Offering training to help providers better understand their own needs and roles is an integral part of introducing services for men. Providers' comfort with sexuality and understanding of their own feelings about gender-related issues can help them interact effectively with male clients, either individually or in a couple.

Rationale

Providers with training on how to promote and increase male involvement demonstrate increased comfort in working and communicating with male clients. This can help increase men's access to information and services, improve men's sexual and reproductive health, and promote the constructive role that men can play in family planning, maternal health, and the prevention of HIV and AIDS in their families and their communities.

Key issues to cover in training on providing male-friendly services include:

- Understanding ways to make services more appealing to male clients
- Understanding gender attitudes and biases
- Helping male clients understand the male and female reproductive physiology
- Developing comfort with demonstrating condom use and promoting condoms with male clients
- Practising counselling skills that help male clients explore their risks for HIV or STI infection and for unintended pregnancy
- Practising counselling skills that help male clients support their partners in making decisions about dual protection

Universal Precautions

Definition

Training on universal precautions involves ensuring that all service providers understand the facility's health and safety policies, as well as how to correctly and consistently practise universal precautions such as hand washing, needle disposal, handling and processing of sharp instruments, and proper waste disposal. Providers should also understand the low risk of HIV infection following occupational exposure and what precautions to take immediately if an injury occurs.

Rationale

Training on universal precautions has a significant impact on preventing HIV transmission in a facility or in the community. These precautions are part of an overall strategy to prevent HIV infection among pregnant and postpartum women and their family members and among providers, while ensuring that clients' rights are respected.

Key issues to cover in training on universal precautions include:

- Understanding facility health and safety policies
- Understanding the relationship between clients' right to safe health services and staff need for adequate infection control supplies
- Understanding and applying protocols for universal precautions
- Preventing needle-stick injuries and other injuries from sharp instruments
- Understanding and applying protocols for postexposure care

Safer Delivery Practises

Definition

Training on safer delivery practises involves ensuring that all health care providers understand the importance of adhering to standard practises for childbirth and to

procedures that reduce foetal contact with maternal blood and secretions, as well as observing universal precautions to protect HIV-negative mothers and their newborns from infection with HIV and other bloodbourne agents.

Rationale

Training on safer delivery practises has a significant impact on preventing MTCT during labour and delivery, as well as on preventing HIV transmission between the health provider and the client or between clients during labour and delivery.

Key issues to cover in training on safer delivery practises include:

- Understanding the clinical practises during labour and delivery that increase the risk of HIV infection from a mother to an infant
- Understanding how to safely manage labour and delivery in HIV-positive women and women of unknown HIV status
- Understanding the importance of consistently and correctly applying universal precautions during labour and delivery, to reduce the risk of HIV transmission to the mother and to the newborn

Reducing Stigma and Discrimination

Definition

Training to reduce stigma and discrimination aims to increase providers' knowledge about the modes and risk of HIV transmission, improve providers' attitudes about groups of individuals commonly stigmatised as a result of HIV, address underlying misconceptions about what it is like to live with HIV infection, and review infection control practises so as to address providers' fears about occupational exposure to HIV and ensure a safe environment for both the client and the provider.

Rationale

Stigma and discrimination related to HIV and AIDS are a persistent problem in maternal health facilities in many countries, particularly those hardest hit by the

HIV epidemic. Stigma and discrimination result in poor-quality care for pregnant and postpartum women who are infected or ill, may thus frighten potential clients in need of maternal health and HIV-related services and hinder them from seeking care, and undermine prevention efforts by limiting access to and utilisation of VCT services, STI management services, and PMTCT services.

Key issues to address in training to reduce stigma and discrimination include:

- Understanding the causes and consequences of HIV-related and AIDS-related stigma and discrimination, including gender dimensions
- Helping clients understand the risks and benefits of disclosing their HIV status
- Promoting clients' right to access services
- Promoting clients' right to carry a pregnancy to term
- Understanding and applying universal precautions

Facilitative Supervision

Definition

Training on facilitative supervision entails helping supervisors develop the qualities and skills they need to perform their roles and responsibilities, to access additional support as needed, to make time to meet and support the staff they supervise, and to encourage staff to solve problems pertaining to quality improvement. Facilitative supervisors require good communication and facilitation skills to focus on the needs of the staff they oversee and to ensure that staff have the supplies and training needed to do their jobs well.

Rationale

Training on facilitative supervision is a critical component of quality improvement and can support the integration of HIV and STI services for pregnant and postpartum women into existing maternal health services.

Key issues to cover in training on facilitative supervision include:

- Understanding facilitative supervision and quality improvement processes
- Understanding whole-site training
- Practising leadership skills to inspire and motivate others, foster trust, establish a nonthreatening environment, and promote teamwork
- Practising communication skills, especially active listening and constructive feedback (Other skills or techniques needed include open-ended questioning, paraphrasing, clarification, and verbal and nonverbal encouragement.)
- Practising facilitation skills to coach and train staff, involve staff in the quality improvement process, manage group dynamics, mediate conflicts, and plan meetings
- Practising team-building skills to encourage different levels of staff to work together, delegate and complete work through others, and manage different personalities

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APPENDICES

APPENDIX A

ACTIVITIES AND TOOLS IN SUPPORT OF PLANNING EFFORTS

APPENDIX A

From *HIV Prevention in Maternal Health Services: Programming Guide*
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Note: This section consists of activities and tools that program planners will find referred to in Chapter 1. They will be useful when implementing the measures discussed in this guide.

Activity A1 Completing a Rapid Assessment of Community Needs

Objectives

1. To learn more about the perceived needs of pregnant and postpartum women in your immediate setting regarding HIV prevention
2. To provide an opportunity for pregnant and postpartum women to discuss and share their experiences regarding sexuality, gender, and HIV and AIDS

Time

3 hours per discussion group

Materials

- Paper and pen
- Refreshments for the discussion group participants

Advance Preparation

1. Select the facilitation team.
   - Conducting a discussion group requires a small team, with at least a facilitator to guide the discussion and someone to take notes.
   - The facilitator should be a native speaker who can put people at ease.
   - The team should have substantive knowledge of the topic under discussion.
2. Select discussion group participants.
   - First, identify the types or groups of pregnant and postpartum women that should be represented in your assessment (such as young pregnant women, older women, sex workers, partners of injecting drug users, etc.). Ideally, you should hold one discussion group for each type of pregnant and postpartum women.
   - Second, identify people for each group who have a good understanding of the issues about which you are interested in learning. One of the best approaches

is to consult key informants who know the issues about which you are interested in learning more.
- One approach is for participants to be homogeneous, from similar socioeconomic and cultural backgrounds.
- Each discussion group should total from eight to 12 people.
- Ideally, the people in each discussion group should not know each other, as anonymity lowers inhibitions.

3. Prepare a discussion guide.
   - A discussion guide is an outline prepared in advance that covers the issues and topics to be discussed. A sample discussion guide is provided in Table A1, page 95.
   - Feel free to use this discussion guide in its entirety or adapt it to meet your needs. Make sure that the discussion guide allows some flexibility to pursue unexpected but related issues that will come up during the course of a discussion.
4. Gain the informed consent of the participants.
   - The participants must be fully informed about the purpose of the discussion group and about how the information will be used, how confidentiality of the information will be guaranteed, and when and how the information will be destroyed.
   - Informed consent to participate in the discussion group must be obtained from each participant.
   - You should consider developing a consent form and having the participants sign it before they arrive for the discussion group or just before the discussion group begins.
5. Ensure the confidentiality of the participants' information.
   - It is your responsibility to ensure that the information you gather is collected in an anonymous fashion and will be kept absolutely confidential.
   - Prior to the discussion group, ensure that there is a confidential place in which to store the notes from the discussion groups until they can be destroyed.
6. Decide on a time and location.
   - Discussion groups should be conducted in a location that allows for privacy.
   - Inform all participants of the time and place for the discussion group.
   - Consider offering the participants refreshments and reimbursement for their transportation. This will help ensure their attendance.

Steps for Conducting a Discussion Group

1. Convene a discussion group.
   - The facilitator should establish rapport by explaining the purpose and format of the discussion group.
   - Phrase questions carefully so as not to impede the discussion. Open-ended questions allow the participants to tell their own story and add details that may result in unanticipated findings.
   - Use probing techniques for fuller, clearer responses.
   - The note-taker should record the discussion. Notes should be extensive and should reflect the content of the discussion. If a tape recorder is available, you can also audiotape the discussion. When using audiotape, remember to include in the participant consent form descriptions of how the recorder will be used and when the audiotape will be destroyed or erased.
2. Summarise the information from the discussion group.
   - Shortly after each group interview, the facilitator and note-taker should summarise the information, the team's impressions, and any implications of the findings. A sample question guide to help you summarise the information is provided in Table A2, page 96.
3. Analyse the data.
   - After each group discussion, assemble the interview notes and summaries to analyse trends and patterns.
   - Prepare a report for the assessment team that includes the common trends and patterns from all discussion groups.
4. Destroy the raw data.
   - Once you have analysed the information from the audiotape and/or handwritten notes, destroy them by erasing the tape and by shredding or burning the handwritten notes.

Table A1. Discussion guide

Topic	Questions
Sexuality	In this community, how do you think most people feel about women's having sex during pregnancy or postpartum? What do you think are women's concerns regarding sex during pregnancy? What do you think are men's concerns regarding sex during pregnancy? How could providers make clients feel more comfortable talking about sex?
Gender	In general, what are the community standards for men's having more than one sexual partner? What are the community standards for women's having more than one sexual partner? Do you think that men and women are at different risk of getting HIV/AIDS or other STIs? If so, why? What can pregnant women do to protect themselves from HIV/AIDS and other STIs? What can men do to protect themselves? What can men do to protect their partners? Do you think that men and women in this community are open to using condoms? In general, how do women feel about using condoms? How about men? Do you think that men feel (or would feel) comfortable using our services? Why or why not?
Stigma	What contributes to people's fear of HIV or of those who are living with HIV and AIDS? What do people in this community believe are the causes of HIV and AIDS? Is it easy for someone to disclose his or her HIV status in your community? Why or why not? Do health providers at this facility treat client information, such as client's HIV status, as confidential? Are all pregnant and postpartum clients coming to this facility treated in the same way? Can you think of examples of any clients who are treated differently? If you thought you had HIV or another STI, where would you go to get tested and treated? Would you come to this facility for HIV or STI services? Why or why not?
Services	Do you have any suggestions for how we can improve the services currently offered or our facilities (i.e., waiting room, exam rooms)? Do you think there is any reason that pregnant and postpartum women are discouraged from using our services? If so, please explain. Are there specific groups of pregnant and postpartum women, such as young women or sex workers, whom you believe could benefit from our services? How do you feel about women's receiving HIV or STI services in a maternal health setting? What kinds of HIV or STI services could clients benefit from having that are not currently being offered here?

Table A2. Summary question guide

Topic	Summary Questions
Sexuality	What types of sexuality concerns would pregnant and postpartum clients like to address with providers? What are some specific suggestions for how providers could make clients feel more comfortable about discussing sexuality?
Gender	What are some of the community customs or taboos regarding sexual behaviour among men and women during pregnancy? How do pregnant and postpartum clients perceive the risks of HIV/AIDS and other STIs among men and women? Are there differences in how men and women in the community feel about condom use? Are pregnant and postpartum clients knowledgeable about the ways in which men and women can protect themselves from HIV/AIDS and other STIs? In general, do pregnant and postpartum clients believe that men would feel comfortable receiving our services?
Stigma	In general, are pregnant and postpartum clients fearful of HIV/AIDS and other STIs? If yes, what are some of the reasons why they are afraid? What are some common misconceptions that pregnant women have about HIV/STIs, or do clients seem well-informed? How do you think this fear is affecting their choices about whether to access HIV and STI services and about where they access these services? Are specific populations of pregnant and postpartum women more stigmatised than others in your community?
Services	What are some of the specific suggestions that pregnant and postpartum clients have given about improving services for pregnant and postpartum women? In general, how do pregnant and postpartum clients feel about addressing HIV and STI concerns in a maternal health setting?

Activity A2 Completing a Rapid Assessment of Existing Services in the Community

Objectives

1. To learn more about the HIV/STI services offered in the community by other governmental and nongovernmental organisations
2. To understand existing linkages and referral networks between various HIV and STI services in the community

Time

3 hours

Materials

- Paper and pen
- Flipchart
- Masking tape

Advance Preparation

1. Select the facilitation team and identify two to seven key programme managers and other staff members to participate in the assessment. Decide on a time and location and inform all of the participants.
2. Prepare the assessment tools. A sample worksheet (Table A3) and discussion guide (Table A4) to help you with your assessment are provided on pages 99–102. Feel free to use the worksheet and discussion guide in their entirety or adapt them to meet your needs.

Steps for Completing a Rapid Assessment of Existing Services in the Community

1. Convene the meeting.
   - The facilitator should establish rapport by explaining the purpose and format of the meeting.
   - The note-taker should record the discussion. Notes should be extensive and should reflect the content of the discussion.

2. Fill in the worksheet.
   - Enter the name of each service-delivery facility you are assessing in the far left column on the worksheet (Table A3, page 99).
   - Enter the relevant information for each facility in each of the accompanying columns under the description of the facility and its HIV and STI services. For example, if you are assessing Facility X, you will need to fill in the relevant information for this facility under each of the columns, from the type of HIV and STI services offered to the funding sources for these services.
   - Use additional copies of the worksheet, as needed.
3. Summarise the information.
   - After completing the worksheet, you can use the questions in Table A4 (pages 100–102) to summarise the information.
   - After the group has completed both the worksheet and discussion guide, designate one or two people to follow up by making telephone calls or by visiting service sites to verify information or to discover services that may be unknown to your staff. For example, you may not know the funding sources for a particular facility and may need to ask the staff at the facility for this information.
   - If time permits, invite representatives from local nongovernmental organisations, government health facilities, traditional healers, and private providers to come and describe their services and to discuss their perceptions of community needs.
   - Alternatively, you could conduct this activity as a "mapping exercise," where a map of the community is drawn and the available services are placed in the appropriate locations.
4. Analyse the data.
   - Assemble the meeting notes, the answers to the discussion guide, and the worksheet to analyse trends and patterns.
   - Prepare a report for the assessment team that includes the common trends and patterns as well as gaps in services.

Table A3. Worksheet for completing a rapid assessment of existing HIV/STI services

Description of Organisation and HIV/STI Services								
Name of facility	Types of HIV/STI services provided	Location of services	Client characteristics	Hours of service	Cost	Relationship with your programme	Accessibility*	Funding sources

*If accessible to your clients, put yes; if not accessible, put no.

Table A4. Summary question guide

Topic	Summary Questions
Types of HIV or STI service-delivery sites	Who are the providers of HIV and STI services in the community? Service providers might include: ■ Government STI clinics ■ Government hospitals ■ Family planning associations ■ Private practitioners ■ Pharmacies ■ Nongovernmental organisations ■ Traditional healers ■ International agencies
HIV and STI services	What types of HIV and STI services are offered? Services may include: ■ Information, education, and communication ■ Group education strategies ■ Prevention counselling (including dual protection) ■ Counselling on infant feeding ■ Condoms (both male and female) ■ Linkages and referral systems ■ Building the capacity of traditional birth assistants, midwives, and community health workers ■ Community outreach ■ Voluntary counselling and testing ■ Syndromic management of STIs ■ Aetiologic management of STIs ■ Screening for tuberculosis ■ Male-friendly services ■ Access for young pregnant women ■ Services for stigmatised populations ■ Universal precautions against infection ■ Safer delivery practises ■ Prevention of mother-to-child transmission ■ Treatment, care, and support services ■ Staff training ■ Facilitative supervision What types of services does the community need but not currently receive?

(continued)

Table A4. Summary question guide *(continued)*

Topic	Summary Questions
HIV and STI services *(continued)*	Compared with the other providers, does your facility appear to have a special niche in service delivery (i.e., are you one of the few organisations that has community health workers, traditional birth attendants, or group education, or that works with partners of maternal health clients, etc.)?
Location of services	Where are HIV and STI services located? Are they stand-alone services or are they part of existing health services?
Client characteristics	What are the characteristics of the clients at each facility (i.e., age, sex, socioeconomic status, marital status, religion, etc.)? How does your client profile compare with that of other providers in the area (i.e., are your clients younger, older, wealthier, poorer, etc.)?
Hours of service delivery	What are the hours of service delivery? Are they convenient for clients?
Cost of services	What is the cost of services to clients? To what extent are there affordable services available to the community (i.e., free or sliding-scale services)?
Relationship of other services to your programme	What type of relationship (if any) do you have with these other providers? To which organisations would it be suitable to refer your pregnant and postpartum clients for services that you do not currently provide? With which organisations would you like to establish more formal ties? What is your plan for establishing ties with these organisations?

(continued)

Table A4. Summary question guide *(continued)*

Topic	Summary Questions
Accessibility of services	Do your own pregnant and postpartum clients utilise these services? To what extent are existing services from other providers convenient to your client base in terms of location and hours? Is there a subpopulation within the community that needs services but is not being reached by those currently provided (e.g., young pregnant women, sex workers, refugees, etc.)?
Sources of funding	How are most service-delivery sites funded in your setting? Government funds? Private funds? International donors? Are there existing funding sources that no other service-delivery site is accessing?

Activity A3 Completing a Rapid Assessment of Staff Training Needs

Objectives

1. To assess the human resource capacity of your facility, in terms of its ability to provide HIV and STI services
2. To determine the types of training required to ensure that your staff have the capacity to deliver HIV and STI services

Time

3 hours

Materials

Paper and pens

Advance Preparation

1. Select the facilitation team and identify two to seven key programme managers and other staff members to participate in the assessment. Decide on a time and location and inform all of the participants.
2. Prepare the assessment tools. A sample worksheet (Table A5) and discussion guide (Table A6) to help you with your assessment are provided on pages 105–108. Feel free to use the worksheet and discussion guide in their entirety or adapt them to meet your needs.

Steps for Completing a Rapid Assessment of Staff Training Needs

1. Convene the meeting.
   - The facilitator should establish rapport by explaining the purpose and format of the meeting.
   - The note-taker should record the discussion. Notes should be extensive and should reflect the content of the discussion.
2. Fill in the worksheet.
   - Answer the questions in the far left corner of the worksheet (Table A5, pages 105–107), by checking "yes" or "no" beside each question.

- Write comments under the "comments" column, if applicable. For example, under the subcategory of "knowledge/attitudes" (see item 1), if some but not all of the staff know basic facts about HIV and STI transmission, note in this area which groups of staff may need training.
- While competing the worksheet, it may be necessary to observe staff in their day-to-day activities and/or ask other staff about their training needs.
- Refer to Chapter 3 while completing this worksheet, for a description of various training topics to be considered.

3. Summarise the information.
   - After filling in Table A5, you can use the questions in Table A6 (page 108) to help you summarise the information.
4. Analyse the information.
   - Assemble the meeting notes, the completed worksheet, and the answers to the discussion guide to analyse trends and patterns.
   - Prepare a report for the assessment team that includes the common trends and patterns, as well as gaps in staff training needs.

Table A5. Worksheet for completing a rapid assessment of staff training needs

Human resource capacity	Yes	No	Comments
(1) **Knowledge/attitudes:** Do all staff know the basic facts about HIV and STI transmission?			
Do all staff know basic HIV and STI prevention recommendations?			
Do all staff have knowledge of sexuality and gender issues related to HIV and STI prevention?			
Do service providers know about the benefits and risks of maternal health practises in terms of HIV and STI transmission?			
Do all staff appear to have nonjudgemental attitudes regarding people with HIV/AIDS or other STIs?			
Have clinical staff received training in taking medical, sexual, and social histories related to HIV/AIDS and other STIs?			
Do service providers know and follow guidelines for HIV and STI risk assessment?			
Do staff understand the importance of routinely screening pregnant women for syphilis?			
Do staff have access to current reference books, guidelines, charts, posters, and other materials on HIV/AIDS and other STIs and on infection control?			

(continued)

Table A5. Worksheet for completing a rapid assessment of staff training needs ***(continued)***

Human resource capacity	Yes	No	Comments
Do all staff know how and where to refer pregnant and postpartum clients for HIV and STI information and services outside their area of expertise?			
(2) **Technical skills:** Have clinical and counselling staff received training on counselling skills related to HIV and STI prevention?			
Do staff have the communication skills to discuss sexual behaviour, pleasure, and dysfunction with clients?			
Do counselling staff have the skills to conduct adequate pretest and posttest counselling for HIV?			
Do clinical and counselling staff know how to explain condom use and do a demonstration using a penis model?			
Have clinical staff been trained in, and do they feel prepared to address, risk assessment, diagnosis and treatment, or referral of pregnant and postpartum clients with HIV/AIDS or other STIs?			
If applicable, do clinical staff know how to follow algorithms for syndromic management of STIs?			
If applicable, are laboratory staff trained in identifying and testing for STIs?			
Do all staff fully understand and carry out infection control practises (i.e., hand washing, waste disposal, etc.)?			

(continued)

Table A5. Worksheet for completing a rapid assessment of staff training needs *(continued)*

Human resource capacity	Yes	No	Comments
Do staff regularly participate in training to acquire new skills or to improve existing skills (for example, in counselling, safer delivery practises, or infection control practises)?			
(3) **Supervision:** Do all staff have a regular opportunity to explore their attitudes about HIV/AIDS and other STIs through on-the-job supervision?			
Do clinical supervisors have the skills to supervise diagnostic procedures?			
Do supervisors ensure that training activities take place regularly?			
Do supervisors have the skills to ensure quality of counselling?			

Table A6. Summary question guide

Summary Question Guide
1. Based on the checklist, in which areas are human resource capacities strongest? 2. In which areas are they weakest? 3. What concerns do you have about your facility's human resource capacities? 4. What steps do you need to take to strengthen human resource capacity in the weak areas? 5. What kind of training should be offered to all staff? (For example, is a basic orientation to HIV/STI services needed?) 6. What kind of training should be offered to doctors, nurses, counsellors, or other staff offering specialised HIV and STI services? (For example, should there be training on prevention counselling, voluntary counselling and testing, STI management, etc.?) 7. What kind of training should be offered to supervisors? (For example, should there be training on facilitative supervision?) 8. Based on the strengths of human resources, on which areas of HIV and STI prevention and management might your facility focus? 9. Do you have in-house training expertise to provide this training yourself? 10. What other resources can you access at the district, regional, or national level to assist you in providing the necessary training for your staff? (For example, does the Ministry of Health have trainers who can work with you to meet your staff's training needs?)

Activity A4 Making a Strategic Plan

Objectives

To develop a strategic plan that will provide the foundation for designing, implementing/monitoring, and evaluating your HIV/STI intervention(s).

Time

4 hours

Materials

Paper and pens

Advance Preparation

1. Select the facilitation team and identify two to seven key programme managers and other staff members to participate in developing a strategic plan. Decide on a time and location and inform all of the participants.
2. Prepare planning resources. Some tips on how to make a strategic plan are provided in Table A7 (pages 113–115), and a sample logical framework is illustrated in Figure A1 (page 111). Feel free to use these tools in their entirety, or adapt them to meet your needs.

Steps for Developing a Strategic Plan

1. Convene the meeting.
   - The facilitator should establish rapport by explaining the purpose and format of the meeting.
   - The note-taker should record the discussion. Notes should be extensive and should reflect the content of the discussion.
2. Compile the information for your framework.
   - Refer to the data you collected from your needs assessment, as well as the other data you collected through your situational analysis, as you make your strategic plan.

- Using the tips and examples provided in Table A7, develop written statements for the important information you want to capture for each of the five basic components of a strategic plan.
- The number of HIV or STI interventions that you end up prioritising in the design step will determine the number of objectives and activities in your strategic plan. Developing a strategic plan is an iterative process, moving back and forth between the design, monitoring, and evaluation steps.

3. Summarise your planning information.
   - Assemble the meeting notes and written statements for the five components of the strategic plan.
   - One of the most commonly used tools for planning is the "causal pathway framework." It is a chart that summarises the main features of a programme and the means by which you can assess your programme's progress. The programme activities form a hierarchy, illustrating the cause-and-effect relationship between the programme's overall goal, its immediate purpose, the outcomes or component objectives, the outputs or results, the activities needed to achieve the outputs, and the inputs (including time and human and financial resources) required to conduct the activities. By setting out the critical assumptions and risks that may affect programme feasibility, this kind of framework provides a means of checking the internal logic of the plan to ensure that it is consistent with the programme's overall vision.
   - Figure A1 (page 111) illustrates a causal pathway framework for one HIV and STI intervention—condom programming. Ideally, such a framework should include each intervention or strategy that you end up prioritising in the design step. This includes specific and clearly defined outputs, activities, and inputs that are linked to the objective(s) and goal(s) in your strategic plan.
   - This framework, along with other important information regarding your programmatic vision, information about HIV and AIDS prevalence in your setting, the programme budget, and monitoring and evaluation plans, among others, also should be included as a background document in your strategic plan.
   - Referring to Figure A2 (pages 111–112), use the strategic plan outline as a guide for integrating all of your information into one document.

Figure A1. Sample causal pathway framework

Objective: Provide quality HIV/STI prevention interventions integrated with maternal health services				
Type of HIV/STI intervention/strategy: Condom programming				
Inputs	**Activities**	**Outputs**	**Effects**	**Impact**
Health providers, financial resources for condom supplies, systems for ordering and tracking condoms	1. Providers will counsel each client on condom use. 2. Providers will distribute condoms to each client	1. Providers are adequately trained in HIV counselling, condom use, and dual protection. 2. Site is adequately stocked.	Increase clients' access to condoms by 100% by the end of the programme.	Reduce the number of new HIV infections among pregnant and postpartum women.

Figure A2. Sample outline for a strategic plan

Strategic Plan Components
1. Introduction
2. The HIV/AIDS situation in your setting ■ Epidemiological data from national surveillance system ■ Description of the limitations of the data ■ Description of HIV prevalence among pregnant and postpartum women ■ Description of infection rates through sexual transmission, vertical transmission, and injection drug use ■ Epidemiological data from national surveillance system
3. Social and economic impact ■ Estimated costs of HIV epidemic ■ Demographic implications (e.g., number of AIDS deaths, number of AIDS orphans) ■ Health system costs ■ Impact on labour force and on strategic sectors

(continued)

Figure A2. Sample outline for a strategic plan *(continued)*

Strategic Plan Components
4. Determinants and risk factors ■ Mobility and tourism ■ The sex industry ■ Sexual patterns associated with abstinence or decreased sexual activity during pregnancy and postpartum ■ Contributing social and behavioural norms ■ Role of lay health practitioners in providing unsafe injections and undertaking cutting procedures ■ Infection control at the facility and in the community ■ Mobilizing and coordinating an expanded multisectoral response ■ Policy and programme development at the national level ■ Prevention efforts nationally and within your setting ■ Sexual patterns of young pregnant and postpartum women ■ Access to HIV/AIDS treatment both for preventing vertical transmission and for the overall health of HIV-positive women ■ Availability of care and support programs for HIV-positive mothers, their children, and their partners ■ Gender inequalities ■ Stigma and discrimination
5. Major partners in the response ■ National government ■ International donors ■ Private sector, including nongovernmental organisations, community-based organisations, and private hospitals/clinics
6. Key gaps and opportunities identified in design step ■ Linkages with existing programmes and activities ■ Resource mobilisation ■ Implementation
7. Statement of priority areas and needs based on needs assessment
8. Explanation of how an HIV/STI programme fits with your current mission statement
9. Statement of expected goals, objectives, inputs, outputs, etc.
10. Statement of interventions/strategies and broad activities required to achieve plan (including a logical programme framework for each intervention/strategy)
11. Description of human resource requirements, based on a needs assessment
12. Inventory of physical assets and equipment requirements, based on a needs assessment
13. Cost analysis and financing strategy
14. Monitoring and evaluation framework (Include implementation, monitoring, and evaluation plans)

Adapted from: Synergy Project, 2002.

Table A7. Tips for defining clear goals, objectives, and targets in a strategic plan

Component of strategic plan	Tips	Example
Goals or impact are the most ambitious results that a programme might feasibly achieve within two to four years. They are the essential conditions to attain or problems to solve in the long term	■ The goal should be in line with your site's vision and should contribute to your mission. ■ Service-delivery sites with more than one programme will have strategic objectives for each programme contributing to the overall organisational goals. ■ Goals should also reflect national HIV and STI strategic goals and should be articulated in such a way to demonstrate how they link up with these broader goals.	Reduce the number of new HIV infections among pregnant and postpartum women

(continued)

Table A7. Tips for defining clear goals, objectives, and targets in a strategic plan *(continued)*

Component of strategic plan	Tips	Example
Objectives refer to specific short-term and long-term results, accomplishments, or desired endpoints that help meet the goal. Short-term objectives refer to those that are a relatively direct and immediate result of programmatic processes and outputs, such as pregnant and postpartum women's being better informed about condom use. Impact (or long-term) objectives refer to the results of programme processes in the longer term, such as increased access to condoms by pregnant and postpartum women.	When considering your objectives, make sure they are "SMART": ■ **Specific** (to avoid differing interpretations) ■ **Measurable** (to monitor and evaluate progress) ■ **Appropriate** (to the problems, goals, and strategies) ■ **Realistic** (achievable yet challenging and meaningful) ■ **Time-bound** (with a specific time frame for achieving the objective)	Provide quality HIV/STI prevention interventions integrated with maternal health services by the end of the five-year programme Increase the number of HIV/STI prevention interventions linked with treatment, care, and support services by the end of the five-year programme Increase community awareness about HIV prevention in pregnancy and the postpartum period, about gender inequities, and about HIV/AIDS-related stigma and discrimination by the end of the five-year programme
Outputs refer to the tangible, immediate, and intended products, services, or consequences of a programme activity that must be in place to meet the objective.		Needs assessments completed Providers trained and competent Referral systems in place Site adequately stocked IEC materials developed and distributed Monitoring/evaluation plan developed and implemented

(continued)

Table A7. Tips for defining clear goals, objectives, and targets in a strategic plan *(continued)*

Component of strategic plan	Tips	Example
Activities refer to the series of steps or procedures through which inputs are transformed to outputs, such as counselling pregnant and postpartum women on condom use. They include the technical and support tasks required to achieve the objective.	When writing your programme activities, consider the following: ■ The "what" and the "who" should be detailed in the description of each activity (e.g., **What** is the activity? **Who** is responsible for conducting the activity?). ■ Make sure the activity is linked to the objective. ■ List each activity separately (such as classes, counselling, training, etc.). ■ Prioritise activities according to project capabilities and time frame (the fiscal year). ■ Establish a time frame for accomplishing each activity within the fiscal year. ■ Finally, make sure the activity will help achieve the objective. Ask yourself, "Why are we doing this?"	Under condom programming, actions would include: ■ Counseling each pregnant or postpartum client on correct condom use ■ Distributing condoms to each client ■ Providing ongoing supervision
Inputs refer to the resources needed to support the activities and create outputs. These may be financial, human, or material.		External donor and local resources Human, financial, and technical resources

Activity A5 Completing an Assessment of Tools and Materials Required for Your Plan

Objectives

To assess the material resource capacity of your health district and/or service-delivery site, in terms of its ability to provide HIV and STI services

Time

2 hours

Materials

- Paper and pens
- Assessment tools

Advance Preparation

1. Select the facilitation team and identify two to seven key programme managers and other staff members to participate in the assessment. Decide on a time and location and inform all of the participants.
2. Prepare the assessment tools. A sample worksheet and discussion guide are provided on pages 118–122 to assist you in your assessment. Feel free to use the worksheet and discussion guide in their entirety, or adapt them to meet your needs.

Steps for Completing the Assessment

1. Convene the meeting.
    - The facilitator should establish rapport by explaining the purpose and format of the meeting.
    - The note-taker should record the discussion. Notes should be extensive and should reflect the content of the discussion.
2. Fill in the worksheet.
    - Answer the questions in the far left hand column of the worksheet (Table A8, pages 118–121), by checking "yes" or "no" beside each question.
    - Write comments under the "comments" column, if applicable (for example,

under the subcategory of "space" [see item 1], if a private space for counselling could be created out of a supply area).

3. Summarise the information.
   - After completing the worksheet, you can use the questions in Table A9 (page 122) to help you summarise the information.
4. Analyse the information.
   - Assemble the meeting notes, the completed worksheet, and the answers to the discussion guide to analyse trends and patterns.
   - Prepare a report for the planning team that includes the common trends and patterns, as well as gaps in tools and resources required for your plan.

Table A8. A worksheet for completing an assessment of the tools and materials required for your plan

Resource	Yes	No	Comments
1) **Space:** Does a private space exist where conversation for counselling cannot be overheard?			
Is there an appropriate private space with adequate light for performing pelvic examinations and for taking genital specimens?			
Does the facility have reliable electricity?			
2) **Laboratory:** Is there a laboratory in your clinic?			
If there is no laboratory, is there space to make one?			
Is a referral laboratory for sending and receiving samples for test confirmation and quality assurance available?			
3) **Educational materials:** Are educational pamphlets on HIV/AIDS and other STIs available?			
Are posters on HIV and STI prevention in the waiting room and exam rooms?			
Are flipcharts or other educational aids available for counselling clients on HIV and STIs?			
Can educational materials on other reproductive health issues be modified to include information on HIV and STI prevention and management?			
4) **Condom promotion:** Is a reliable supply of male condoms available?			
Is a reliable supply of female condoms available?			

(continued)

Table A8. A worksheet for completing an assessment of tools and materials... ***(continued)***

Resource	Yes	No	Comments
Do all clients (men, women, and adolescents) have access to free or affordable condoms?			
Are models for condom demonstration available?			
5) Voluntary counselling and testing supplies: Is there a reliable supply of test kits (minimum, two tests with different testing formats and referral, or in-house lab for a third tiebreaker test)?			
Are the following supplies and equipment available?			
■ Rapid-test kits			
■ Automated analyzer (for ELISA)			
■ Reagents and controls for ELISA testing (if appropriate)			
■ Centrifuges			
■ Refrigerator(s)			
■ Test tube racks			
■ Timers			
■ Pipettes and pipette tips			
■ Specimen tubes			

(continued)

Table A8. A worksheet for completing an assessment of tools and materials... ***(continued)***

Resource	Yes	No	Comments
6) **STI management supplies:** Is there a reliable supply of test kits and reagents?			
Is there a reliable supply of treatment drugs?			
Is the following equipment available?			
■ Speculum			
■ Exam table			
■ Exam gloves			
■ Exam drapes			
■ Light			
■ Instruments for IUD removal			
7) **Infection control supplies:** Is there a reliable supply of the following?			
■ Clean water, soap, and towels (i.e., hand-washing facilities)			
■ Pails for decontamination			
■ Chlorine			
■ Detergent			
■ Brushes			
■ Functioning sink			

(continued)

Table A8. Worksheet for completing an assessment of tools and materials... ***(continued)***

Resource	Yes	No	Comments
■ Utility gloves			
■ Functioning boiler/steamer			
■ Covered storage containers (for sharps and other medical waste)			
■ Equipment for sterilisation			
■ Protective eye gear and clothing			
8) **Financial resources:** Are there grants available for HIV and STI prevention for which your facility is qualified to apply?			
Have your regular funders expressed interest in supporting HIV and STI interventions			

Table A9. Summary question guide

Summary Question Guide
1. Based on the checklist, what material resources needed for HIV and STI work are readily available in your facility? 2. What material resources are lacking, or are difficult to obtain? 3. In general, based on the resources currently available or readily accessible, which aspects of HIV and STI prevention and management for pregnant and postpartum women would be most feasible for your facility to implement (e.g., the development and distribution of educational materials, the provision of laboratory testing for STIs, etc.)? 4. What steps need to be taken to secure the resources necessary for your facility to carry out the HIV and STI prevention and management activities identified in the previous question?

Activity A6 Prioritising Key HIV/STI Prevention Interventions for Your Setting

Objectives

1. To consider factors in your setting influencing the best approach to integrating HIV and STI interventions into existing maternal health services
2. To prioritise and select achievable HIV and STI interventions for your setting

Time

4 hours

Materials

Paper and pens

Advance Preparation

1. Select the facilitation team and identify two to seven key programme managers and other staff members to participate in prioritising your HIV/STI interventions. Decide on a time and location and inform all of the participants.
2. Prepare the planning resources. A sample worksheet and discussion guide are provided on pages 126–130 to assist you in your assessment. Feel free to use the worksheet and discussion guide in their entirety, or adapt them to meet your needs.

Steps for Prioritising Key HIV/STI Interventions

1. Convene the meeting.
   - The facilitator should establish rapport by explaining the purpose and format of the meeting.
   - The note-taker should record the discussion. Notes should be extensive and reflect the content of the discussion.
2. Fill in the worksheet.
   - The far left column on the worksheet (Table A10, pages 126–127) lists potential HIV and STI interventions for consideration (as described in Chapter 2).

The rows along the top of the worksheet list criteria to consider in selecting HIV and STI intervention(s) and in designing an HIV and STI programme for pregnant and postpartum women.

- You can use the following criteria illustrated in the worksheet while completing this activity, as well as developing other criteria that are relevant to your particular setting:
  - **Available resources (material/human):** Which HIV/STI activities can you do now or with few additional resources? Which options can be done with existing staff? Which options are most cost-effective and affordable?
  - **Potential impact:** Which activities will have the greatest impact on the quality of services for pregnant and postpartum women?
  - **Building on strengths:** Do any of these activities build on or improve upon existing programmes or projects?
  - **Greatest needs:** Which activities are designed to address clients' greatest needs (as perceived by pregnant and postpartum clients and assessed by the staff)?
  - **Feasibility:** Which activities are most realistic, given internal or external barriers, such as a conservative culture and limited resources and staffing, among others?
- Consider each of the interventions on the worksheet and rate them, from 1 (low priority) to 5 (high priority), for each of the criteria. For example, if a facility has abundant resources, it would be assigned a rating of 5 under the resource column for a given intervention.
- Add the points for each activity and write the total in the far right-hand column. The activity with the lowest total score has the lowest priority, while the activity with the highest total score has the highest priority. While you are completing the rating process, remember to refer to Chapters 2 and 3, as needed, for more information about each intervention and about training topics to consider under the staff training intervention.
- Many HIV and STI interventions for pregnant and postpartum women do not require abundant resources or a complex infrastructure. When you conduct this activity, before considering more specialised and expensive interventions (such as voluntary counselling and testing, STI management, tuberculosis screening, and prevention of mother-to-child transmission), consider integrating the following interventions as a basic or minimum HIV and STI package offered to all pregnant and postpartum women. (Appendix B provides examples of suggested programme designs for different settings.)
  - IEC materials, including pamphlets and posters

- Group education strategies
- Prevention counselling (including dual protection)
- Counselling on infant feeding
- Condom demonstration and distribution (both male and female condoms)
- Referral for voluntary counselling and testing, STI services, tuberculosis screening, prevention of mother-to-child transmission services, and treatment, care, and support services

Note: These tools are meant to be a guide in designing HIV/STI interventions. The results based on using these tools should be interpreted according to contextual factors in a given setting. For example, voluntary counselling and testing, although a more expensive intervention, may still end up being a top priority in a setting with high prevalence of HIV, despite cost or the level of service utilisation in the setting.

3. Summarise the information.
   - After filling in the worksheet, you can use the questions in Table A11 (pages 128–130) to help you summarise the information.
   - Refer to Appendix C for a summary of advantages and disadvantages of various service-delivery approaches to integrating HIV and STI interventions with maternal health services.

Note: It is important to remember that HIV and STI services may be integrated at any level in the health system or in the community. Besides planning new services or strengthening existing services, integration also involves establishing referral systems within a facility, between facilities, and between facilities and community organisations. Integration of HIV and STI services in maternal health settings may take place in any or all of the ways outlined in Appendix C.

4. Analyse the information.
   - Assemble the meeting notes, answers to the discussion guide, and the worksheet to analyse priorities and consider the best service-delivery approach to programme design.
   - Prepare a report for the design team that includes your top priorities, as well as the recommended service-delivery approach to integrating HIV and STI interventions.

Table A10. Worksheet for prioritising HIV/STI interventions

HIV/STI interventions	Available resources	Potential impact	Building on strengths	Greatest needs	Feasibility	Other factors	Total priority rating
IEC							
Group education strategies							
Prevention counselling							
Counselling on safer infant feeding							
Condom programming (male and female)							
Linkage and referral systems							
Building the capacity of traditional birth attendants, midwives, and community health workers							
Community outreach strategies							
Voluntary counselling and testing services							
Syndromic management of STIs							
Aetiologic management of STIs							
Screening for tuberculosis							
Providing male-friendly services							

(continued)

Table A10. Worksheet for prioritising HIV/STI interventions *(continued)*

HIV/STI interventions	Available resources	Potential impact	Building on strengths	Greatest needs	Feasibility	Other factors	Total priority rating
Improving access for young pregnant women							
Making services friendlier for stigmatised populations							
Universal precautions							
Safer delivery practises							
Staff training							
Facilitative supervision							

Table A11. Summary question guide

Topic	Summary questions
Resources	1. What financial resources do you have available to launch the new programme? 2. Are there any HIV-related resources in your setting that you can access? 3. Are there additional sources of funding or prospects for income generation that you may explore? 4. If you are in a **low-resource setting**, what basic HIV and STI interventions can you consider integrating that will not cost a lot of money or require new infrastructure? 5. If you are in a **high-resource setting**, are your resources sufficient to allow expansion of programmes to include voluntary counselling and testing, STI services, and PMTCT services? 6. Do you already have clinical services that you can strengthen? 7. Do you have a limited clinic (without a laboratory or voluntary counselling and testing services) or a full-service clinic?
Service utilisation	1. Do the majority of pregnant and postpartum women in your setting use antenatal and postpartum services? 2. How many pregnant women still deliver at home? 3. Does geography or the location of your services pose a barrier for some pregnant women's ability to access services? 4. If you are in a **low-utilisation setting**, how can you increase service utilisation to ensure that pregnant and postpartum women have access to HIV testing, prevention, treatment, care, and support? 5. What kinds of linkages can you develop with the community to increase utilisation? 6. Do you currently work with traditional birth attendants, midwives, and community health workers? 7. How can you help strengthen networks of these service providers? 8. If you are in a **high-utilisation setting**, how can you scale up your existing services? 9. Are there still some groups of pregnant and postpartum women who are not accessing services because of stigma and discrimination? 10. If so, how can you help strengthen community outreach efforts to reach these women?
HIV prevalence	1. Is your facility located in a high-prevalence or low-prevalence setting? 2. If you are in a **low-prevalence setting** (i.e., HIV prevalence is less then 1% in the general population and/or HIV prevalence

(continued)

Table A11. Summary question guide *(continued)*

Topic	Summary questions
	is 1% to 5% in concentrated subpopulations), what kinds of assumptions are you making that could influence the priority you assign HIV prevention in pregnancy? (*Note:* General population prevalence rates tend to hide concentrated local epidemics and can influence health workers and leaders into wrongly believing that HIV is not a problem and will not become a problem in their setting.) 3. Do you know what the distribution of risk is for various subpopulations (e.g., sex workers, women who exchange sex for goods or services, single pregnant women, women with a history of mental illness, women with a history of STIs, injecting drug users or partners of injecting drug users, partners of men with STIs, refugees, or members of other migratory groups)? 4. Are there any subpopulations of pregnant women at elevated risk of HIV infection that you can target with outreach efforts? 5. How can you strengthen the quality of existing referral systems for STIs, for voluntary counselling and testing, for PMTCT and for treatment, care, and support services? 6. How can you support other interventions for the general population that raise awareness about HIV, to reduce stigma and discrimination? 7. If you are in a **high-prevalence setting** (i.e., HIV prevalence is greater than 1% in the general population), how can you scale up existing STI and HIV counselling and testing, and prevention of mother-to-child transmission services to have a positive impact on the HIV epidemic? 8. How can you make services more comprehensive, so as not to miss any opportunities to provide counselling and HIV testing to pregnant women? 9. How can you provide outreach to pregnant women in HIV-vulnerable subpopulations? 10. How can programmes featuring traditional birth attendants, midwives, and community health workers increase their outreach to pregnant women in rural areas?
Need for targeted interventions	1. Who is your audience for services and what are their specific needs? 2. Are you considering approaches to more actively involve the male partners of pregnant clients in services (counselling, STI diagnosis and treatment, etc.)?

(continued)

Table A11. Summary question guide *(continued)*

Topic	Summary questions
	3. Do you already work with a large number of young pregnant women and therefore plan to develop specialised integrated services geared to their needs? 4. Are there any stigmatised populations of pregnant women, such as sex workers, who require services tailored to their specific needs? 5. Are many of your clients older women or women who have completed their desired family size (i.e., those who are towards the end of their reproductive years)?
Service adjustments	1. After your assessment of in-house material resources and staffing capacity, what can you realistically hope to accomplish? 2. Have you taken into account whether your facility has adequate space, privacy, and technical capacity and resources to provide counselling, diagnosis, and treatment services? 3. Which HIV or STI activities and strategies outlined in Chapter 2 are you thinking about integrating into your current services? 4. Given your resources, in-house capabilities (strengths and expertise), client needs, and available resources, what are you ready to take on? 5. Given your current approach to service delivery, how can you integrate HIV and STI services to minimise the extent of service adjustments? 6. Does it make more sense to have one person provide all of your HIV and STI services and have other providers refer clients to that person within your facility than it does to train several staff to provide such services? 7. Is it more feasible to have all providers offer the same minimum package of HIV and STI services and have certain providers offer specialised HIV and STI services? 8. Is it more feasible to refer your clients to specialised HIV and STI services off-site? 9. In other words, given all of the information gathered and the factors considered, what is a realistic goal for your programme? What are the corresponding activities and interventions? What is the best approach for HIV and STI service delivery? (Do not overreach.)

APPENDIX

APPENDIX B

EXAMPLES OF PROGRAMME DESIGN FOR DIFFERENT SETTINGS

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Examples of Programme Design for Different Settings

Setting or Context	Suggested Interventions	Rationale
Low HIV prevalence, low utilisation of services, low level of resources	A. Implement basic package[8] of HIV/STI interventions for all pregnant and postpartum women, including: ■ IEC materials, including pamphlets and posters ■ Group education strategies ■ Prevention counselling (including dual protection) ■ Counselling on infant feeding ■ Condom programming (both male and female condoms) B. Conduct referral for voluntary counselling and testing (VCT), STI services, tuberculosis screening, PMTCT services, and treatment, care, and support services	■ HIV epidemic is concentrated in high-risk groups. ■ No additional resources for equipment or infrastructure are needed. ■ No additional resources are needed for expanded traditional birth attendant, midwifery, and community health worker programmes and community outreach to vulnerable subpopulations of women. ■ Extensive training of providers is not required.
High HIV prevalence, high utilisation of services, low level of resources	A. Implement basic package of HIV/STI interventions, as outlined above B. Conduct referral for VCT, STI services, tuberculosis screening, PMTCT services, and treatment, care, and support services	■ Generalised and concentrated HIV epidemics ■ No additional resources for equipment or infrastructure ■ No additional resources for expanded traditional birth attendant, midwifery, and community health worker pro-

(continued)

[8] The basic package of HIV/STI interventions does not require abundant resources or equipment, and most staff can undertake these interventions with limited training.

Examples of Programme Design for Different Settings *(continued)*

Setting or Context	Suggested Interventions	Rationale
		grammes and targeted outreach to vulnerable subpopulations of women ■ No additional resources for staff training
Low HIV prevalence, low utilisation of services, high level of resources	A. Implement basic package of HIV/STI interventions, as outlined above B. Strengthen referral networks for VCT, STI services, tuberculosis screening, PMTCT services, and treatment, care, and support services C. Consider adding the following HIV/STI interventions: ■ Expanded traditional birth attendant, midwifery, and community health worker programmes ■ Targeted outreach to vulnerable subpopulations of women	■ HIV epidemic concentrated in high-risk groups ■ Additional resources for expanded traditional birth attendant, midwifery, and community health worker programmes and targeted outreach to vulnerable subpopulations of women ■ HIV prevalence rate may not justify investment in expensive equipment and infrastructure for VCT, STI management, tuberculosis screening, and PMTCT
High HIV prevalence, low utilisation of services, high level of resources	A. Implement basic package of HIV/STI interventions, as outlined above B. Strengthen referral networks for VCT, STI services, tuberculosis screening, PMTCT services, and treatment, care, and support services	■ Generalised and concentrated HIV epidemics ■ Additional resources for expanded traditional birth attendant, midwifery, and community health worker programmes and targeted outreach to vulnerable subpopulations of women

(continued)

Examples of Programme Design for Different Settings *(continued)*

Setting or Context	Suggested Interventions	Rationale
	C. Consider adding the following HIV/STI interventions: ■ VCT services ■ STI management services ■ Tuberculosis screening ■ PMTCT services ■ Treatment, care, and support services ■ Expanded traditional birth attendant, midwifery, and community health worker programmes ■ Targeted outreach to vulnerable subpopulations of women ■ Community outreach to general population	■ Additional resources for training staff ■ Availability of other VCT, STI management, tuberculosis screening, PMTCT, and treatment, care, and support services may meet current demand or may be necessary to provide your own services and mobilise community to use them
High HIV prevalence, high utilisation of services, high level of resources	A. Implement basic package of HIV/STI interventions, as outlined above B. Add the following HIV/STI interventions: ■ VCT services ■ STI management services ■ Tuberculosis screening ■ PMTCT services ■ Treatment, care, and support services ■ Expanded traditional birth attendant, midwifery, and community health worker programmes ■ Targeted outreach to vulnerable subpopulations of women ■ Community outreach to general population	■ Generalised and concentrated HIV epidemics ■ Additional resources for expanded comprehensive HIV/STI services ■ Additional resources for training staff ■ Demand for services justifies rapid scale-up of comprehensive HIV/STI services

APPENDIX C

APPROACHES TO HIV/STI SERVICE DELIVERY IN MATERNAL HEALTH SETTINGS

APPENDIX C

From *HIV Prevention in Maternal Health Services: Programming Guide*
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Approaches to HIV/STI Service Delivery in Maternal Health Settings

Approach	Advantages	Disadvantages
One health provider at a health clinic offers all health services, including comprehensive HIV/STI services and maternal health services.	■ Potential for stigma is less when services are part of routine maternal health programmes. ■ Every client-provider interaction involves HIV/STI prevention.	■ Depending on location of clinic, direct referral to relevant HIV-related care may not be possible. ■ There may be dilution of services and potentially lower-quality HIV/STI services. ■ Quality assurance may be more difficult to implement. ■ Management capability to run complex programmes may be limited. ■ Potential for provider burn-out is higher. ■ Providers require more specialised training, which can be time-consuming. ■ Cost of laboratory equipment can be high.
Health provider(s) at a maternal and child health unit in a hospital or health clinic offer basic HIV/STI services and refer clients either on-site or off-site for more specialised HIV/STI services.[9]	■ Potential for stigma is less when services are part of routine maternal health programmes. ■ Every client-provider interaction involves HIV/STI prevention. ■ Direct referral to relevant HIV-related treatment and care is possible. ■ There is potential for high volume of clients. ■ Capacity for scale-up is great.	■ There may be dilution of services and potentially lower-quality HIV/STI services. ■ Quality assurance may be more difficult to implement. ■ Management capability to run complex programmes may be limited. ■ Client waiting times may be long. ■ Potential for provider burn-out is higher.

[9] Specialised interventions include VCT, STI management, PMTCT, and treatment, care, and support services. Specialised interventions require greater resources and infrastructure, such as laboratories, quality control of tests, drug procurement, etc., as well as specialised training in VCT, STI management, etc.

Approaches to HIV/STI Service Delivery in Maternal Health Settings *(continued)*

Approach	Advantages	Disadvantages
		■ Providers require more specialised training, which can be time-consuming. ■ Cost of laboratory equipment can be high.
Health provider(s) at a maternal and child health unit in a hospital or health clinic offer comprehensive HIV/STI services.	■ Potential for stigma is less when services are part of routine maternal health programmes. ■ Every client-provider interaction involves HIV/STI prevention. ■ Direct referral to relevant HIV-related treatment and care is possible. ■ There is potential for high volume of clients. ■ Capacity for scale-up is great.	■ There may be dilution of services and potentially lower-quality HIV/STI services. ■ Quality assurance may be more difficult to implement. ■ Management capability to run complex programmes may be limited. ■ Client waiting times may be long. ■ Potential for provider burn-out is higher. ■ Providers require more specialised training, which can be time-consuming. ■ Cost of laboratory equipment can be high.
Traditional birth attendants, midwives, and community health workers linked with a maternal and child health unit in a hospital or health clinic offer basic HIV/STI services and refer clients to	■ Access for populations not using other integrated services or for rural populations is improved. ■ Staffing hours can be flexible. ■ Potential for stigma is less, as services are delivered in venues the client frequents.	■ Confidentiality of services and follow-up are difficult to ensure. ■ Capacity to deliver more specialised HIV/STI services is limited. ■ Quality assurance is difficult.

(continued)

Approaches to HIV/STI Service Delivery in Maternal Health Settings *(continued)*

Approach	Advantages	Disadvantages
more specialised HIV/STI services at the hospital, health clinic, or antenatal care unit.		
Provider(s) at a maternal and child health unit in a hospital or health clinic offer mobile VCT services and refer clients to a hospital, health clinic, or maternal and child health unit for more specialised services.	■ Access for stigmatised populations such as sex workers and injecting drug users is improved. ■ Access for marginalised and/or rural populations is also improved.	■ Experience with this approach is limited. ■ Approach requires programme to assume the cost of a transport vehicle. ■ Confidentiality of services and follow-up are difficult to ensure. ■ Quality assurance is difficult. ■ Potential for stigma is less.
Community organisations offer comprehensive HIV/STI services and refer clients to a maternal and child health unit for routine antenatal care and/or management of complications related to pregnancy or unsafe abortion.	■ Management may be improved due to limited focus. ■ Staffing and clinic hours can be flexible. ■ Quality assurance may be easier because of limited focus. ■ Potential for stigma is less, as services are delivered in the community.	■ Approach is contingent on outside funding. ■ Capacity to scale up services is limited. ■ Approach may divert resources from other core activities, such as advocacy.

APPENDIX D

APPENDIX D

RAPID APPRAISAL METHODS FOR COLLECTING BASELINE, MONITORING, AND EVALUATION DATA

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Rapid Appraisal Methods for Collecting Baseline, Monitoring, and Evaluation Data

Method	Characteristics	Rationale
Key informant interview	■ Open-ended questions on a topic of interest are posed to individuals selected for their knowledge and experience. ■ Interviews are qualitative, in-depth, and semistructured. ■ Interview guides list topics or questions. ■ Method can be used to gather information from both clients and providers.	Method is appropriate when: ■ Time, funding, and personnel are limited. ■ In-depth information is required about a small number of topics. ■ The topic is very sensitive.
Focus-group discussion	■ Eight to 12 carefully selected participants with similar backgrounds participate in a facilitated discussion. ■ The facilitator uses a discussion guide. ■ Note-takers record comments and observations.	Method is appropriate when: ■ Time, funding, and personnel are limited. ■ In-depth information is required about a few topics. ■ The topics are not sensitive.
Direct observation	■ A detailed observation form is used to record what is seen and heard at a programme site. ■ The information may be about ongoing activities, processes, discussions, social interactions, and observable results.	Method is appropriate when it is necessary to observe an organisation or group of people, much like an ethnographer would.

(continued)

Rapid Appraisal Methods for Collecting Baseline, Monitoring, and Evaluation Data *(continued)*

Method	Characteristics	Rationale
Minisurvey	■ A structured questionnaire with a limited number of closed-ended questions is administered to 50 to 75 people. ■ Respondents may be selected randomly or purposefully.	Method is appropriate when: ■ It is necessary to quantify responses. ■ Group or peer pressure (as in focus groups) would inhibit responses and cloud the meaning of results.
Document reviews	Periodically review existing documents and reports, including: ■ Client service statistics ■ Staff training records ■ Monthly or quarterly reports ■ Programme reports and studies ■ Clinic inventories of supplies and commodities	Method is appropriate when: ■ It is necessary to quantify program results. ■ Information is already available or being collected on an ongoing basis.