Ensuring choices, providing services

Promising practices in HIV prevention

UNFPA

2013/14

ABOUT THIS REPORT

UNFPA East and Southern Africa works with 23 countries in the region to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled.

The East and Southern African (ESA) Region of the United Nations Population Fund, UNFPA, is host to 18 countries in which the HIV epidemic has been classified by UNAIDS as high burden, severe/hyper-endemic or concentrated endemic with geopolitical relevance.

Gains in addressing HIV can only be made and sustained if HIV is addressed within the context of UNFPA's mandate areas. The focus of our mandate on adolescents, young women, and women in particular, will remain central to our HIV interventions. Many of those who cannot be left behind also fall within those classified as key populations. These key populations have the right to comprehensive sexual and reproductive health services.

The purpose of this second HIV publication of UNFPA's East and Southern Africa Regional Office is to highlight the promising practices that were identified during the 2012/13 UBRAF reporting cycle. These can become good practices with sustainable results, with the feasibility of replication in other countries.

The publication also seeks to highlight the value of data collection and documentation. It is hoped that the results of interventions in this publication will be of value to others.

These promising practices have been approved for publishing by the relevant UNFPA Country Offices.

Cover photo credit: UN Zambia

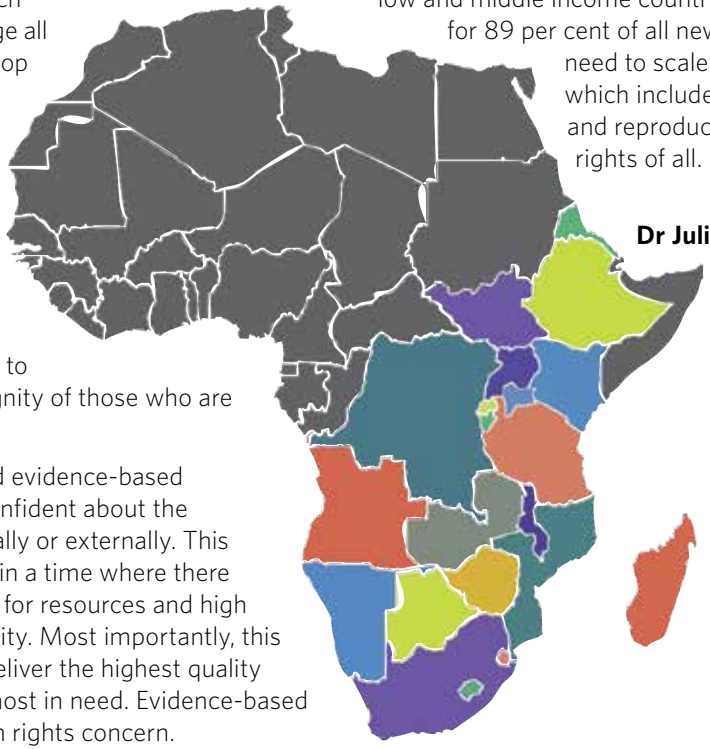
CONTENTS

FOREWORD

Let me begin by congratulating all the countries that have shared their promising practices for this report. I have personally read each submission and encourage all countries to further develop them into best practices.

I have also taken note of the human rights dimension of most of these stories. The area of human rights is close to the heart of UNFPA programming – it strengthens the space, to safeguard the human dignity of those who are often left behind.

Evidence-based data and evidence-based reports allow us to be confident about the results we report, internally or externally. This is an important element in a time where there is increased competition for resources and high demands for accountability. Most importantly, this allows practitioners to deliver the highest quality programmes for those most in need. Evidence-based programming is a human rights concern.



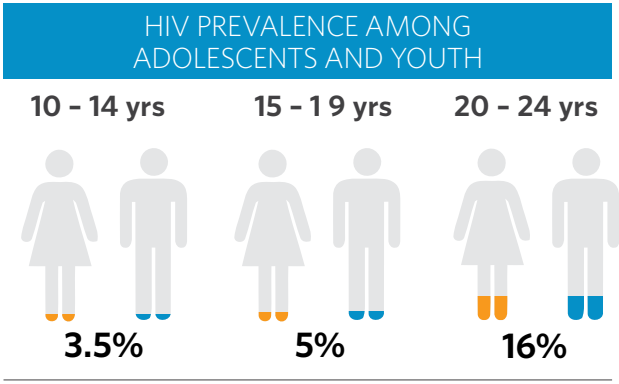
If AIDS is to be ended by 2030, the 14 countries within East and Southern Africa that are classified as low and middle income countries – and also account for 89 per cent of all new HIV infections – will need to scale up efforts in prevention, which include addressing the sexual and reproductive health needs and rights of all.

Dr Julitta Onabanjo
Regional Director
UNFPA East and Southern Africa

BOTSWANA: SRHR FOR ADOLESCENTS AND YOUNG PEOPLE

In Botswana, statistics for teenage pregnancy and HIV clearly demonstrate a need to increase young people's knowledge of and access to sexual and reproductive health information and services. While teenage pregnancy has dropped from 16.6 per cent in the 1990s to the current national level of 9.7 per cent, this is still high.

Some districts have recorded levels well above the national figure (eg Mahalapye, 15.9 per cent and North East District, 13.8 per cent), based on District Health Management Team (DHMT) statistics.



These figures prompted a need to intensify advocacy and social and behaviour change communication regarding adolescent sexual and reproductive health and HIV prevention among youth, especially to upscale the establishment and support of sexual and reproductive health (SRH) peer groups among parents and spiritual groups.

Adults oppose services for young people

An evaluation of Botswana's adolescent sexual and reproductive health implementation strategy in 2010 showed that young people had little knowledge of contraceptive methods. It was shown that 80 per cent of service providers approved adolescents having access to HIV testing and counselling (HTC), pregnancy and antenatal care, sexuality education and contraception/family planning/condoms.

Most of the implementers who disapproved were religious leaders, parents, community leaders and political leaders. They felt that the promotion of sexual and reproductive health and reproductive rights for young people went against cultural morality because it encouraged young people to engage in sex at an early age.

Youth lack knowledge of family planning

It was noted in the same evaluation that young people had little knowledge of contraceptive methods. There were significant levels of sexually transmitted infections, including HIV, high levels of unwanted pregnancies and school drop-out, abortion, transactional sex, intergenerational sex and forced sex. They also faced the challenge of inadequate access to information on youth-friendly adolescent sexual and reproductive health (ASRH).

The report also showed that communication on SRH between adolescents and the people they live with was low. Adolescents preferred to discuss SRH with their friends (70 per cent) and teachers (56 per cent) rather than their mothers (41 per cent), fathers (22 per cent), or religious and community leaders (19 per cent).

Objectives of the project

The specific objectives of the project were to:

- Engage and train faith-based organisations and community leaders on the sexual and reproductive health and rights of young people and to recognise their important role in young people's health;
- Support faith-based organisations and community leaders in disseminating adolescent sexual and reproductive health information to young people;
- Strengthen partnerships with faith-based organisations and community leaders in addressing youth sexual and reproductive health and rights challenges and improve the health of young people; and
- Reduce community-based cultural barriers to the provision of sexual and reproductive health information and services for young people.

Strategy targets religious and community leaders

Botswana Council of Churches' Rev. Godfrey Mosimanegape Jankie with the trained facilitators for ASRH training at community and church levels. Photo: UNFPA Botswana

The strategy took a four-pronged approach. Firstly, religious leaders received two weeks' training to support the training of their peers on adolescent sexual and reproductive health and HIV prevention among young people. This training was carried out by the Botswana Council of Churches with support from the Ministry of Health.

Secondly, the Ministry of Health provided training for religious leaders and community leaders on sexual and reproductive health issues, in particular showing the relationship between maternal health, morbidity and mortality with adolescent sexual and reproductive health, family planning and male involvement in SRH issues.

Thirdly, the Botswana Council of Churches, the Ministry of Health, the Botswana Family Welfare Association and youth centres held meetings with religious and community leaders to support the provision of adolescent sexual and reproductive health messages to young people in their respective areas.

Community training during a workshop on adolescent sexual and reproductive health. Photo: UNFPA Botswana

Lastly, peer educators received a week's training by the Botswana Council of Churches and youth centres using the Peer Approach to Counselling by Teens (PACT).

Challenges or constraints faced

A number of challenges were faced, as follows:

- There was limited coverage and intensity for provision of youth-friendly information and services – three districts by Council of Churches; five districts by Botswana Family Welfare Association (BOFWA) with only one supported by UNFPA; and 14 youth-friendly clinics through government health facilities.
- Weak implementation of planned activities by leaders, after action plans were developed after training due to lack of funding and human resource constraints at central level.
- Weak supervision and plans for support visits, resulting in some community leaders not implementing their planned actions after workshops.
- Some religious and community leaders are unemployed. There is a challenge to provide training incentives to the participants. Efforts are made during training to cater for transport for local community leaders who cannot afford transport costs to get to training venues.
- High turnover of peer educators due to low honoraria. Efforts are made to revise honoraria for the peer educators but the volunteer peer educators are not encouraged to stay for long, rather to pursue an education for a better future.

Progress: declines in teen pregnancy and HIV prevalence

To date, the initiative has made some gains. Parent-child communication sessions have been established through youth centres, though these have been established in only a few districts. It is noted that parents appreciate and release their young people to participate at the youth centres.

Chiefs are now comfortable with the initiative and consequently invite youth centre programme managers and trained peer educators to share information with their communities at traditional meetings.

Through UNFPA-supported youth centres, parents and religious leaders participate in committees established to support youth centre activities. The committees comprise parents, chiefs, headmen, religious and other community leaders.

Some chiefs/headmen are actively involved in mobilising parents to participate in parent-child communication sessions in their community to discuss adolescent SRH and HIV prevention issues.

Religious leaders trained as trainers work closely with the Botswana Council of Churches to train other religious leaders and follow up on their trained church groups, such as women's groups and youth groups within the churches.

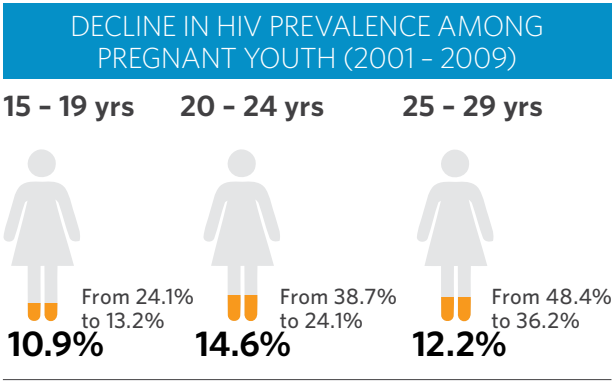
The Tamar Campaign, for which the Botswana Council of Churches (BCC) used the Tamar Story found in the Bible for its 16-day campaign, enabled the BCC to use its full capacity in terms of membership and its influential position to work with churches on gender mainstreaming at all levels.

Through BCC activity monitoring, teenage pregnancy is declining, especially in Etsha, one of the remote areas supported by the BCC. This has been ascribed to youth accessing counselling and ASRH services.

BCC stakeholders have collaborated with church youth to form a counselling committee in addition to Peer Education groups, which visit the church regularly to conduct group discussions on Adolescent Sexual and Reproductive Health issues, including HIV/AIDS.

Through the Botswana Family Welfare Association, efforts are made on an annual basis to establish and train parent peers on ASRH and HIV prevention as a way to encourage one another to talk to their children about SRHR issues. A total of 43 parents were trained on parent-child communication skills in 2012 by the second quarter, covering 13 to 16 parents.

HIV prevalence among pregnant women is declining (Sentinel Surveillance, 2001 and 2009). This drop is, however, not attributed only to this project but due to the overall performance of the national response.



Lessons learned: including key decision-makers is critical

This intervention has shown a number of lessons, as follows:

- Successful promotion of ASRH and HIV prevention among young people requires timely engagement, understanding, partnership and support by community leaders, including parents, chiefs and religious leaders, who are key decision-makers for the youth in their respective communities.
- Engaging church leaders as trainers of their peers is critical to facilitate smoother collaboration and cooperation in successfully addressing young people's sexual and reproductive health issues.
- It is important to support FBOs and community leaders to make informed decisions on their specific roles to support SRH issues in their community, drawing on the cultural background of each community.

Strong partnerships are emerging

The intervention is bearing fruit in strengthening support for the promotion of SRH interventions among young people by their local community leaders. A strong partnership between the youth programme and FBOs and community leaders is emerging, as evidenced by community leaders' engagement in ASRH activities and willingness to allow service providers to participate in their committees, meetings and activities. Community leaders are also supportive during youth and SRH-related activities in their districts. Faith-based organisations, community leaders and parents provide committees with oversight advice and encouragement to youth and youth officers and the community.

Recommendations: leaders should share good practices

The following actions are recommended:

- Annual sharing of good practice on ASRH/HIV prevention by religious and community leaders.
- Media houses to be trained on youth-friendly services to facilitate clear packaging of information on youth and SRH and HIV prevention issues, taking into account cultural contexts.
- Botswana Council of Churches to develop monitoring and evaluation framework to assist in effectively monitoring results of the interventions by religious leaders.
- There is need to support the development of SRH and youth IEC materials by church groups through trained religious leaders and church groups.

For more information, please contact:

UNFPA Botswana Country Office: +267 39 14 753 or botswana@unfpa.org

Mareledi Segotso
Assistant representative: +267 36 33 753, or segotso@unfpa.org

Kabelo Poloko
BOFWA: kpoloko@bofwa.org.bw

RÉPUBLIQUE DÉMOCRATIQUE DU CONGO: RÉDUIRE LE VIH

La transmission du VIH étant majoritairement hétérosexuelle en République démocratique du Congo (RDC). l'Impact du travail du sexe dans la chaîne de transmission est très importante. Les données disponibles font état d'une prévalence de 16,9 pour cent auprès des PS des grandes villes du pays: Kinshasa, Lubumbashi, Kisangani, Matadi, Mbandaka et Mbuji Mayi (PNLS, BSS).

Site fixe de résidence des PS femmes. Fotografie: FNUAP RDC

Des données plus récentes issues du Rapport de mise en œuvre d'un projet ciblant les populations clé dans quelques sites (Rapport PSSP), ont révélé une prévalence de 5.8 pour cent auprès des PS femmes, ce qui reste toujours élevé au regard de la prévalence moyenne au sein de la population générale estimée à 2.5 pour cent. Parmi les hommes ayant des rapports sexuels avec les hommes, le niveau de prévalence VIH est estimé à 7.8 pour cent (Rapport GARP PNMLS 2012).

Au regard de ces chiffres, les professionnels de sexe constituent une population clé sur laquelle doivent être orientés d'importants efforts de lutte contre l'épidémie du sida. Celle-ci se propage dans la population générale par suite des comportements à risque des populations dites passerelles.

L'ampleur du phénomène de commerce de sexe n'est pas suffisamment décrite au niveau national. De même, l'offre des services en rapport avec l'infection à VIH et la santé de la reproduction ciblant les professionnels de sexe et leurs clients n'est que peu documenté. Ces dernières années, la riposte a consisté principalement en des actions ponctuelles de sensibilisation, promotion des préservatifs, prise en charge des infections sexuellement transmissibles et de dépistage. Le phénomène de commerce de sexe prend plusieurs formes dans les agglomérations urbaines surtout dans les quartiers populaires, impliquant aussi bien les femmes que les hommes.

Jusqu'à un passé récent il n'existait pas encore un état des lieux pouvant établir clairement les sites de concentration des professionnels de sexe, la typologie du commerce de sexe, ainsi que les intervenants et interventions de lutte contre le VIH ciblant particulièrement cette couche de la population. C'est dans ce contexte qu'une étude pour la cartographie du phénomène de commerce de sexe a été menée par le Programme National Multisectoriel de lutte contre

le sida (PNMLS), avec l'appui technique et financier de l'UNFPA et de l'ONUSIDA, afin de permettre une meilleure connaissance de la problématique en RDC.

Stratégie, défis et mise en œuvre clés

L'objectif général était de réaliser la cartographie du phénomène du commerce du sexe et des intervenants et interventions dans le domaine de la lutte contre le VIH & SIDA ciblant les professionnels de sexe dans quatre provinces en RDC (Kinshasa, Bas Congo, Orientale & Katanga).

Vidéo forum sur la prévention du VIH, dans un site permanent des PS. Fotografie: FNUAP RDC

L'étude a été menée dans 16 villes/cités de quatre provinces sélectionnées sur base de plusieurs critères, notamment le niveau de la prévalence du VIH, la taille de la population, l'ampleur des activités et échanges commerciaux et économiques, l'importance du trafic routier ou fluvial et l'accessibilité géographique.

Quelques défis majeurs ont été relevés, notamment la nécessité de procéder à une analyse des approches d'autonomisation des PS; l'élaboration d'une stratégie nationale de prévention du VIH ciblant les PS; le financement régulier et durable des interventions ciblant les PS et la mise en place des mécanismes facilitant l'accès aux services de prise en charge des IST et de prévention de l'infection au VIH aux professionnels de sexe hommes (Hommes ayant des rapports sexuels avec des hommes) et aux PS femmes.

UNFPA a assuré un appui technique dans la collecte des données sur terrain, en collaboration avec le consultant recruté par ONUSIDA sur financement de DFID; et a organisé sous le lead du PNMLS l'atelier national de finalisation et de restitution de l'étude. Puis, en partenariat avec le projet PROVIC de l'USAID et le PNMLS, un plan opérationnel a été élaboré pour appuyer les interventions ciblant les professionnels de sexe masculins et féminins dans la lutte contre le VIH.

Progrès et résultats

A la suite de la publication de cet état des lieux, un plan d'action opérationel ciblant les PS a été élaboré. L'heure est à la vugarisation de ce plan et à la mobilisation des ressources pour sa mise en oeuvre.

19,876 professionnels de sexe ont été dénombrés, parmi lesquels 18,169 de sexe féminin (91.4 pour cent) et 1,707 hommes ayant des rapports sexuels avec les hommes (8.6 pour cent) dans les 1,300 sites de commerce de sexe répertoriés dans les quatre provinces.

L'accès aux services de prévention et de prise en charge des IST et du VIH est très faible parmi les professionnels de sexe, alors que le taux de prévalence demeure élevé dans cette population.

Les leçons apprises

Face aux attitudes de déni du phénomène de l'homosexualité dans certains milieux dans le pays, l'étude a permis de se rendre compte de la vraie ampleur de l'implication des hommes ayant des rapports sexuels avec les hommes dans le commerce de sexe dans la zone de l'étude.

La clandestinité dans laquelle vivent les HSH impliqués dans le commerce de sexe suite à la stigmatisation dont ils sont victimes, empêche la mise en œuvre des actions efficaces de lutte contre le VIH en leur faveur.

Le partenariat UNFPA et ONUSIDA à travers un appui conjoint au PNMLS pour réaliser la cartographie des PS a incité d'autres acteurs à se joindre à ce processus, au stade d'élaboration du plan opérationnel (PNUD, USAID), un modèle de partenariat très positif.

Conclusion et recommandations

Cette étude a concerné les professionnels de sexe, incluant aussi bien les femmes que les hommes, notamment les hommes ayant des rapports sexuels avec les hommes. Le besoin d'informations relatives aux hommes ayant des rapports sexuels avec les hommes indépendamment du commerce de sexe est indéniable et doit faire l'objet d'études spécifiques.

Le commerce de sexe masculin, exercé par des hommes ayant des rapports sexuels avec des hommes est majoritairement clandestin alors que celui féminin est de plus en plus affiché, bien que sous des formes diverses.

La mobilisation des ressources requises pour la mise en œuvre effective du Plan opérationnel ciblant les PS, incluant les PS hommes ayant des rapports sexuels avec les hommes est une priorité.

L'extension de l'étude aux six autres provinces du pays a été préconisée, pour une meilleure connaissance du phénomène de commerce de sexe.

Pour plus d'informations, s'il vous plaît contacter:

RDC UNFPA Bureau de Pays: +243 81 99 47 292; +243 81 71 52 250; +243 81 53 04 060 or alauwa@unfpa.org

Dr Alphonse Matondo
Agent du Programme National VIH: +243 81 26 86 317 or matondo@unfpa.org,

KENYA: SCALING UP ROUTINE HIV TESTING IN HEALTH FACILITIES

Data in Kenya show an HIV testing coverage among the adult population of 36.6 per cent (Kenya AIDS Indicator Survey, 2008) and 53.6 per cent (Kenya Demographic Health Survey, 2009). Of those who were infected with HIV, 82 per cent did not know their HIV status and 26 per cent believed that they were HIV negative, based on previous testing.

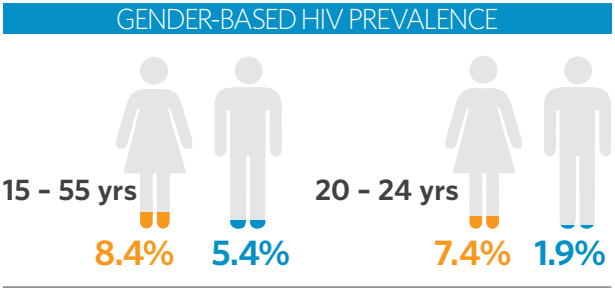
About 450,000 couples (45 per cent) were estimated to be in discordant relationships, with only 3 per cent having knowledge of their partner's HIV status. With this in mind, an HIV testing and counselling (HTC) target was set for 80 per cent of the general population to have correct knowledge of their HIV status by 2011.

The context of the HIV epidemic in Kenya

Kenya's population was approximately 39 million, 60 per cent of whom were under 35 years of age and 52 per cent were women. The national HIV prevalence among Kenyan adults aged 15 to 64 was 7.1 per cent, with a higher burden of disease in rural areas where 70 per cent of HIV-infected Kenyans reside. Three types of epidemics co-exist:

- Generalised: driven by couple discordance, multiple concurrent partners and low rates of male circumcision.
- Concentrated: sex workers, prisoners, truckers, MSM, IDUs and fishing communities.
- Geographically differentiated: Nyanza in the west, at 16 per cent HIV prevalence, and North-Eastern, at less than 1 per cent.

HIV prevalence also presented a significant gender-based pattern in the local epidemic – there was a prevalence of 8.4 per cent among women aged 15 to 55 years compared to 5.4 per cent of men; and a 7.4 per cent prevalence among women aged 20 to 24 years in contrast to 1.9 per cent of men.



Kenya's HTC services are offered mainly through Voluntary Counselling and Testing (VCT). From 2001 to 2008, the number of sites offering VCT increased rapidly from 3 to 1,026. By 2007, 54 per cent of registered VCT sites were at public health institutions while 12 per cent were stand-alone sites.

The National AIDS and STI Control Programme (NASCOP) recognised the need to increase HIV testing and achieve universal access (80 per cent correct knowledge of HIV status). With financial assistance from development partners, including UNFPA, NASCOP facilitated the piloting of a range of service delivery approaches, including workplace, mobile, outreach, home-based and facility-based services implemented by partners.

An HIV testing and counselling roadmap was developed with a range of stakeholders in 2008/09. This aimed to respond to emerging challenges, new evidence from studies, and the HIV epidemiology needs, as well as to operationalise the Kenya National AIDS Strategic Plan III.

However, in Kenya the diagnosis of infection with HIV continued to occur late among HIV-positive individuals. As a result, this campaign aimed to increase routine testing at health facilities (PITC) countrywide. Feedback from regions and implementing partners had identified low rates of offer and uptake of HTC in facilities, in spite of government attempts to promote routine PITC. Reports indicated that health providers lacked the motivation to routinely undertake HTC.

Strategy targets service delivery

The campaign was launched by the Minister of Public Health and Sanitation, Beth Mugo, and had a high media presence. It ran from 23 November to 12 December 2009 and targeted the general population.

The main service delivery strategy was PITC, with community-based testing and counselling complementing a predominantly facility-based approach. This model is offered as routine medical care, and is initiated by health workers with an opt-out approach. It provides an opportunity for early detection of infection and referral.

A national quality assurance/control subcommittee was established to oversee the implementation and reporting of quality management activities and ensuring the utilisation of QA tools.

Communication and publicity campaigns aimed to improve general awareness of HTC and boost uptake of the service. Media representatives were invited to be members of the planning committee, to enable them to understand all the issues surrounding the campaign.

Social mobilisation and media coverage were critical to the success of the HTC week. Key messaging included the benefits of knowing one's HIV status, who needs to get tested, current statistics on HTC and a call for action. Publicity materials included flyers, posters and banners for the general public, wristbands for the youth, and World Cup materials for men.

Challenges to the campaign

The campaign faced a number of challenges. For instance, while task-shifting was intended in the facilities where HTC counsellors provided testing and post-test counselling services, referral for ongoing counselling, supported disclosure, and index client follow-up, there was no national guidance on its application. Also, the linking of HIV-positive people identified using the PITC approach to the HIV care clinic is not documented, and there are no institutionalised mechanisms to ensure enrolment into care for those becoming HIV positive.

Results of the campaign

During the month-long campaign, almost 1,220,000 people were tested for HIV, representing 122 per cent of the target. An HIV prevalence of 4.2 per cent was noted.

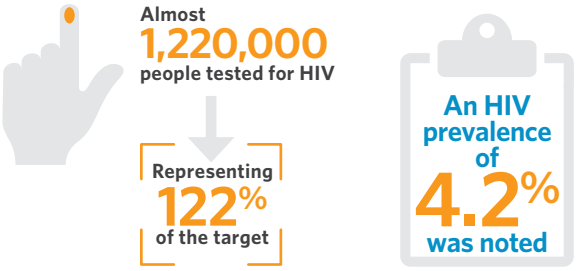
The results showed the following:

- It is necessary to include a wide range of partners with competencies in planning and coordination, logistics, quality assurance, training and social mobilisation. Greater involvement of partners at

the district and facility levels is necessary to ensure implementation of the campaigns.

- Planning is needed for close monitoring of service provision and management of commodities.
- Despite an elaborate baseline analysis for human resource requirements, not enough staff members were deployed due to funding and time constraints experienced during the campaign.

RESULTS DURING THE MONTH-LONG CAMPAIGN



HTC is vital for response to HIV

The benefits of HTC campaigns in Kenya suggest that they are vital in the HIV response. HIV prevention is optimised through behaviour change and treatment as prevention. Any biomedical intervention requires ongoing knowledge of HIV status.

There is a need to change the HTC strategy from a focus on one's knowledge of HIV status, to also include post-test preventive interventions and treatment services. There should be strong emphasis on data collection, monitoring and effective referral systems.

The campaigns should provide programme implementers with targets that are based on the HIV disease burden of geographical areas, populations being targeted, cost-effectiveness and employment of a combination of prevention interventions.

The suggested next steps of the campaign are to:

- introduce a unique identifier given to people at the point of testing, to be used by all post-HIV test referral services. This would allow healthcare workers to track patients across different services, such as treatment for Tuberculosis or anti-retroviral treatment (ART), and also to track those who use different facilities, which is common due to the stigmatising nature of HIV/AIDS. It would validate testing and enable proper data collection, while ensuring continuity;
- implement self-testing with the establishment of a committee to conceptualise, design and pilot interventions that address potential logistical, ethical and quality concerns; and
- make use of HTC services as an opportunity to integrate additional healthcare services and information, including reproductive health and TB services.

For more information, please contact:

UNFPA Kenya Country Office: +254 20 76 24 404; +254 20 76 24 405; +24 20 76 24 401 or ken.staff@unfpa.org

Geoffrey Okumu
Programme Specialist RH/HIV and AIDS:
+254 20 76 25 556 or
okumu@unfpa.org

MOZAMBIQUE: HIV/AIDS – MAPPING VULNERABLE GROUPS

Mozambique's National Strategic Plan (2010 to 2014) recognises female sex workers (FSW) and their clients, men who have sex with men (MSM), truck drivers, inmates, injectable drug users (IDUs) and people with disability as priority groups in the fight against HIV/AIDS.

However, the lack of programmes addressing the specific needs of these groups, associated with risk and vulnerability factors, the limited access to specific health services and information, the issue of unprotected sex, alcohol abuse, stigma and discrimination, and social exclusion, contributes to their significant exposure to HIV infection and other sexual and reproductive health issues. In addition, effective interventions have been hindered by insufficient data on the real extent of the problem in these populations in the country.

Recording a sexual and reproductive health video in sign language for people who are hard of hearing. Photo: UNFPA Mozambique

Information on marginalised, at-risk and vulnerable groups is needed to deliver effective interventions and track progress towards achieving universal access to SRH services, including HIV prevention, treatment, care and support. Sexual and reproductive health (SRH) and HIV/AIDS programmes cannot operate in a vacuum. Strategic information is necessary to show how poor SRH and HIV vulnerability directly affects progress towards the MDGs. It is also used for advocacy, policy development, strategic planning and programming, national and global monitoring and reporting, donor reporting, and programme monitoring and evaluation.

In 2008, at the beginning of the Inclusion Project in partnership with the Ministry of Justice, Ministry of Women and Social Affairs, Pathfinder International, LAMBDA and FAMOD, the lack of estimates of the population size (except for inmates) called for specific strategies for the mapping and targeting of each group.

The main objective of this intervention was to contribute to the reduction of HIV infection among key populations through the improvement of access to non-discriminatory information on sexual and reproductive health and health services.

HIV risk for vulnerable populations in Mozambique

In Mozambique, people with disability (PwD)[1] are an important risk group as almost 7 per cent of the population has at least one disability, a national representative study by SINTEF (2009) shows. There are no representative data related to HIV prevalence in this group; however, they are included due to their increased number in the population and their

vulnerability to HIV and SRH risks because of their general challenges in accessing health services and information, experience of social stigma, high illiteracy rate, high poverty and high unemployment.

The preliminary results of the Behavioural Study among FSW and MSM by CDC in 2011 points to a population of female sex workers of approximately 30,000 and an HIV prevalence of 31.2 per cent in Maputo, 23.6 per cent in Beira and 17.8 per cent in Nampula. The population of men who have sex with men (MSM) is around 10,121 in Maputo, 2,024 in Beira and 3,069 in Nampula, while the HIV prevalence is 33.8 per cent, 32.1 per cent and 10.3 per cent, respectively, among MSM aged 25 years or older.

The National Prison Services database is updated on a daily basis. It contains statics of the prison population and the main health problems.

Key challenges faced

A number of key challenges were identified, as follows:

- Insufficient knowledge about health needs of key populations and particularly the target group.
- Poor health services and information and data recording for key populations.
- Non-existence of a specific national health programme/guidelines addressing these populations.
- Social exclusion of key populations targeted by the project.

Strategy and project implementation

The mapping process took place as follows:

Sex workers

Meetings were held with implementing partners, the Ministry of Health and Provincial Health Directorate to ensure their involvement in the process. A technical working group comprising UNFPA, Pathfinder and PSI was created. This group was responsible for developing the strategy.

The sex work 'hot spots' were identified, where the '100 per cent life' project would be implemented. Field workers (sex workers) were trained and deployed to the hot spots. In two weeks they collected a considerable amount of information, such as the number of sex workers, their peak working hours, and the availability of commodities, such as condoms and lubricants, in hot spots.

Following these activities, the main hot spots for implementation of the project were identified and the short-, middle- and long-term intervention strategies were developed.

People with disability

The programme targets hearing impaired and blind people. Identification and assessment of national organisations working with PwD and their health needs, including SRH and HIV, were identified and assessed. These included AMODEFA, Handicap International – Mozambique and ADEMO (Mozambican Association for Handicapped people).

A joint session with blind people to assess their needs. Photo: UNFPA Mozambique

A technical working group comprising UNFPA, Pathfinder, the Ministry of Women and Social Affairs and FAMOD (Forum of National Associations for People with Disability) was established. The guidelines for data collection were designed. Detailed information was collected on the associations for people with disability. In addition, in-depth interviews, focus group discussions and provincial workshops were held with the associate members, key stakeholders and partners to assess their specific needs in sexual and reproductive health and the number of people.

Men who have sex with men, and lesbian, gay, bisexual, transgender and intersex people

For men who have sex with men (MSM) and lesbian, gay, bisexual, transgender and intersex (LGBTI) people, the project created a database for LAMBDA association (Mozambican Association for sexual minorities). This data was collected by peer educators doing sensitisation work.

Progress and results

The Provincial Directorates of Health have assumed leadership of the programme in the targeted provinces. Specific strategies for the mapping of each group were developed and implemented with key partners from civil society and government.

Detailed information was collected for the key populations, particularly their information needs (eg type of materials, most appropriate source of information, and most needed health services). A database was designed for each group.

Information on sexual minorities was made available through support to a local association for sexual minorities (LAMBDA) through the database, the production of monthly bulletins and the website (www.lambda.org.mz).

As a result of the mapping exercise, planning of the '100 per cent life' project was improved and became more targeted. Specific HIV prevention services for MARPs were increased: more than 2,500 registered sex workers attended night clinics for sex workers from 2008 to 2011, and 939 of them were tested. Training was provided for 130 peer educators in prison sites, 54 peer educators in LAMBDA youth associations, 85 young people with disabilities as peer educators, and 122 sex workers as peer educators, to operate in seven sites in Maputo, Nampula, Beira and Chimoio.

About 150 health providers were trained in human rights and issues related to sex workers, MSM and PwD in order to provide non-discriminatory health services. HIV prevention commodities, condoms and water-based lubricants, were made available to MSM, FSW and PwD. Counselling and testing services were provided for hearing-impaired people (HIP), reaching 1,291 of them in Maputo City and province.

Knowledge of gender-based violence and human rights was increased through the production and distribution of 5,000 brochures on sex workers' rights. Knowledge about HIV and human rights was increased among HIP and visually impaired people (VIP) through the production of IEC material in braille and sign language.

The mapping provided an opportunity for integrated SRH/HIV programming for the growing, marginalised population group of PwD.

Lessons learned

A number of lessons were learned during this process. For instance, the mapping process allowed for the development of tailored actions to specific groups to enhance HIV prevention and to guarantee respect for human rights. The availability of recent data was useful for making a case for acknowledging the existence of key populations and their specific SRH needs and human rights.

The involvement of the target group in the mapping process and in the implementation phase was crucial (peer education strategy). The involvement of key government institutions such as the Ministry of Health, Women and Social Affairs provided the ground for raising awareness of issues related to vulnerable groups.

Knowledge of HIV prevention and access to prevention services among key populations (sex workers, prisoners, MSMs, young people with disabilities) increased through support to Ministries of Justice, Women and Social Action, Association of Homosexuals, Transvestites and Lesbians in Mozambique and Youth Associations, in order to implement a comprehensive SRH and HIV prevention programme for the key groups.

Conclusions and recommendations

The mapping of key MARPs in Mozambique was vital to the planning process. Despite the fact that this initiative targeted particular hot spots, the information that was collected helped create the environment needed for improving the provision of services for MARPs.

However, there is a need for more comprehensive and thorough mapping of MARPs throughout the country to enable better understanding of the extent to which these key populations are affected by SRH conditions and the HIV and AIDS epidemic. This, in turn, will allow for better planning and implementation of strategies and programmes to address these problems.

Government involvement contributes to sustaining of the strategies through integration of the project activities in the Government Work Plan (strategic and operational) and strengthening of the linkages with Civil Society Organisations (CSOs). The reinforcement of monitoring activities is essential to ensure the quality of the interventions.

Partners: Pathfinder International, PSI, Ministry of Health, Women and Social Affairs and FAMOD.

For more information please contact:

UNFPA Mozambique Country Office:
+258 21 494 469; +258 21 497 164; +258 21 490 686
or foffice@unfpa.uem.mz

Amélia Zawangoni
Technical Advisor: zawangoni@unfpa.org

1 People with Disability (PwD) are defined as people with physical, mental, intellectual and sensorial long-term incapacity, which in interaction with several barriers can prejudice their partial/full effective participation in society on equitable basis with others (International Convention on Human Rights for People With Disabilities, Mozambique ratified it in 2010).

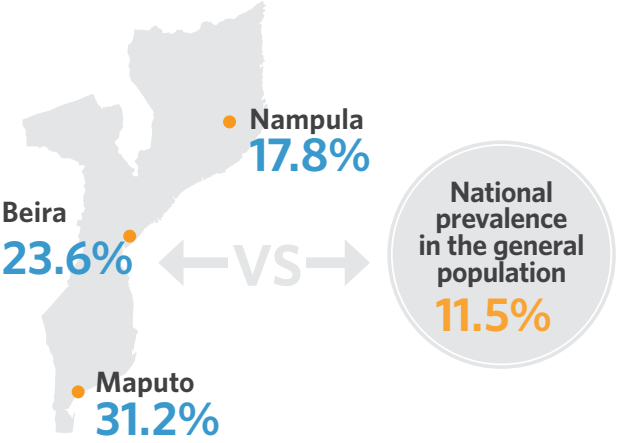
MOZAMBIQUE: INNOVATING HIV SERVICES FOR SEX WORKERS

In Mozambique, HIV infection has been found to spread among sex workers before it spreads to the general population. It is therefore important to understand the diverse nature of sex work as well as the attitudes, behaviour patterns and context, as the interplay of these dynamics intensifies the risk of HIV transmission.

New HIV infections high in sex workers

Sex work accounts for 19 per cent of new HIV infections (Modes of Transmission Study, NAC/UNAIDS, 2009) in the country. A survey of sex workers conducted in three provinces (Maputo, Beira and Nampula) pointed to a prevalence of 31.2 per cent, 23.6 per cent and 17.8 per cent respectively in major metropolitan areas, against a national prevalence in the general population of 11.5 per cent (Biological and Behavioural Survey, IBBS, 2011/12). Sex workers tend to be concentrated in peripheral and urban areas as well as border and port corridors.

HIV PREVALENCE IN SEX WORKERS



The high need for health services

Sex workers in Mozambique are considered a high risk group for HIV. Yet despite recognition by the Mozambican Government that this is a high priority group for HIV prevention interventions, not enough has been done to address their specific needs.

Sex workers in Mozambique have limited access to health information and services, and their low economic status makes it difficult to meet health costs. Their own perception of health requirements, low capacity to negotiate safer sex, and the social stigma and discrimination associated with lack of specific services contribute to deepening their vulnerability to HIV and STIs.

One of the key issues of this programme, therefore, was to provide access to health services that are tailored to sex workers' needs. This meant having services that would fit sex workers' schedules, particularly at night, and provided by trained health staff outside of routine service times.

In 2008, UNFPA, Pathfinder International, Population Services International and later, AMODEFA, partnered with the Provincial Health Directorates in five provinces to implement the 100 per cent LIFE Project. Its main objective was to reduce HIV infection among female sex workers.

How the project was implemented

Implementation of the project involved a number of strands.

Strategic advocacy: The local authorities at Provincial level were engaged, particularly the Provincial Health Directorates (DPS) and more specifically, the Provincial Health Director and Chief Medical Doctor, in order to advocate for the need for health services that are tailored to sex workers' needs. One particular issue that was discussed with authorities was the need for the health workers to provide services to sex workers at times that are more appropriate to enable them to attend. Health facilities in Mozambique, especially health centres, typically operate from 08:30 to 15:30 (though emergency services run for 24 hours). It was stressed that health workers would have to provide these services out of their regular working hours. In order to motivate health workers to provide services at times that fit in with sex workers' work hours, a financial incentive was proposed and approved. Within this agreement, health workers would work additional hours, from 15:30 to 20:00, in order to accommodate sex workers' work schedules.

The project staff also engaged with the sex worker organisation 'Tiyane va vasate', in order to learn the best way to involve sex workers. The organisation's members were included in the project working group and their contribution was invaluable.

Selection of target health centres: Four health centres were identified in locations with high sex work activity in three provinces – one in the northern province of Nampula (Nacala-Porto Health Centre), one in the central province of Manica (Inchope Health Centre), and two in Maputo City (Frigo Health Centre and Porto Health Centre).

Identification of focal point: In each of the health centres a focal point for the project was identified and in most cases, this was the director of the centre. Technicians and nurses were identified according to their area of work to address the needs of the sex workers, namely, general services or other reproductive health services, according to the potential specific needs of sex workers and their clients.

Capacity building: The staff members at the health centres were trained in human rights and sex work issues, as well additional health content. These trainings occurred regularly each month and were supported by a curriculum that was developed specifically for this intervention.

A reference system was developed with health staff at the centres. This begins in the community with the training of sex workers to function as peer educators, who then refer their peers to the clinics while working. The sex workers receive an invitation card offered to them in their workplace, which they present at the clinics. Within the health clinics, the referral system uses the existing routine referral system.

Thousands of sex workers receive services

The results have been impressive. From 2008 to 2011, four health centres offered night services for sex workers, as follows:

- Peer educators referred 9,025 sex workers to the night clinics and of these, 2,521 were attended to at the clinics.
- Around 70 per cent of the consultations were for sexual and reproductive health services. The remaining 30 per cent of the consultations related to general health and gender-based violence.
- A total of 939 sex workers benefited from counselling and testing for HIV.
- A total of 122 sex workers were trained as peer educators.

In addition, 90 health providers benefited from training on sex work issues and human rights, as well as updating on general health issues. This aimed at ensuring that the services they provided matched the needs of sex workers.

Lessons learned

A number of lessons can be learned from this project. For instance, health services should be provided according to the specific needs of the target group. A crucial step for implementation of any intervention for sex workers is the engagement of provincial authorities to advocate the need for specific services. Other lessons are as follows:

- Financial incentives motivate health workers to provide services to sex workers at times that are more suited to them. However, financial incentives

are not a sustainable way of maintaining these services.

- Capacity building of all clinic health staff on sensitive issues such as human rights, gender-based violence and sex work is crucial for addressing the specific needs of sex workers.
- Provision of services at night ensures considerable adherence and has the potential to reach sex workers' clients as well.
- Supportive supervision is crucial for maintenance of these activities.

Conclusions drawn from the project

Sex workers have specific health needs that must be addressed through the available health services. The health services should be tailored to their needs and should include addressing their sexual and reproductive health, particularly in terms of the time period that these services are available. The provision of health services that address sex workers' needs potentially improves access to services and therefore the health of sex workers, as well as their clients.

Using peer educators and health workers to disseminate adequate information to promote the services is critical for adherence to the services.

Continuous capacity building of health providers through training helps improve the quality of health services for sex workers, free of discrimination, and assures a certain level of sustainability, which additionally improves adherence. It is crucial to engage the health authorities when implementing such programmes.

And finally, the intervention has provided information that can serve as a platform for discussion with policy makers in terms of potential areas for addressing the needs of high risk populations and in particular, sex workers.

For more information please contact:

UNFPA Mozambique Country Office: +258 21 494 469 +258 21 497 164; +258 21 490 686 or foffice@unfpa.uem.mz

Amélia Zawangoni
Technical Advisor: zawangoni@unfpa.org

SOUTH AFRICA: SEX WORKERS' RIGHTS AND 2010 FIFA WORLD CUP

Sex work is currently a criminal offence in South Africa. The stigma and criminalisation of a marginalised group drives that group underground and away from essential health and social services. This results in an increase in the vulnerability of sex workers to HIV due to multiple concurrent partnerships, a lack of access to services, stigma, the inability to negotiate safer sex, the threat of violence, and the need for harm reduction.

Sex work received increased attention in South Africa during the 2010 FIFA World Cup, with preparations including calls for the temporary legalisation of sex work, the mandatory HIV testing of sex workers and registration with a regulatory authority. Human rights groups strongly resisted these calls. A pragmatic and human rights-based response based on sound public health principles is more appropriate.

Sisonke Sex Worker Movement running an outreach campaign.
Photo: UNFPA South Africa

International sporting events are increasing in popularity and magnitude. It was estimated that the World Cup would bring 450,000 visitors to South Africa, the country that has the largest number of people with HIV/AIDS in the world. It was anticipated that a number of tourists would seek to combine attending the soccer matches with sex. It was therefore foreseen that a government priority would be to attempt to reduce the transmission of HIV during this period.

It was vital that the South African Government, civil society and the police services responded to the interaction between sex work and the increase in tourism in a hyper-endemic country in a pragmatic and appropriate way. Moreover, it was imperative that partnerships were formed to address crime concerns facing sex workers and the clients of sex workers.

Objectives of this initiative

In order to address human rights concerns and the sexual and reproductive health (SRH, including HIV prevention) needs of sex workers, UNFPA partnered with Sex Worker Education and Advocacy Taskforce (SWEAT) to implement activities during this period. The objectives were as follows:

- To conduct research on the supply and demand of sex work and sex worker experiences during the World Cup in reference to human rights violations and access to services.
- To conduct human rights training and public health messaging in the context of sex work.

- To provide messages for the South African Government and Parliament, encouraging a moratorium on the harassment of sex workers around 2010 FIFA World Cup and progress in the debate around the legal status of sex work.
- To develop the capacity of sex workers as a key element in building a sustainable national movement and ensuring that sex workers' voices were heard.
- To build support for sex workers through the establishment of a sex worker hotline, monitoring of the abuse of sex workers and building capacity to offer a constructive response to such abuse.

Strategy to increase sex worker awareness

Demonstrators calling for the decriminalisation of sex work.
Photo: UNFPA South Africa

The initiative involved human rights training and public health messaging. SWEAT and Sisonke increased their outreach activities in Cape Town during the World Cup and distributed safer sex materials and information to sex work hot spots and pubs for sex workers and their clients. The World AIDS Campaign (WAC) developed an information booklet that focused on sex work, human rights and the criminal law.

Sex worker leaders from Sisonke Johannesburg and Cape Town were trained over three days in understanding human rights and actions that can be taken in response to human rights violations. In addition, psycho-social training was provided to impart an understanding of how to address the emotional needs of those subjected to human rights violations.

Lack of systematic research into sex work during sporting events

A review of the literature showed that there was very little research that had provided baseline information on sex work before a major sporting event, and then measured the changes that occurred during the period of increased tourism and sporting activity. If this information became available, it could provide important insight into sex trafficking and paid sex during sporting events. Thus, researchers from Ghent University (Belgium), Wits University (South Africa) and University of Stellenbosch (South Africa) teamed up with SWEAT, Sisonke and the Reproductive Health and HIV Research Unit (RHRU) to conduct research into the demand and supply of paid sex during the 2010 FIFA World Cup.

Their research entailed the following:

- A sex worker hotline pilot project was launched during this period. Cape Town sex workers were trained as helpline counsellors and provided telephonic assistance to sex workers. The calls received during the World Cup confirmed an increase in intimidation from the police and in particular, Cape Town's 'Vice Squad'.
- A workshop on sex worker arrest was held in Johannesburg in collaboration with Tswaranang Legal Advocacy Centre and the Women's Legal Centre. Human rights organisations, NGOs and CBOs discussed the harassment of sex workers by police, the implications of the judgement given in the Western Cape High Court against the police and what legal recourse sex workers may have. A memorandum was sent to the Gauteng Premier, Nomvula Mkonyane, and the MEC for Community Safety, urging them to stop the unlawful arrest of sex workers contravening municipal by-laws. There was no response to the memorandum.

Challenges around sex work programming remain focused on stigma and discrimination. SWEAT received a bomb threat in the first week of the helpline implementation. As sex work is criminalised in South Africa, many sex workers feared speaking out against injustices and joining coalitions and movements aimed at protecting their rights.

Progress and results

The 2010 FIFA World Cup generated international interest in South Africa, and sex work received considerable attention, which was strategically harnessed at times. A number of sex workers granted interviews to the media and this built their confidence in their ability to engage the media. Sex worker advocates received a deluge of requests for interviews and it became clear that a larger number of spokespeople who could comment on the issue was required to deal with the demand.

The UNFPA-supported November 2009 Consultation on Sex Work and the World Cup was a useful and strategic forum for engagement, but further work remains to generate sufficient momentum for an ongoing partnership on sex work and human rights issues.

Official recognition that sex workers required specific interventions during the World Cup was lacking. More work should have been done to link the World Cup to the delay in law reform processes on sex work, and to put public pressure on the government to take up the moratorium on sex work-related arrests. Potentially useful strategies that could have been taken up include more focused media attention, building a stronger coalition and involving well known people such as human rights activists to draw attention to the issues surrounding sex work.

Lessons learned

The 2010 FIFA World Cup created an opportunity to highlight the ongoing victimisation of sex workers under a criminalised system in South Africa, and to mitigate some of the health and social consequences of these abuses. From this initiative, it is clear that the government, World Cup organisers and the HIV/AIDS community need to strengthen linkages to safeguard public health and human rights. Government attention and resources were focused on fears of an increase in human trafficking in South Africa during the World Cup (the figure of 40,000 trafficked women and children was mentioned in the media). However, the evidence shows that this did not materialise. The Department of Justice and Constitutional Development reported at a parliamentary meeting that not one case of human trafficking during the World Cup came to light.

There was a limited proactive response from civil society organisations and the international donor community to the challenge of soccer mania mixed with paid sex. However, they provided sex work-specific health programmes and activities, albeit on a limited scale, but could not reach all of the host cities or all the places where sex work takes place in South Africa.

Conclusion and recommendations

It is hoped that other countries that host large-scale international sporting events in future would be able to benefit from the lessons learnt in South Africa and pressurise their governments as well as international sporting bodies to include sex worker rights in their strategy, planning and most importantly, implementation of programmes.

For more details, please contact:

UNFPA South Africa Country Office:
+27 12 354 8401; +27 12 354 8420 or
zaf.admin@unfpa.org

Beatrice Pembanyali
Programme Associate: +27 12 354 8407 or
pembanyali@unfpa.org

Tlangelani Shilubane
HIV Prevention and Youth Development Programme Officer: shilubane@unfpa.org

SWAZILAND: AN EVIDENCE-BASED STRATEGY FOR MSM

A crowd gathers to watch a Condomise! campaign performance. Photo: UNFPA Swaziland/Sabelo Mthethwa

Until recently, little was known about HIV prevalence or risk factors among men who have sex with men (MSM) populations in Swaziland. A bio-behavioural surveillance study of 328 men who have sex with men was conducted in Swaziland in 2011 to examine HIV prevalence and risk factors among them. This was the first BSS study on MSM in the country, and work with this group is relatively new. A most-at-risk populations (MARPs) Technical Working Group (TWG) was set up last year to give this group priority.

The study examined HIV prevalence and risk factors among sex workers in Swaziland, and is the most rigorous one in this respect to date. It received ethical approval from the Swaziland Ministry of Health and Johns Hopkins Bloomberg School of Public Health institutional review boards. The overall objective was to develop an evidence-informed strategic plan on MARPs, including MSM.

The study formed part of the Ministry of Health Bio-behavioural Surveillance Surveys, the first phase of which focused on factory workers, seasonal workers, and youth in and out of school. This information will help the Ministry of Health and partners to better plan and develop the most effective, evidence-based strategy for combating HIV in Swaziland.

The study objectives were to examine the HIV prevention, care and treatment needs of MARPs (sex workers and MSM) living with HIV to better tailor programmes for these populations. The methodology used three focus groups with MSM and one-on-one in-depth interviews with key stakeholders and MARPs. It also involved a peer-referral system that allows for adjustment for network sizes and homophily (the concept that people recruit people who are similar to themselves).

Dual stigma leads to reduced healthcare

MSM reported that they experienced discrimination and violence from a wide range of individuals, including their partners, families, members of the general public and during police raids. They experienced dual stigma related to being HIV-positive and their MSM identities, which led to a lack of disclosure. They also perceived stigma in healthcare settings, which led to lack of care-seeking behaviour. Some MSM reported that the clandestine nature of sexual orientation may lead to an increase in casual sexual partnerships. In Swaziland, for instance, same sex relationships are illegal. Together with the dual stigma, this encourages non-disclosure, which may lead to multiple casual partnerships, putting them more at risk.

Members of Swaziland's Condomise team entertain a crowd. Photo: UNFPA Swaziland/Sabelo Mthethwa

Preliminary findings show the following:

- HIV prevalence among MSM was 17.6 per cent, with most of the infected in the age group of 20 to 24 years. This figure was 5 per cent higher than that for the general male population, while HIV prevalence in the same age group in the general population was found to be 26.5 per cent. Evidently, HIV prevalence among MSM is 8.9 per cent higher than among males of the same age group in the general population. This confirms that MSM have a higher risk of HIV infection.
- Just over 50 per cent of MARPs always used a condom with a male partner. MSM had greater access to condoms than lubricants.
- A majority of the MSM reported limited access to healthcare services due to stigma and discrimination. This is perpetuated by a wide range of individuals, including partners, families, healthcare workers and the general public.
- Just over 30 per cent experienced legal discrimination due to their sexuality.
- Only 26 per cent had ever been treated by a healthcare provider.

Lessons learned

- Implementing an MSM peer education programme 'training of trainers' model is key in providing HIV prevention education among this population. MSM, like all other population groups, are comfortable with those they identify with; as such they accept each other and there is no discrimination among them.
- Using their network for distribution is key to increasing condom distribution, and lubricants in particular, to the wider MSM population.
- Working with selected, trusted and acceptable NGOs is essential for service uptake by MARPs.

Conclusions and recommendations

The Ministry requires a targeted MSM intervention informed by the study, which suggested that when MSM are approached in a constructive manner, they are interested in participating in HIV prevention, care and treatment decisions for their communities.

Finalisation of the MARPs BSS report is proceeding concurrently with the development of a MARPs Strategic Plan to respond to MSM needs.

For more information, contact:

UNFPA Swaziland Country Office: +268 2404 1793; +268 2404 2301; +268 2404 2304 or registry.sz@undp.org

Bongani Dlamini
EU Project Programme Analyst – SRHR and HIV: +268 2404 2301/2 or bodlamini@unfpa.org

UGANDA: EMTCT AS AN ENTRY POINT FOR INTEGRATED SERVICES

Uganda ranks among high HIV impact countries that require concentrated efforts in dealing with the epidemic to achieve impact. About 75 per cent of new HIV infections are attributed to unprotected heterosexual sexual contact and 22 per cent to mother-to-child transmission (MTCT).

It is estimated that 1.5 million pregnancies occur annually in the country and of these, HIV prevalence is estimated at 5 to 6 per cent. Each year, about 25,000 babies would be born infected with HIV if there were no interventions for preventing MTCT.

Uganda initiated a national Programme on Prevention of Mother to Child Transmission of HIV (PMTCT) in 2000. The programme evolved from a pilot research study that tested the efficacy of anti-retroviral drugs in reducing transmission from infected mother to baby, to the globally guided comprehensive four-pronged approach focusing on:

1. primary prevention among women of reproductive age;
2. prevention of unintended pregnancies;
3. prevention of transmission from HIV-positive pregnant mother to baby; and
4. care and support for the mother and baby.

A 2008 review of the PMTCT programme in collaboration with the regional IATT team revealed several achievements and weaknesses. There were noted drops in service uptake in the programme cascade from ANC attendance, to uptake of HCT, enrolment on the programme for those infected and finally enrolment of exposed babies on prophylaxis. The PMTCT programme was established in a vertical emergency mode that also led to loss of opportunities and limited exploitation of synergies to ensure comprehensive delivery on all the prongs.

Uganda's First Lady, Mrs Janet Museveni, takes a public HIV test at the launch of the End Mother-to-Child Transmission (EMTCT) campaign in Kampala City. Photo: UNFPA Uganda

Reviews pointed out the limited focus on prongs 1 and 2, low uptake of ANC services for all four visits, low deliveries in health facilities at 43 per cent and high unmet need for family planning (FP) at 41 per cent (2006 UDHS). A 2009 study on reproductive health (RH) choices for people living with HIV/AIDS estimated the unmet need for family planning at 32 per cent. Localised reviews have revealed unintended repeat pregnancies among mothers who have previously gone through the PMTCT programme.

Against this background, UNFPA prioritised its focus on advocacy for scaled-up programming for prongs 1 and 2, specifically promoting integrated sexual and reproductive health (SRH)/HIV approaches, hingeing the PMTCT programme fully on the mother and child

health (MCH) platform and scaled-up programming for family planning, and more specifically for sexually active HIV-infected people. These efforts have been boosted at national level by the expanded programming for family planning, maternal health and adolescents and young people supported by UNFPA and other partners.

Objectives and strategy

The objective of the intervention was to strengthen the focus on prongs 1 and 2 in the planning and implementation of the National PMTCT programme 2009/12.

To address the identified challenges and to scale up the focus on prongs 1 and 2, the UNFPA country team employed a multi-pronged approach for the promotion of SRH/HIV linkages and integration. The objective was to provide guidance for heightened and streamlined programming for FP and maternal health through HIV programming and *vice versa*. The following strategies were applied:

- Generation of evidence with specific focus on assessment of SRH/HIV linkages and integration applying the global tool, and establishing reproductive health choices for people living with HIV in Uganda.
- Provide support to policy and strategy setting, including utilisation of the rapid assessment findings to inform development of national guidance on SRH/HIV integration.
- Resource leveraging and mobilisation utilising evidence to influence processes for large funding streams such as Global Fund Round and PEPFAR of the US Government.
- Engagement in health sector technical working groups and partner programme development processes to apply local evidence and global guidance to inform programmes, tools and processes.
- Engagement in leadership advocacy efforts targeting Parliament, First Ladies, political leaders at lower levels, religious and cultural leaders.
- Capacity building for key technical people in Ministry of Health and partner agencies. For example, the National PMTCT programme coordinator and a national consultant participated in the UNFPA regional training on global guidance for prongs 1 and 2 in Lilongwe, Malawi.

Challenges to implementation

The focus on prongs 1 and 2 of PMTCT required clear national guidance on sexual and reproductive health (SRH) integration, yet SRH and HIV programmes have largely been running parallel. UNFPA and WHO supported national processes to apply the global assessment tool and use the findings to develop a National Strategy for Integration of SRH&R and HIV/AIDS. There were delays in getting the government to endorse the Strategy from January 2011 to April 2012. Structurally, the PMTCT programme is managed under the AIDS Control Programme, which falls under a different department than SRH and maternal health aspects. This has been an

obstacle to the harmonising of efforts. Through the UNFPA-supported Annual Work Plan implemented by the Ministry, efforts are being made to ensure joint programming and reviews.

The limited focus on prongs 1 and 2 over the years was partly due to an assumption that family planning and primary prevention are being handled adequately through other programmes. Annual reviews in relevant areas have, however, underscored the need for a comprehensive focus on all key aspects hingeing on projections that EMTCT can only be achieved if national targets in areas like family planning, maternal and child health have been achieved.

Weak health infrastructure, especially for maternal health, is acknowledged as a major challenge but increasingly, the relatively high volume of funding for HIV is being used to address this, for example through using HIV external resources to recruit health service providers and developing the laboratory system for all conditions. Unstreamlined logistics and commodity supply systems also previously hindered integrated service delivery, but through lobbying the Ministry has rationalised these processes to support seamless access to commodities from different sources at service delivery points. Sustaining adequate stocks for example for HIV test kits remains a challenge.

Implementation

The PMTCT programme in Uganda is spearheaded by the Ministry of Health (MoH) and implemented with support from a range of partners, including USAID, CDC, PEPFAR, DFID, UNICEF, WHO, UNAIDS and UNFPA. The partners are coordinated by a National Advisory Committee at the policy level and a National Steering Committee at the technical level, and both are led by the Ministry of Health. Several other established fora, including the National Partnership Committee of the National AIDS Council, the UN Joint Team and the AIDS Development Partners Group, also prioritise the focus on EMTCT in the country.

Following the 2008 programme review, the MoH led processes for the development of the National PMTCT Scale-up Plan. Following on from global actions driven by the US Secretary General's Initiative on women and children, Uganda developed a national EMTCT plan in 2011 that provided emphasis on all the four prongs of EMTCT. EMTCT was also priotised in the National HIV Prevention Strategy 2011/14 that emphasises SRH/HIV integration. In 2012, Uganda adopted the WHO endorsed Option B+ of EMTCT that advocates for enrolment of all HIV-positive pregnant mothers on lifelong anti-retroviral therapy, irrespective of their CD4 status. The aim is to reduce HIV-related morbidity and mortality as well as the potential for infecting babies during pregnancy, child birth and breastfeeding.

Throughout these processes, UNFPA has provided financial and technical support, and has actively taken part in relevant technical and sector working groups. The Fund has been a leading partner in drawing the attention of the stakeholders to PMTCT prong 1 and 2 guidelines and ensuring they are used in developing national guidance and resource mobilisation documents.

The Ministry of Health ran an elimination of mother-to-child transfer (EMTCT) of HIV campaign. Photo: UNFPA Uganda

UNFPA is represented on several PMTCT technical task teams, for example for developing national funding proposals, advocacy plans targeting political leadership, and developing programme, communication and service delivery tools. UNFPA has also provided technical assistance to large PMTCT funding programming, including facilitating at national implementing partner technical workshops on prongs 1 and 2.

Beyond a specific focus on PMTCT, UNFPA has, together with WHO and other global partners, supported Uganda in generating evidence on RH/HIV integration and using it to develop national guidance, largely using PMTCT as a primary entry point.

Progress and results of the intervention

Through UNFPA's support and contributions:

- An SRH/HIV rapid assessment report was generated in 2010 and a report on a cross-sectional study on Reproductive Health choices for people living with HIV in Uganda was published in 2010.
- The National Strategy for Integration of SRH&R and HIV/AIDS was developed and endorsed by Ministry of Health in April 2012, with specific guidance on integrating PMTCT into MCH and focus on FP through the HIV treatment programme; the first National HIV Prevention Strategy 2011/14 and the revised National HIV Strategic Plan 2011/14 provide a focus on SRH/HIV integration.
- The National PMTCT Scale-up Plan 2010/14, which initiated an expanded focus on prongs 1 and 2 was developed and has now been updated into the Elimination Plan for MTCT 2011/12 – 2014/15. This provides full focus on prongs 1 and 2, hingeing on global guidelines and evidence.
- The option B+ policy shift guidance was endorsed by the government in 2012 and by the end of 2013, implementation had been rolled out to all 112 districts in the country.
- Resources have been mobilised for PMTCT, including $40 million from the US Government. Funding from Global Fund Round 9 on health systems strengthening support catered for the recruitment of more midwives and the procurement of male and female condoms for dual protection.

- PMTCT is currently the only biomedical intervention where service delivery aspects have been formally fully integrated into mainstream health system tools hingeing on the MNCH platform.
- The First Lady of Uganda agreed to serve as PMTCT national champion in 2012 and has since traversed the country to inspire action and boost community sensitisation for service uptake. As part of her national PMTCT campaign, the First Lady and the President of the Republic of Uganda took tests for HIV in public. They called on people to find out their status and be supported appropriately to make and sustain healthy HIV prevention and care choices.
- Religious and cultural leaders made resolutions to support national HIV, maternal health and GBV programmes. Five main religious denominations have translated these commitments into common leadership handbooks to guide community mobilisation and education within their respective social teachings.

According to UDHS 2011, the unmet need for family planning has declined from 41 per cent in 2006 to 34 per cent in 2010/11. An increase has been noted in ANC attendance, estimated at 94.9 per cent of all pregnancies in 2010/11. Deliveries with skilled attendance have increased from 41 per cent to 58 per cent between 2006 and 2010/11, despite a stagnating trend in the maternal mortality rate. Annual PMTCT programme reviews since 2008 have reflected increasing trends in PMTCT service coverage. The proportion of pregnant women tested for HIV increased from 65 per cent in 2009 to 90.4 per cent in 2013; the proportion of pregnant women living with HIV receiving ARVs increased from 50 per cent in 2009 to 96 per cent in 2012; and estimates from modelling indicate that in 2012, 15,000 babies were born with HIV, compared to 25,000 babies in 2009. The UN currently rates Uganda among high performing countries that are likely to achieve EMTCT targets by 2015.

Lessons learnt

The following lessons can be made from this intervention:

- Evidence from local contexts is crucial for influencing policy and programming. This, however, needs to be generated through mandated government organs to promote ownership of the process and outcomes and the motivation to act on them.
- Strategic positioning of global partners in sector and national discussions at policy and technical levels is key. Advocating for an agenda requires being on the relevant table(s) consistently until a result is achieved. Some issues fall off not because they are not important but because there is no one to keep an eye on them.
- Technical knowledge of the subject and application in local contexts is a key ingredient, though financial support creates more opportunities and adds an edge to negotiations. UNFPA largely gains financial support from UNICEF and other partners for PMTCT-specific aspects but commands credibility in the area of technical input and the broader support to FP and maternal health.
- Attaining a critical mass of stakeholders, especially development partners, is needed to sustain the focus on an agenda. Identifying and working with allies on a given issue ('selling the niche') creates opportunities for taking a common message to different fronts,

with positive impacts. Honest partnerships hinged on declaring intentions foster good working relationships.

- Functional UN Joint Programmes on AIDS create synergies and opportunities for stronger UN voices that mobilise action from other global, government and non-government stakeholders; employing multiple approaches to comprehensively address the issue from policy, programming and service delivery is necessary as well as ensuring linkages to programming in related areas.
- These approaches can potentially be replicated in other settings based on clear knowledge of local contexts and environments.

Conclusions and recommendations

If HIV interventions are to be systematically and rapidly scaled up for impact, multi-partner programming is critical – as evidenced in the national EMTCT programme in Uganda. The UN generally, and UNFPA specifically, has a major role to play in national EMTCT programmes and in particular, in promoting SRH/HIV linkages and integration for more efficient use of resources and greater impact at community levels. In Uganda, existing resources can be exploited to achieve positive HIV, reproductive and maternal health outcomes. SRH/HIV integration is feasible but cannot happen automatically.

UNFPA Country Offices need to be proactive and push for the adoption of global guidance hingeing on locally generated evidence to promote home-grown solutions, create synergies within the UN family and build partnerships with development partners to leverage resources, and present a common front in working with government and other national partners within comparative advantages. The Fund needs to make resources available to ensure UNFPA's technical presence and positioning to exploit opportunities for advancing ICPD agendas, such as through political, policy, technical and community leadership.

For more information, please contact:

UNFPA Uganda Country Office: +256 417 744 500 or nangobi@unfpa.org

Rosemary Kindyomunda
HIV/AIDS Officer: +256 414 345 600/344 871 or kindyomunda@unfpa.org

ZIMBABWE: REACHING SEX WORKERS FOR HIV PREVENTION

Zimbabwe has one of the largest and most sustained HIV epidemics in the world, though there is evidence that HIV prevalence is declining. The prevalence dropped from 26.5 per cent in 1997 to 14.3 per cent to date.

While the majority of HIV infections occur in the general population, specific sub-populations, including female sex workers, are at higher risk. It is estimated that 11 per cent of new adult HIV infections occur among female sex workers, their clients and clients' partners[1].

More specifically, HIV prevalence among female sex workers and women living near plantations and mining areas is high, ranging from 64 to 75 per cent[2].

Despite such a high HIV prevalence among female sex workers, interventions in the country were fragmented and conducted on a project-by-project basis, without a clear national vision. This can be attributed to the fact that sex work is criminalised and stigmatised. According to the Sexual Offences Act, (2001), it is an offence to make a living from the proceeds of sex work, to recruit others, to solicit and to pay for sex. This has led to regular police raids, making sex work an underground activity in many settings. In general, Zimbabweans have a deep-seated traditional and religious value system that is prejudiced against sex work.

[1] The Modes of Transmission Study (2010)
[2] National AIDS Council (Zimbabwe), International Organisation for Migration, UNAIDS and UNFPA. Sex work and HIV/AIDS in Zimbabwe: Analysis of current settings, policies, and interventions (2009)

Situation and response analysis of female sex work and HIV

In 2009, the National AIDS Council (NAC), in conjunction with UNFPA, UNAIDS and IOM, commissioned a situation and response analysis to understand the dynamics of female sex work and HIV in Zimbabwe. The study found that female sex workers ranged from 12 to 60 years old and entertained from one to 12 clients a day. The most offered service is penile-vaginal sex, which is charged on the basis of the amount of time the sex worker spends with the client, and whether or not a condom is used. Irrespective of whether services are provided for a short time, longer time or for the whole night, sex without a condom earns higher rates.

A peer educator demonstrating how to use a condom to clients waiting to be assisted at a static clinic. Photo: UNFPA Zimbabwe/ Emma Mulhern

The study also noted that awareness of and interest in using condoms was high. However, actual use was inconsistent because of the popular risk calculus formulae, which include physical attraction of clients, long-term relationships and the association of sex without a condom with greater financial gain.

The study recommended the provision of clinical and non-clinical services to sex workers to reduce their vulnerability to HIV. Also, the Zimbabwe National HIV and AIDS Strategic Plan II (2011 to 2015) emphasises the need for strengthening and expanding targeted interventions for sex workers and their clients.

Programme to reduce vulnerability to HIV

A nurse/counsellor attending to a client wears ordinary clothes to better create a rapport with female sex workers, who are stigmatised by most health workers (identifiable by their uniforms) and do not feel comfortable to talk to them. Photo: UNFPA Zimbabwe/Phylis Munyama

In 2009, NAC in partnership with UNFPA and UNAIDS commissioned the Zimbabwe AIDS Prevention Programme (ZAPP) to pilot a targeted HIV prevention programme for sex workers as part of the National Behaviour Change Programme. Two service provision models were piloted – a static site (drop-in centre) in Harare, which is an urban setting, and outreach (mobile) sites at four growth points (in a rural setting) along the Harare-Nyamapanda highway, where mobile clinic facilities were offered one day a week.

Based on the results of the pilot programme and lessons learnt, it was recommended that the programme be scaled up. This was commenced by Regai Dzive Shiri in 2009, with financial support from the Expanded Support Programme and further financial and technical assistance from UNFPA. The target was to establish three static sites and 13 mobile sites.

In 2012, UNFPA mobilised additional resources through the Integrated Support Programme on Sexual and Reproductive Health and Prevention of HIV and GBV, which is being funded by the governments of Britain, Sweden and Ireland to sustain established sites and establish an additional three static sites and 17 outreach sites. The programme is being implemented by the Centre for Sexual Health and HIV/AIDS Research Zimbabwe (CeSHHAR), formally known as Regai Dzive Shiri, for the period of 2012 to 2015.

Implementation of targeted HIV prevention project

The objective of the programme is to reduce new HIV infections among female sex workers, their clients and clients' partners, and to improve the rights of sex workers. This entails the following:

- Establish service delivery sites offering clinical and non-clinical services for female sex workers at identified hot spots (areas with a high concentration of sex work) in both urban and rural areas.

- Increase demand for and utilisation of HIV prevention and sexual and reproductive health and rights (SRHR) services by female sex workers.
- Increase coverage of effective peer education on safe sexual practices, services uptake and female sex workers' rights.
- Improve the rights of female sex workers, including their SRHR, and mitigate abuse and violence.

A peer educator demonstrates how to use the female condom during an outreach session. Photo: UNFPA Zimbabwe/Stewart Muchapera

Strategies to ensure success

The overall strategy involves providing multi-sectoral and comprehensive clinical and non-clinical HIV prevention and SRHR services to female sex workers. This includes establishing linkages with health, legal and counselling service providers, such as the Zimbabwe Republic Police Victim-Friendly Unit (ZRP-VFU), the Zimbabwe Lawyers for Human Rights (ZLHR) and the Ministry of Health and Child Care (MOHCC) at national, provincial and district levels.

Key strategies used in implementing the programme

Stakeholder sensitisation: This included meetings with female sex workers, service providers including the MOHCC, legal service providers, the police and local line ministry heads as well as local non-governmental organisations. Due to the illegality of and stigma associated with sex work in Zimbabwe, these meetings were critical for acceptance and ownership of the programme in the different settings (rural or urban).

Recruitment and training of peer educators: Peer educators are active female sex workers who are literate and appreciate the voluntary nature of the work. Their training includes sessions on HIV prevention, STIs and contraception, sex workers' rights, and the development of their skills to be able to undertake HIV prevention activities among their peers.

Creating a user-friendly environment: This includes: (i) identifying accessible sites for clinics; (ii) ensuring stakeholder buy-in before setting up clinics; (iii) training of friendly healthcare providers to ensure positive health-seeking behaviour by female sex workers; so they will be treated with respect; (iv) recruitment of staff who are willing to work without bias with female sex workers at the clinics; and (v) engaging the police through the ZRP-VFU, which also supports the training of peer educators with regards to the law, ensuring that female sex workers who face abuse feel free to report their cases without fear of victimisation.

Engaging with female sex workers: Focus group discussions were held with female sex workers to assess and respond to their needs. This process has created an environment in which sex workers felt included and hence programme ownership was realised.

Collectivisation of female sex workers: This involves creating space for female sex workers to socialise and form bonds, via support groups, solidarity and collectivisation. It is a powerful tool for health promotion and the provision of psycho-social support. One of the peer educators provides a manicure service at the static site, allowing the women to discuss critical issues in a relaxed environment.

Provision of a minimum package of services to female sex workers, including clinical and non-clinical services. This included the following:

- HIV prevention and reproductive health services, including male and female condom promotion, STI treatment, family planning, voluntary testing and counselling, assistance with referral for HIV treatment and care services, and opportunistic infection referrals. With ISP funding, service provision was expanded to include cervical cancer screening, provision of long-acting methods of family planning and ART for prevention.
- Legal services: The ZLHR provides free legal advice to and representation for sex work, and abuse cases are referred to the ZRP-VFU.
- Para-legal education: Selected peer educators have been trained to provide para-legal education and support to their peers.
- Peer education: Peer educators offer HIV prevention and sexual health advice and support to female sex workers. They also provide feedback on the impact of the programme and views from their peers.
- Community mobilisation: This provides a platform for information dissemination and discussion, building trust, strengthened support networks, and reduced competition among sex workers. Community mobilisation has emerged as an effective strategy to support sex workers in preventive behaviours, and in accessing HIV testing and adherence to treatment.
- Other services: The programme also networks with other service providers for the benefit of female sex workers. Population Services Zimbabwe offers free family planning, including post-abortion care; the Sexual Rights Centre trains female sex workers on advocacy issues and standing up for their rights; the Nehemia project in Bulawayo offers female sex workers support for income-generating projects; the Zimbabwe Women Lawyers in Southern Africa assists with issues of domestic violence and acquisition of national identity cards or birth certificates by female sex workers and their children.

Results: accessing services without fear of stigma

Overall, female sex workers appreciate the programme as they are able to access services without fear of stigmatisation, harassment or imprisonment. In 2012, the programme was nominated the best HIV prevention programme in Mashonaland East and Central provinces.

Some of the key results are as follows:

- Six static sites were established in Harare, Mutare, Bulawayo, Masvingo, Karoi and Gweru. These are open daily and provide both clinical and non-clinical services. They are supported through outreach activities by peer educators.
- Thirty outreach sites have also been established and these are located at key points along major highways

and in sex worker 'hot spots'. They are open once a week and are nested within public health facilities for easy transition to the public system for long-term sustainability.

- More than 160 active female sex workers have been trained as peer educators to cover all the sites. Some peer educators have been elevated to programme interns while others are junior outreach workers to ensure sustainability.
- A total of 39,239 new sex workers accessed programme-supported sites between July 2009 and September 2014.
- There were 51,989 visits by clients (new and old) for SRHR services between July 2009 and September 2014.
- A total of 31,406 person-exposures to SRH and HIV prevention messages delivered by peer educators were recorded between January 2014 and September 2014.
- About 18,218 sex workers were treated for STIs between July 2009 and September 2014.
- A total of 7,818 HIV tests were administered between July 2009 and September 2014. Of these 3,238 were diagnosed HIV positive and referred for ART services.
- Between July 2012 and September 2014, a total of 2,804,378 male and 219,471 female condoms were distributed to sex workers.

Critical elements of success

- The involvement of female sex workers from the onset of the programme is critical, as this ensures ownership and utilisation of services.
- Engagement with referral centres (health, legal and police) to destigmatise sex work is essential in building positive and lasting linkages and a user-friendly atmosphere when female sex workers access services at the facilities.
- Providing comprehensive healthcare services or a 'one-stop-shop' approach is critical to the success of the programme, especially in an environment where sex work is criminalised and stigmatised.
- Decentralised static sites are more effective and efficient than outreach or mobile sites. For example, when the Mutare site was converted to a static site the number of female sex workers who accessed services increased from 140 to more than 750 in six months.
- Establishing a fully functional site takes time, as gaining the trust of sex workers can take months. Their positive experiences at the clinic are essential in increasing utilisation of services by other female sex workers.
- Clinic staff need counselling and debriefing sessions to avoid burnout as they see many clients with a number of health and emotional problems.

Key challenges experienced

The criminalisation and stigmisation of sex work in Zimbabwe perpetuates sex workers' harassment by the police and negative attitudes of healthcare providers. This also makes female sex workers reluctant to access referral services (for example, testing for CD4 count and HIV treatment) or reporting harassment and violence. The programme is making great inroads in addressing negative attitudes of the police through advocacy and sensitisation. The dismissal and demotion of some police officers who abused female sex workers in Victoria Falls in 2012 is one such example.

Challenges are particularly experienced in reaching female sex workers under the age of 19 years, despite the evidence that they constitute a large proportion of female sex workers. The programme offered incentives to female sex workers to bring younger female sex workers to the clinics. Although this was effective, it could not be sustained due to limited resources. The programme is looking into introducing innovative initiatives to be able to engage them.

Potential for expanded coverage

The female sex worker programme has been implemented at 36 sites across the country. The continued increase of female sex workers seeking treatment and a better understanding of their SRHR is an indication that the programme is worthwhile. It is therefore essential that the programme continues within the established sites and be expanded to cover other geographical locations, especially Mashonaland Central.

For more details, please contact:

UNFPA Zimbabwe Country Office:
+263 4 338 771 or 338 836/44

Dagmar Hanisch, Technical Specialist HIV/SRH:
hanisch@unfpa.org

Samson Chidiya
Programme Officer: chidiya@unfpa.org

Phylis Munyama
Programme Associate: munyama@unfpa.org

ACKNOWLEDGEMENTS

We would like to thank the UNFPA East and Southern African Country Offices whose promising practices were selected for this report, and for their support in preparing them for publication.

Delivering a world where
every pregnancy is wanted
every childbirth is safe
every young person's potential is fulfilled

UNITED NATIONS POPULATION FUND (UNFPA)
East and Southern Africa Regional Office
9 Simba Road
PO Box 2980, Sunninghill, 2157, South Africa

Tel: +27 11 603 5300

Email: esaro.info@unfpa.org
Website: esaro.unfpa.org or unfpa.org
Facebook: UNFPA East and Southern Africa Regional Office
Twitter: @UNFPA_ESARO