

Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region





*Minimum Standards for the Integration of HIV and Sexual & Reproductive
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Contents

Acknowledgements	2
Acronyms and Abbreviations	3
Definitions of Key Terms and Concepts.....	4
1.0. Background and Contextual Analysis.....	7
1.1. Overview of SRH and HIV in the SADC Region	7
1.2. Rationale for the Minimum Standards	10
2.0. Process for Developing Minimum Standards	12
3.0. Conceptual Framework for the Minimum Standards.....	13
4.0. Scope, Purpose and Expected Outcomes.....	16
4.1. Scope	16
4.2. Purpose	16
4.3. Expected Outcomes	16
5.0. Guiding Principles	17
6.0. The Minimum Standards.....	19
6.1. Minimum Standards at Policy Level	19
6.2. Minimum Standards at Systems Level	20
6.3. Minimum Standards at Facility Level	22
6.4. Minimum Standards at Community Level	28
6.5. Minimum Standards for Adolescent and Youth-Friendly Sexual and Reproductive Health Level	29
6.6. Cross-cutting Minimum Standards	31
7.0. Implementation of the Minimum Standards	32
7.1. Key steps for Implementation of the Minimum Standards	32
7.2. Stakeholders' Roles and Responsibilities	32
7.2.1. SADC Secretariat	32
7.2.2. Member States	33
7.2.3. Other Stakeholders	33
7.3. Financing Mechanisms	34
7.4. Monitoring and Evaluation	34
7.4.1. Monitoring and Evaluation at Member State Level	34
7.4.2. Monitoring and Evaluation at SADC Regional Level	35
References	36

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Acronyms and Abbreviations

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
CD4	cluster of differentiation 4
CSE	comprehensive sexuality education
ECD	early childhood development
EMTCT	elimination of mother-to-child transmission of HIV
GNP+	Global Network of People Living with HIV and AIDS
HIV	human immunodeficiency virus
HTC	HIV testing and counselling
ICPD	International Conference on Population and Development
ICW	International Community of Women Living with HIV and AIDS
IPPF	International Planned Parenthood Federation
LGBTI	lesbian, gay, bisexual, transgender and intersex
MDG	Millennium Development Goal
MICS	multiple indicator cluster survey
MMR	maternal mortality rate
MSM	men who have sex with men
OVC&Y	orphans and vulnerable children and youth
SADC	Southern African Development Community
SGBV	sexual gender-based violence
SRH	sexual and reproductive health
SRHR	sexual reproductive and health rights
SRMNCH	sexual, reproductive, maternal, neonatal and child health
STI	sexually transmitted infection
TB	tuberculosis
UCSF	University of California, San Francisco
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Definitions of Key Terms and Concepts

The following definitions have been adopted in the context of this Minimum Standards document.

Adolescent: Any person between the ages of 10 and 19.

Adolescent and youth-friendly health services: Health services that are both responsive and acceptable to the needs of adolescents and youth and which are provided in a non-judgmental, confidential and private environment, in times and locations that are convenient for adolescents and youth.¹

Comprehensive sexuality education (CSE): This refers to provision of age-appropriate, culturally relevant, scientifically accurate, realistic, non-judgmental information about sex and relationships. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk-reduction skills about many aspects of sexuality.²

Health system: The sum total of all the organizations, institutions and resources whose primary purpose is to ensure delivery of quality services to all people, when and where they need them. The World Health Organization (WHO) identifies six core components or 'building blocks' of a health system: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing and (vi) leadership/governance.³

Gender-based violence (GBV): All acts perpetrated against women, men, boys and girls on the basis of their sex which causes or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed or other forms of conflict. It covers domestic violence, sexual harassment in the workplace, human trafficking and sexual and emotional abuse, to name a few examples. When referring to gender-based violence SADC recognises that the discussion is not just about the act of violence, but also about education and prevention, as well as victim assistance.⁴

Integration: The process of bringing together, in a holistic manner, different kinds of related sexual and reproductive health (SRH) and HIV and AIDS interventions at the levels of legislation, policy, programming and service delivery to ensure access to comprehensive services in an efficient and effective manner.⁵

Key populations: Groups of people who are more likely to be exposed to or to transmit HIV and whose engagement is critical to a successful HIV response. The SADC HIV and AIDS Strategy Framework defines key populations as young women, sex workers, mobile and displaced populations, injecting drug users, prisoners and sexual minorities, or as defined by the Member States in alignment with international and regional standards.⁶

1 SADC Minimum Standards for Child, Adolescent, HIV, TB and Malaria Continuum of Care and Support. (2013–2017).

2 Adapted from UNESCO (2009) *International Technical Guidance on Sexuality Education: An evidence informed approach for schools, teachers and health educators*, Paris.

3 Adapted from WHO (2010). *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*.

4 <http://www.sadc.int/issues/gender/gender-based-violence/>.

5 Adapted from *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: a Generic Guide*, prepared and published by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives, 2009.

6 SADC. (2010). HIV and AIDS Strategic Framework 2010–2015.

Linkages: The bi-directional synergies between laws, policies, programmes, services and advocacy around SRH and HIV and AIDS. It is recognized that sexual and reproductive ill health and HIV and AIDS share root causes which include poverty, gender inequality, gender-based violence and social marginalization. SRH and HIV and AIDS should therefore be addressed in a holistic manner.⁷

Reproductive rights: The basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. These rights also include the right to the highest attainable standard of sexual and reproductive health and the right of all people to make decisions concerning reproduction, free from discrimination, coercion and violence.⁸ Reproductive rights are articulated in SADC Member States' legislation as well as in international human rights documents.

Rights-based approach: The recognition that citizens of SADC Member States have a right to health services, products and information and that the individual States have an obligation to ensure that their citizens realize this right. Citizens have a corresponding responsibility to seek health services and to live healthy lifestyles.⁹

Sexuality: A central aspect of being human which encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. This is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, roles and relationships throughout an individual's whole life.¹⁰

Sexual rights: Human rights which relate specifically to sexuality and which are articulated by national laws, international human rights documents and other international agreements.¹¹ Sexual rights seek to ensure that all people can express their sexuality free of coercion, discrimination and violence.

Sexual gender-based violence (SGBV): Any sexual act or unwanted sexual comments or advances using coercion, threats of harm or physical force, by any person, regardless of their relationship to the survivor, in any setting. SGBV is usually driven by power differences and perceived gender 'norms'. It includes forced sex, sexual coercion and rape of adult and adolescent men and women, and child sexual abuse.¹¹

Sexual minorities: Sexual minorities are groups whose sexual identity, orientation or practices differ from those of the majority of the surrounding society. Usually, sexual minorities comprise lesbian, gay, bisexual and transgender individuals.¹²

Social determinants of health: These are the social, cultural, religious, economic and political conditions in which people are born, grow, live, work and age which influence their access to and utilization of health services, products and information.¹³

Systems thinking: A holistic approach to analysis that focuses on linkages, interrelationships, Interdependency and interactions between the components that comprise the entirety of a defined whole whose properties and defining characteristics would be lost if the system were to be taken apart (Churchman, 1968; Ackoff 1997; Roberto, 2002).

Youth: Any person between the ages of 15 and 35 years.¹⁴

7 Adapted from *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide*, prepared and published by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives, 2009.

8 Adapted from UN Programme of Action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994, Para 7.3.

9 Modified and contextualized from http://en.wikipedia.org/wiki/Rights-based_approach_to_development.

10 Adapted from World Health Organization, Draft Working Definition. October 2002.

11 Adapted from Population Council. (2008). Sexual and Gender-Based Violence in Africa.

12 Adapted from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3657897/>.

13 Adapted from http://www.who.int/social_determinants/en/.

14 African Union Commission, 2006, African Youth Charter.



I.0. Background and Contextual Analysis

I.1. Overview of SRH and HIV in the SADC Region

Overall, SADC Member States have reported gradual improvement in SRH and HIV indicators.

Malawi and Tanzania, for instance, have been reported as having achieved the Millennium Development Goal (MDG) target on reducing under-five mortality while Madagascar, Mauritius, Mozambique, Namibia and Seychelles are reported to be on track. In addition, Botswana, Namibia and Swaziland have achieved the 80% universal coverage target for antiretroviral therapy (ART).¹⁵

Despite this progress, most Member States are not on track to meet MDG 4 on reduction of child mortality, MDG 5 on maternal health and MDG 6 on HIV and AIDS. With nine Member States – Botswana, Lesotho, Namibia, Malawi, Mozambique, South Africa, Swaziland, Zambia and Zimbabwe – having HIV prevalence above 10%, the region continues to experience the worst HIV epidemic in the world. Adolescent and youth SRH and HIV indicators in the region are worrisome. A UNICEF report indicates that 2.7 million young people (over 50% globally) in Southern and East Africa are living with HIV. In Botswana, Lesotho and Swaziland, more than one in ten young people are infected with HIV.¹⁶ The region has high levels of teenage pregnancy with four countries, that is, Mozambique (38%), Madagascar (36%), Malawi (35%) and Zambia (34%) having had more than 30% of women aged 20–24 years giving birth before the age of 18 years.¹⁷

Table 1 provides more detailed information on the SADC context for HIV and SRH.

¹⁵ <http://www.countdown2015mnch.org/>.

¹⁶ http://www.unicef.org/esaro/5482_HIV_prevention.html.

¹⁷ UNFPA. (2013). Adolescent Pregnancy Review of Evidence.

TABLE 1: SELECTED SRH AND HIV INDICATORS IN SADC

Country	HIV-prevalent adults % ¹⁸	ART coverage % ¹⁸	Prevention of mother-to-child transmission coverage % ¹⁸	Under-five mortality rate % ¹⁹	Maternal mortality rate %	Antenatal care % ²⁰	Total fertility rate %	Family planning ²¹	Skilled birth attendance %	Teenage pregnancy rate %
Angola	2.1	36	16	205	460 ²²	44 ²³	6.4 ²⁴	18.4 ²⁵	49 ²⁶	16.5 ²⁷
Botswana	23.4	93	94	53.8	147.9	94 ²⁸	2.8 ²⁹	NR*	95 ³⁰	16.5 ³¹
Democratic Republic of the Congo ³²	1.1	NR	NR	197.8	549 ³³	88.4 ³⁴	6.6	24.2	80.1	18.6
Lesotho ³⁵	23.3	58	55	117	490	92	3.3	23	61.5	19.6
Madagascar ³⁶	0.3	3	11	100.2	448 ³⁷	82.1 ³⁸	5.0	18	44.3	36.9
Malawi ³⁹	10	67	53	120.2	675	94.7	5.7	26	71	25.6
Mauritius ⁴⁰	1	37	74	16.2	65	100	1.4	3.3	99.5	8.7 ⁴¹
Mozambique ⁴²	11.3	46	51	122	408	90.6 ⁴³	5.9	28.5	54.3	37.5
Namibia ⁴⁴	13.4	95	85	51.6	449	95	3.6	3	81	15.4
Seychelles ⁴⁵	2.5	NR	100	18.5	0.0	98	2.3	NR	99.4	15.3
South Africa ⁴⁶	17.3	66	108	71.7	310	40 ⁴⁷	2.35	13	82	NR
Swaziland ⁴⁸	26	83	97	101.7	320	77	3.7	13	82	NR
Tanzania ⁴⁹	5.1	40	74	105.8	454	96	5.4	25	51	23
Zambia ⁵⁰	12.5	82	86	160.3	583 ⁵¹	19 ⁵²	5.9 ⁵²	27	47	28
Zimbabwe ⁵³	14.9	77	54	94.3	525	88.5	4.1	12.8	66.2	23.5

* Not reported

18 UNAIDS. (2013). Global Report for 2013.

19 SADC Statistics Yearbook 2012.

20 Refers to ANC (antenatal care) first visit, unless otherwise stated.

21 Refers to unmet need for family planning.

22 2014 WHO.

23 2010 Inquérito Integrado sobre o bem-estar da População.

24 2010 Inquérito Integrado sobre o bem-estar da População.

25 2010 Ministério do Planeamento e Desenvolvimento Territorial Report.

26 2010 Inquérito Integrado sobre o bem-estar da População.

27 2011 WHO.

28 Botswana Family Health Survey, 2007.

29 Census 2011.

30 Botswana Family Health Survey, 2007.

31 Botswana Family Health Survey, 2007.

32 Data for DRC from Demographic and Health Survey 2011, preliminary results unless otherwise stated.

33 Demographic and Health Survey 2007.

34 Demographic and Health Survey 2007.

35 Data from Lesotho, unless otherwise indicated, is from Demographic and Health Survey 2009.

36 Data from MDG Survey 2012, unless otherwise indicated.

37 Data from Madagascar Demographic and Health Survey 2007, unless otherwise indicated.

38 MDG Survey 2012.

39 Data from Malawi, unless otherwise indicated, is from Demographic and Health Survey 2010.

40 Data from Mauritius, unless otherwise indicated, is from 2012, Ministry of Health Statistics Unit.

41 CP Survey, 2002.

42 Data from Mozambique 2011 District Health Information System, unless otherwise stated.

43 Namibia 2011 Health Information System.

44 Data from 2006/7 Demographic and Health Survey, unless otherwise stated.

45 Data from 2008-2012, national authority report, unless otherwise stated.

46 Data from South Africa, 2013 MDG report, unless otherwise stated.

47 Refers to first ANC before 20 weeks of pregnancy.

48 Data from 2010 MICS, unless otherwise indicated.

49 Data from 2010 Demographic and Health Survey, unless otherwise stated.

50 Data from Zambia Demographic and Health Survey, unless otherwise indicated.

51 First ANC attendance in the first trimester.

52 Data from Zambia Demographic and Health Survey 2007, unless otherwise stated.

53 Data from 2010/2011 Zimbabwe Demographic and Health Survey, unless otherwise indicated.

All Member States, albeit at varying levels, have made progress towards SRH and HIV integration. By end of 2013, 11 SADC Member States – Botswana, the Democratic Republic of the Congo, Lesotho, Madagascar, Malawi, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe – had conducted SRH and HIV linkages and integration rapid assessments as a step towards introducing integration of the two streams of HIV and SRH.⁵⁴ Through regional integration initiatives such as the UNFPA/UNAIDS SRH-HIV linkages project and other country specific interventions, positive results have been reported. All seven Member States involved in the UNFPA/UNAIDS SRH-HIV linkages project – Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe – have been able to develop policies, strategies, guidelines and standards for promoting SRH and HIV integration.⁵⁵

UNAIDS and UNFPA are implementing a programme targeting seven Member States. The project seeks to expand access to integrated HIV and SRH services. Its activities focus on three main areas:

- Supporting seven countries in Southern Africa to allow full linking of HIV and AIDS and SRH in national health and broader development strategies, plans and budgets;
- Enabling seven countries in Southern Africa to integrate SRH and HIV services more effectively and to scale up; and
- Stimulating the formulation and dissemination of lessons learned in the Southern Africa region, formulating best practices and facilitating South-South cooperation in this field.

At policy level there have been efforts to ensure the development of integrated policies and strategies – although this differs across Member States. For instance, the Elimination of Mother-to-Child Transmission of HIV (EMTCT) plan, which has been adopted by all Member States, for the most part integrates maternal, newborn and child health interventions. In addition, Member States are reviewing their EMTCT and maternal, neonatal and child health strategies, policies and protocols in alignment to the ‘double dividend’ initiative, which is intended to catalyse accelerated action towards the dual goals of ending paediatric HIV and AIDS and improving child survival.⁵⁶ For instance, Botswana has developed an SRH and HIV integration strategy to provide strategic guidance for integration.

In relation to access to adolescent sexual and reproductive health services and HIV and AIDS education, in December 2013 in Cape Town all Member States reaffirmed their commitment to provide comprehensive sexuality education and to improve sexual and reproductive health services for adolescents and young people through the Time to Act Now Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa.

Additionally, current integration efforts at a systems level in the region include the establishment of technical working groups and committees for promoting HIV and SRH integration, as well as the development of integrated monitoring and evaluation tools.

In all countries, antenatal care and maternity registers include columns to capture information on EMTCT, including HIV testing and provision of antiretrovirals for HIV-positive mothers. Whether

⁵⁴ http://srhhivlinkages.org/wp-content/uploads/2013/11/RA_implementation_country_information_2013.pdf. Accessed on March 28, 2014.

⁵⁵ <http://esaro.unfpa.org/public/news/pid/15309>. Accessed on March 25.

⁵⁶ http://www.unicef.org/aids/files/Action_Framework_Final.pdf. Accessed on August 5, 2014.

planned or routine, integration at the facility level in most Member States has also been reported. Studies covering the region have shown the integration of family planning and HIV and AIDS interventions at the facility level, including HIV testing and counselling (HTC), EMTCT, condom promotion for dual protection, integration of sexually transmitted infection (STI) prevention and management, HIV prevention and information, and the integration of antenatal care and HIV testing for EMTCT.⁵⁷ However, very little integration at the community level has been reported.

Despite this progress, the delivery of SRH and HIV integration in the region faces policy, systems, facility and community level-related challenges. Policy-related challenges include: the lack of a policy framework to guide integration; vertical HIV and SRH departments/units; inadequate funding; and a lack of supportive legal and policy frameworks in the provision of SRH and HIV information, services and products. These shortcomings relate in particular to key populations. Challenges at the systems level include poor leadership in coordination of an integrated response, weak health systems infrastructure – such as inadequate trained health workers – and poor monitoring and evaluation systems. Facility and community level challenges include inadequate capacity of health workers and community health workers, inadequate supplies, poor supportive supervision, and stigma and discrimination.

1.2. Rationale for the Minimum Standards

The importance of linking SRH and HIV has become increasingly clear in the context of harmonization, collaboration, the call for increased accountability and the pressure to achieve the MDGs. Since 1994, when the first call for integration was made at the Cairo International Conference on Population and Development (ICPD), several global declarations have been made, including the Glion Call to Action on Family Planning and HIV and AIDS in Women and Children (2004) and the New York Call to Commitment: Linking HIV and AIDS and Reproductive Health (2004).

The development of these Minimum Standards is within the mandate of the SADC Secretariat of “promoting and harmonization of policies and strategies of Member States”. As a result of increased movement of citizens of Member States across SADC Member State borders, there is a need for citizens to access harmonized integrated SRH and HIV services in each of the 15 Member States. SADC Member States have committed themselves to addressing the SRH and HIV challenges, and more specifically, integrating the two thematic areas. Member States have adopted a number of SRH and HIV integration declarations at regional and global levels.

These declarations and commitments provide the foundation for the development of these Minimum Standards.

At the regional level, the Member States have ratified the SADC Protocol on Health and adopted the Maseru Declaration on the Fight Against HIV and AIDS, the SADC 50 by 15 Campaign (which focuses on halving the rates of HIV infection by 2015), the Continental Policy Framework on Sexual and Reproductive Health and Rights and its Plan of Action (Maputo Plan of Action, African Union, 2006), and the Abuja Call for Accelerated Action Towards Universal Access to STI/HIV and AIDS, TB and Malaria Services in Africa (African Union, 2006).

The Minimum Standards for the Integration of HIV and SRH in the SADC Region are aligned to, and seek to operationalize, other SADC SRH and HIV-related strategies, policies and guidelines. For instance, the SADC Protocol on Health calls for “developing regional policies and plans that recognize the inter-sectoral impact of HIV and AIDS/STDs and the need for an inter-sectoral approach to those diseases”.⁵⁸ In support of this, the SRH Strategy identifies HIV and AIDS as one of the diseases that has contributed to poor maternal and newborn health indicators in the region. It notes that “this calls

57 <http://www.igh.org/linkages/SRH-HIV-Report-full.pdf>. Accessed on July 28, 2014.

58 SADC Protocol on Health, signed in 1999 and entered into force in 2004.

for integration and strengthening linkages of SRH and HIV and AIDS/Malaria, Nutrition and TB activities”⁵⁹ while the SADC HIV and AIDS Strategic Plan identifies one of the key action areas: to “develop guidelines and Minimum Standards for its integration with SRH and HIV”.

The majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. People living with HIV are more likely to require SRH services while other people accessing SRH services are likely to be sexually active and therefore require HIV information and services such as HIV testing. Some SRH services have been proven to be effective as part of strategies to prevent HIV transmission. The reduction of the unmet needs of women of reproductive age in relation to family planning – which is one of the targets of MDG 5 (maternal health) – has also been identified as an effective strategy for the elimination of mother-to-child transmission of HIV.⁶⁰ Sexual and reproductive ill-health and HIV share root causes, including economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and the social marginalization of the most vulnerable populations.⁶¹

Programming for SRH takes into consideration the critical enablers and development synergies that are important in HIV and AIDS response. For example, sexual and reproductive health services for people living with HIV are also important for HIV prevention, care and support, and are therefore considered a critical programme enabler in the HIV response. Linkages between SRH and HIV policies, programmes and services are key to influencing both HIV and SRH response outcomes, and are therefore understood to be an important development synergy.

59 Sexual and Reproductive Health Business Plan for the SADC Region 2011–2015. Version 3, July 2012.

60 WHO (2011). Technical guidance note for GF HIV proposals, EMTCT of HIV.

61 UNAIDS (2010). 26th Meeting of the UNAIDS Programme Coordinating Board. Geneva, Switzerland.

2.0. Process for Developing Minimum Standards

These Minimum Standards were developed following an extensive consultative process with Member States, development partners, civil society organizations working on HIV and/or SRH streams and other stakeholders, including representatives from youth-focused organizations. This process included a regional technical review and consultative forums supported by review of global, regional and Member States-level literature and key regional informant interviews. The Minimum Standards were also informed by the outcomes and experiences of a regional HIV and SRH integration project implemented by UNFPA/UNAIDS in seven SADC Member States – Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe – between December 2010 and June 2014.

3.0. Conceptual Framework for the Minimum Standards

HIV and AIDS and poor SRH are major causes of morbidity and mortality in the SADC region, impacting on the social, psychological and economic wellbeing of its people.

HIV and SRH responses are closely interlinked and have mutually beneficial impacts on each other's outcomes. Figure 1 illustrates how standard SRH and HIV interventions intersect, and where linkages have been identified. Examples of overlapping responses include, but are not limited to, family planning in the context of EMTCT programmes; ending gender-based violence and child marriage in the context of prevention of HIV among adolescent girls and women; providing HTC within antenatal care; and promoting condoms within family planning programmes, as well as for STI management and treatment, and HIV prevention.

The SADC SRH Strategy already reflects the linkages and overlapping responses between SRH and HIV through the prioritization of HIV and AIDS within its framework. However, the overwhelming impact of HIV and AIDS over the last two decades and the resulting increase in focus on this disease has led to HIV and AIDS becoming a separate, vertical issue which is mainly addressed in isolation from broader SRH policies and programmes. This approach has compromised the effectiveness of both SRH and HIV interventions.

SADC's position is to address SRH and HIV using a 'systems theory' approach which recognizes the interrelatedness, interconnectedness and interdependence between phenomena such as HIV and SRH, where "the whole is greater than the sum of its component parts". This entails delivering comprehensive services for SRH and HIV in an integrated manner which also takes into account related social and economic factors.

In order to ensure effective SRH and HIV integration, an enabling environment which includes supportive legal and policy frameworks and stronger health systems is an essential prerequisite.

Several studies, including emerging evidence from the Integra research project by International Planned Parenthood Federation (IPPF), the London School of Hygiene and Tropical Medicine and the Populations Council, have demonstrated the enhanced benefits of integrated SRH and HIV interventions compared with vertical programmes.⁶² These include reduced HIV-related stigma and discrimination, increased access to quality HIV and SRH services, reduced gender-based violence and improved programme efficiency.

Using a holistic approach, the Minimum Standards identify the priority linkages between standard SRH and HIV interventions, as well as opportunities for integration. This includes possible entry points, opportunities and overlaps for bi-directional linkages between SRH and HIV interventions.

The Minimum Standards draw upon the SRH interventions outlined in the SRH Strategy for the SADC Region 2006–2015. These include: safe motherhood; family planning; prevention of abortion and post-abortion care; prevention and treatment of reproductive tract infections and STIs, HIV and AIDS; diagnosis and treatment of reproductive health cancers; promotion and education on exclusive breastfeeding; prevention and treatment of infertility; addressing harmful practices such as female

⁶² <http://www.integrainitiative.org>.

genital mutilation/cutting; adolescent and youth sexual and reproductive health; and prevention and management of gender-based violence.

The Minimum Standards also draw upon HIV prevention, treatment, care and support interventions as identified in the SADC HIV and AIDS Strategy Framework for 2010–2015. The Minimum Standards recognize that integration of SRH and HIV is a process and that Member States should commence efforts by focusing on ‘low hanging fruits’, namely, integration interventions which have already been proven to be effective. These include family planning and HTC; family planning and EMTCT; and HTC and adolescent and youth-friendly services. Member States are expected to draw from these examples of successful integration with a view to scaling up the provision of integrated services.

In recognition that efficient health systems are a prerequisite for effective integration, six pillars or key components of health systems strengthening have been identified. These are: leadership and governance; service delivery; human resources for health; health care financing; essential medicines and supplies; and health information systems. (See Figure 1.)

The Minimum Standards further recognize that access to and uptake of integrated SRH and HIV services, products and information is influenced by various social determinants of health, including a range of socio-economic, political, cultural and religious factors. Member States will identify and design effective strategies to address the context-specific social determinants that hinder access to and utilization of integrated services by their populations.

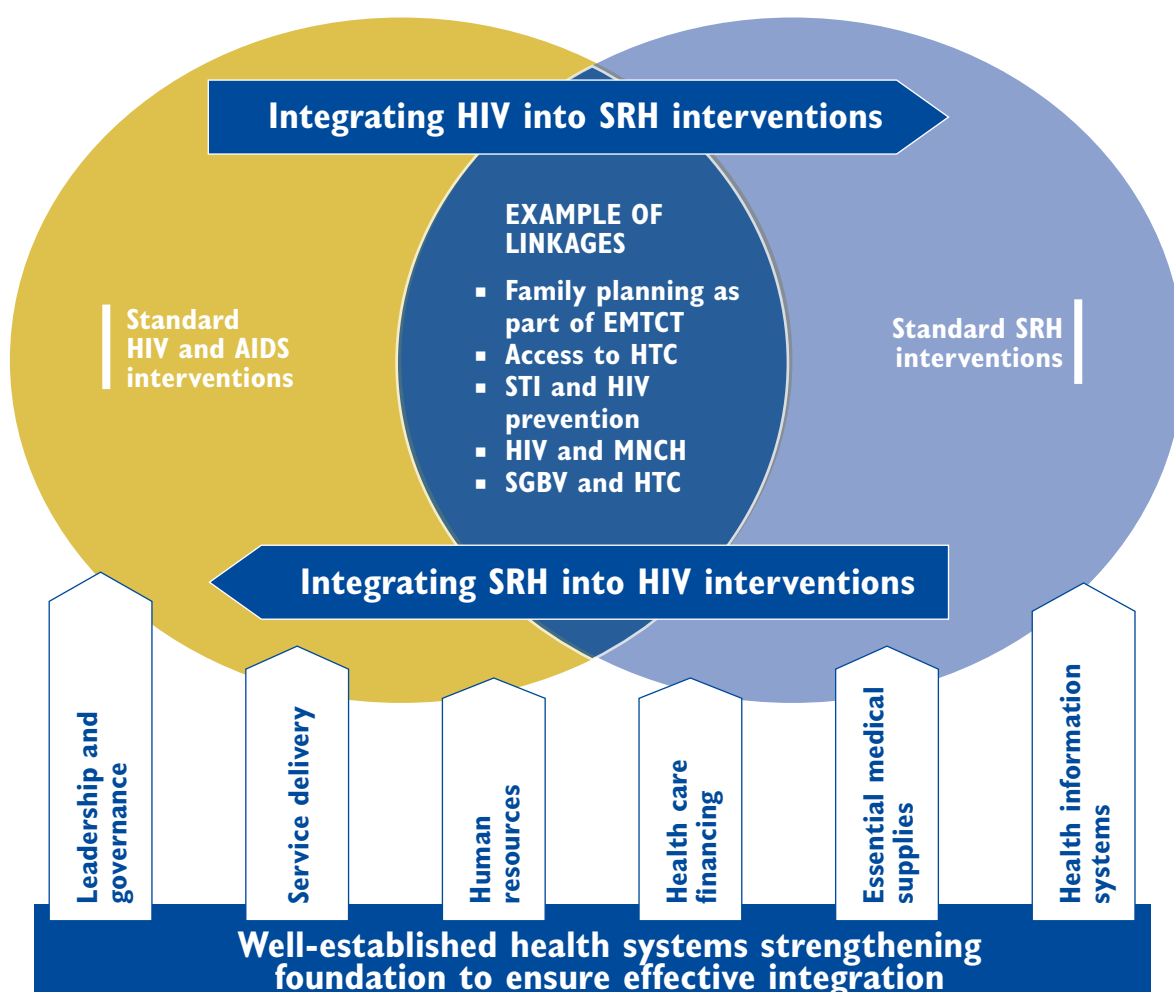


FIGURE 1: SRH AND HIV LINKAGES FRAMEWORK

The Minimum Standards are also underpinned by the human life cycle development approach. This approach recognizes that individuals have different SRH needs and face different and unique HIV and AIDS prevention, treatment, care and support needs depending on their age and stage of development. In these Minimum Standards, SADC advocates for integrated SRH and HIV programming tailored to the challenges that both men and women face at different times in their lives. Figure 2 illustrates the human life cycle development approach and provides examples of distinct SRH and HIV and AIDS challenges, as well as examples of essential services at different stages of human development.

Developmental stage	SRH and HIV challenges	Integrated responses
INFANCY	<ul style="list-style-type: none"> • High mortality rates • Possibility of mother-to-child transmission 	<ul style="list-style-type: none"> • EMTCT and immunizations • Newborn care interventions • Nutrition • Early infant male circumcision • Integrated management of childhood illnesses
CHILDHOOD	<ul style="list-style-type: none"> • High mortality rates • Risk of mother-to-child transmission • Sexual violence 	<ul style="list-style-type: none"> • Child health interventions and EMTCT • Life skills • Integrated management of childhood illnesses
ADOLESCENCE AND YOUTH	<ul style="list-style-type: none"> • Unprotected sexual intercourse • Early pregnancy • Onset of puberty 	<ul style="list-style-type: none"> • Comprehensive information and life skills education on SRH and HIV • Provision of reproductive health commodities (contraceptives, equipment and sanitary pads) • Youth-friendly health services/corners
ADULTHOOD	<ul style="list-style-type: none"> • High maternal death rates • Risk of SGBV • Low male participation 	<ul style="list-style-type: none"> • Maternal health interventions • Male involvement interventions • Option B+* • Prevention of gender-based violence • Screening cancers of the reproductive health system • Non-communicable diseases
OLD AGE	<ul style="list-style-type: none"> • Menopause • Risk of cancers of reproductive system • SGBV and discrimination for men 	<ul style="list-style-type: none"> • Issues of mid-life concerns • Non-communicable diseases • Training health workers on SRH and HIV needs for older people • Screening and treatment of cancers of the reproductive health system

* Option B+: Every pregnant woman is put on antiretrovirals without taking into consideration the CD4 count level.

FIGURE 2: HUMAN LIFE CYCLE DEVELOPMENT APPROACH

4.0. Scope, Purpose and Expected Outcomes

4.1. Scope

These Minimum Standards are a framework which can guide Member States when programming for services around SRH and HIV. The framework also includes approaches which address the social determinants of health that hinder access to SRH and HIV services. Additionally, the Minimum Standards provide guidance on the integration of SRH and HIV at the policy, systems, facility and community levels in an effort to ensure universal access to SRH and HIV and AIDS services for the SADC region's population.

The Minimum Standards do not seek to limit the ambitions and continued progress of Member States which have already put SRH and HIV integration strategies in place, but rather to ensure that all Member States meet a set of minimum requirements necessary to attain the regional integration and development aspirations of SADC as outlined in the Treaty.

4.2. Purpose

The overall purpose of the Minimum Standards is to benchmark and harmonize the provision of integrated SRH and HIV interventions and services among SADC Member States, with a view to accelerating the effective delivery of quality and comprehensive health and related social services for all people, irrespective of age, sexual orientation, marital status and gender. The Minimum Standards also serve as an advocacy tool which highlights the need for and benefits of an integrated SRH and HIV response.

4.3. Expected Outcomes

The implementation and operationalization of these Minimum Standards is expected to result in:

- Increased harmonization of SRH and HIV responses within the SADC region;
- Improved, integrated, SRH and HIV responses at policy, systems, facility and community levels;
- Increased access to quality and comprehensive SRH and HIV services, products and information;
- Improved programme efficiency in the delivery of SRH and HIV services; and
- Improved monitoring, evaluation and reporting of integrated SRH and HIV responses.

5.0. Guiding Principles

The guiding principles define the values that should be applied and upheld by Member States in the delivery of integrated SRH and HIV services in the SADC region. These principles are:

Human rights centred, gender sensitive and respectful of confidentiality: SRH and HIV services should be guaranteed and provided for all people in a gender-sensitive and age-responsive manner, which respects the confidentiality of the clients.

Involvement and participation: People living with HIV and AIDS, children, adolescents and youth as well as other key populations and members of the community should be adequately consulted and supported to participate at all levels of SRH and HIV integration programming.

Equality and non-discrimination: Policies, programmes and services should uphold non-discrimination practices in all situations, regardless of HIV status, age, sex, gender, sexual orientation, religion, and sociocultural and economic status.

Partnerships and holistic approach: Ensure the provision of comprehensive information and services for SRH, HIV and AIDS and address the related social and economic determinants through engaging in meaningful partnerships and networks with clearly defined roles and responsibilities.

Evidence-based and context-specific: Implementation of SRH and HIV integration interventions should be guided by evidence and contextualized to country-specific needs to ensure sustainability and ownership.

Equity and accessibility: The importance of ensuring universal access to SRH and HIV integrated services by all is recognized, including the particular needs of key populations in the provision of services.



6.0. The Minimum Standards

These Minimum Standards are categorized into six main subheadings: Policy; Systems; Facilities; Adolescent and Youth-Friendly Sexual Reproductive Health; Community; and Cross-cutting Standards. The Minimum Standards are based on the criteria of: alignment to relevant SADC policies and standards; feasibility; documented evidence; relevance and acceptability; ethical soundness; and sustainability of the integrated intervention.

6.1. Minimum Standards at Policy Level

SRH and HIV integration at this level provides direction, guidance and a mandate for integration at the systems, facility and community levels. The list below provides the Minimum Standards that should be implemented at policy level by all Member States. The Minimum Standards are grouped according to: policies, national laws, and guidelines and operational plans.

Policies

- 6.1.1. Review and revise relevant SRH and HIV policies to ensure integration of the two streams.
- 6.1.2. Develop policies which address prevention of mother-to-child transmission and child survival using the 'double dividend' approach.
- 6.1.3. Review and develop policies that integrate SRH and non-communicable disease issues.
- 6.1.4. Develop policies that support the provision of essential reproductive health commodities, age-appropriate services and information to adolescents and youth, especially sanitary pads and male and female condoms and contraceptives.
- 6.1.5. Review and revise Ministry of Education and other related policies to ensure the integration of SRH and HIV and provision of comprehensive sexuality education for children, adolescents and youth, including those who are not at school.
- 6.1.6. Review and revise or develop new policies that support access to integrated SRH and HIV services for key populations, especially adolescents, youth, migrant populations, lesbian, gay, bisexual, transgender and intersex (LGBTI) persons and people with disabilities.
- 6.1.7. Review and revise national youth policies to ensure responsiveness to SRH and HIV integration for adolescents and youth.
- 6.1.8. Develop policies which address the issues of SRH and HIV among the elderly.

National laws

- 6.1.9. Conduct an assessment of legal frameworks which impact on access to SRH and HIV services and information for key populations, especially adolescents and youth, men who have sex with men (MSM) and sex workers. Review or develop new legal frameworks based on the findings of the assessment.

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- 6.1.10. Review or develop new laws and legal frameworks that promote zero rate taxation on the importation of essential SRMNCH and HIV life-saving commodities. Promote the local production of these commodities.
 - 6.1.11. Review, improve or/and enact new laws that address negative cultural practices that hinder optimal access to SRH and HIV services and information.
 - 6.1.12. Review, improve or enact new laws to address gender-based violence (and SGBV) against women, men, children, adolescents and youth.
 - 6.1.13. Develop or enact laws that ensure access to and utilization of SRH and HIV services by key populations.

Guidelines and operational plans

- 6.1.14. Review or develop strategies, guidelines and protocols that support the linkages and integration of services based on the SADC Minimum Standards for SRH and HIV integration at all levels.
- 6.1.15. Develop guidelines on inter-sectoral and inter-ministerial collaboration to ensure bi-directional integration between SRH and HIV streams.
- 6.1.16. Review and, where necessary, revise SRH and HIV operational plans to ensure integration and explicit interventions for key populations.
- 6.1.17. Review and revise explicit interventions for key populations in line with the SRH and HIV operational plans.
- 6.1.18. Develop a national plan of action and schedule for the implementation of the Ministerial Commitment on CSE and SRH Services for Adolescents and Young People in Eastern and Southern Africa.
- 6.1.19. Ensure Member States develop plans and strategies for systematically including SRH and HIV integration in all relevant post-2015-related accountability frameworks.
- 6.1.20. Ensure the post-2015 health-related goals include SRH and HIV integration targets.

6.2. Minimum Standards at Systems Level

Integration at this level provides the structures necessary to ensure that SRH and HIV integration policies are translated into practice at facility and community levels. The following are the Minimum Standards at the systems level that all Member States are required to implement. For ease of reference, these have been grouped under planning, implementation and monitoring and evaluation; human resources; financial resources; and logistics and supplies.

Planning, implementation, and monitoring and evaluation

- 6.2.1. Establish multi-sectoral coordination mechanisms and structures at all levels for SRH and HIV integration which have clear terms of reference.
- 6.2.2. Establish, strengthen and coordinate effective and seamless referral systems to ensure access to comprehensive service delivery for SRH and HIV.

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- 6.2.3. Put systems in place, including the necessary facility and community service provision modifications and infrastructure, to facilitate access to SRH and HIV services by key populations, especially adolescents, youth, LGBTI persons and people with disabilities.
 - 6.2.4. Put in place systems to ensure availability of male-friendly services and information at facility and community levels.
 - 6.2.5. Revise, adapt or develop tools and standard operating procedures for quality assurance in the provision of integrated SRH and HIV services.
 - 6.2.6. Revise or develop single or linked registers and tools for integrated SRH and HIV services to facilitate recording, monitoring and reporting of integration indicators.
 - 6.2.7. Develop systems for the documentation and sharing of best practices on SRH and HIV integration.
 - 6.2.8. Review and/or develop monitoring and evaluation tools to ensure data disaggregation by age and sex.

Human resources

- 6.2.9. Develop or adapt a comprehensive human resource strategy to facilitate SRH and HIV integration.
- 6.2.10. Conduct training needs assessments among service providers (health workers, teachers, law enforcement officers) for SRH and HIV integration and implement capacity-building interventions as appropriate.
- 6.2.11. Review, adapt or develop a pre- and in-service curriculum for health workers and other service providers, including teachers, to effectively provide and support integrated services to all populations, in all settings.
- 6.2.12. Develop and implement strategies for the motivation of health workers and other SRH and HIV service providers.
- 6.2.13. Develop strategies, including supportive supervision and mentorship for health workers and other service providers, to ensure quality assurance in the provision of integrated services.

Financial resources

- 6.2.14. Conduct a national resource gap analysis for the promotion of SRH and HIV integration and develop a resource mobilization strategy.
- 6.2.15. Review and revise existing national and regional budgets on SRH and HIV to ensure integrated interventions.
- 6.2.16. Develop systems to facilitate integrated SRH and HIV budgeting processes at all levels.

Logistics and supplies

- 6.2.17. Build capacity of health workers to ensure efficient forecasting and procurement of essential sexual, reproductive, maternal, neonatal and child health (SRMNCH) and HIV life-saving commodities.
- 6.2.18. Develop systems to ensure joint planning, procurement and supply chains for essential SRMNCH and HIV commodities.
- 6.2.19. Develop an efficient procurement, distribution and supply chain management system to enable consistent and regular provision of essential SRMNCH and HIV commodities, including sanitary pads for adolescent girls.

6.3. Minimum Standards at Facility Level

The outline below presents the Minimum Standards that each Member State will ensure are integrated at the various SRH and HIV service delivery points and in all health facilities, including those in educational institutions, juvenile correctional centres and prison settings. The Minimum Standards recognize that service delivery points may be set up differently depending on the level of health facility, as well as the model of integration adopted by each Member State. However, it is critical to ensure bi-directional integration between the various SRH and HIV service standards at each service delivery point. The Minimum Standards in this section are grouped into the various SRH and HIV services delivery points as outlined below:

6.3.1. Provide a package of SRH and HIV services at outpatient departments, which should include:

- 6.3.1.1. Family planning information, counselling, provision of contraceptives or referrals.
- 6.3.1.2. HTC, including provider-initiated testing and counselling services and referral for clients testing HIV-positive.
- 6.3.1.3. TB screening for all clients testing HIV-positive as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.
- 6.3.1.4. STI screening, treatment and referrals.
- 6.3.1.5. Information on HIV prevention, including provision of male and female condoms.
- 6.3.1.6. Screening for hepatitis C.

6.3.2. Provide a package of services at STI service delivery points which should include:

- 6.3.2.1. Information, counselling and treatment for infertility.
- 6.3.2.2. Family planning information, counselling, provision of contraceptives or referrals.
- 6.3.2.3. Information on and screening for cancers of the reproductive system.
- 6.3.2.4. Information on availability of human papilloma virus vaccine.
- 6.3.2.5. HTC, including provider-initiated testing and counselling services and referral for clients testing HIV-positive.

6.3.2.6. TB screening for all clients testing HIV-positive and management of those testing TB-positive as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.

6.3.2.7. Information on HIV prevention, including provision of male and female condoms.

6.3.3. Integrate the following services at TB service delivery points:

6.3.3.1. HTC, including provider-initiated testing and counselling and referral for clients testing HIV-positive.

6.3.3.2. Provision of TB prevention and management for HIV-positive clients.

6.3.3.3. Family planning information, counselling, provision of contraceptives and/or referral.

6.3.3.4. Information on HIV prevention, including provision of male and female condoms.

6.3.3.5. Information and counselling on nutrition to all clients and nutritional support and referrals for TB clients, including those co-infected with TB and HIV.

6.3.4. Provide the following services at SGBV service delivery points:

6.3.4.1. Safe legal and post-abortion care services.

6.3.4.2. Psychosocial and trauma counselling and referral for legal aid.

6.3.4.3. HTC, including provider-initiated testing and counselling services and referral for clients testing HIV-positive.

6.3.4.4. Information, counselling and services for key populations, especially MSM and sex workers.

6.3.4.5. Information on and provision of post-exposure prophylaxis.

6.3.4.6. TB screening for all clients testing HIV-positive and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.

6.3.4.7. Information on HIV prevention, including provision of male and female condoms.

6.3.4.8. Emergency contraceptives and pregnancy testing.

6.3.4.9. Information, screening and treatment services for STIs.

6.3.5. Provide a package of services to clients seeking family planning services, which should include:

6.3.5.1. HTC, including provider-initiated testing and counselling referral for clients testing HIV-positive.

6.3.5.2. TB screening for all clients testing HIV-positive and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.

6.3.5.3. Information on HIV prevention, including provision of male and female condoms.

6.3.5.4. Information, screening and treatment services for STIs.

- 6.3.5.5. Information on and screening for cancers of the reproductive system.
- 6.3.5.6. Information on and provision of human papilloma virus vaccine services.
- 6.3.5.7. Advocacy campaigns and targeted social behaviour change communication campaigns to promote male involvement in uptake of SRH and HIV services.

6.3.6. Provide a package of services at stand-alone HTC service delivery points, in particular:

- 6.3.6.1. Family planning information, counselling, provision of contraceptives and/or referrals.
- 6.3.6.2. Information on and screening for cancers of the reproductive system.
- 6.3.6.3. STI screening and treatment.
- 6.3.6.4. Information on HIV prevention, including provision of male and female condoms.
- 6.3.6.5. Information on voluntary medical male circumcision.
- 6.3.6.6. Advocacy campaigns and targeted social behaviour change communication campaigns to promote male involvement in uptake of SRH and HIV services.
- 6.3.6.7. TB screening for all clients testing HIV-positive and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.
- 6.3.6.8. Information on SGBV and provision of post-exposure prophylaxis information and services.
- 6.3.6.9. Provision of essential SRH services and commodities to key populations such as MSM and sex workers.
- 6.3.6.10. Safe legal abortion and post-abortion care services.
- 6.3.6.11. Referrals to harm-reduction units or programmes for intravenous drug users to minimize substance abuse.

6.3.7. Provide a package of services at focused antenatal care service delivery points, which should include:

- 6.3.7.1. Screening for malaria and provision of relevant malaria in pregnancy prevention and treatment services.
- 6.3.7.2. EMTCT, including HTC and provision of antiretrovirals both for prophylaxis and treatment.
- 6.3.7.3. Information on HIV prevention, including provision of male and female condoms.
- 6.3.7.4. Family planning information, counselling and provision of contraceptives and/or referrals.
- 6.3.7.5. Information on ART prophylaxis and early infant diagnosis for HIV-positive clients.
- 6.3.7.6. Information and counselling on infant and young child feeding.
- 6.3.7.7. Laboratory services, such as CD4 and viral load testing, for HIV-positive clients.
- 6.3.7.8. Advocacy campaigns and targeted social behaviour change communication campaigns to promote male involvement in uptake of SRH and HIV services.

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- 6.3.7.9. Information on access to corticosteroids for women in pre-term labour to prevent respiratory distress syndrome in premature babies.
 - 6.3.7.10. Information on the importance of facility delivery, as opposed to home delivery, especially for HIV-positive pregnant women.
 - 6.3.7.11. Information on re-testing for HIV in antenatal care for HIV-negative clients.
 - 6.3.7.12. Information on and provision of couple counselling and HIV-testing services.
 - 6.3.7.13. TB screening for all clients testing HIV-positive and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.

6.3.8. Provide other services at maternity and newborn service delivery points, including:

- 6.3.8.1. Provision of emergency obstetric and newborn care.
- 6.3.8.2. HIV counselling and testing and provision of treatment services for clients testing HIV-positive.
- 6.3.8.3. TB screening for all clients testing HIV-positive and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.
- 6.3.8.4. Information and services for HIV-exposed infants, including early infant diagnosis.
- 6.3.8.5. Initiation of paediatric care for HIV-positive children.
- 6.3.8.6. Information on HIV prevention, including provision of male and female condoms.
- 6.3.8.7. Family planning information, counselling, provision of contraceptives and/or referrals.
- 6.3.8.8. Information on and screening for cancers of the reproductive system.
- 6.3.8.9. Information on and provision of early infant male circumcision.

6.3.9. Provide a package of services at post-natal care service delivery points, in particular:

- 6.3.9.1. HTC and services for clients testing HIV-positive.
- 6.3.9.2. Information on human papilloma virus vaccine.
- 6.3.9.3. TB screening for all clients testing HIV-positive and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.
- 6.3.9.4. Information on HIV prevention, including provision of male and female condoms.
- 6.3.9.5. Antiretroviral treatment for all pregnant HIV-positive women.
- 6.3.9.6. Information on and screening for cancers of the reproductive system.
- 6.3.9.7. Family planning information, counselling, and provision of contraceptives and/or referrals.

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- 6.3.9.8. Information on ART prophylaxis for newborns and provision of early infant diagnosis services for HIV-exposed infants.
 - 6.3.9.9. Information and counselling on exclusive breastfeeding for the first six months of life, or exclusive formula feeding in situations where breastfeeding is contraindicated.
 - 6.3.9.10. Information and counselling on and provision of essential childhood immunization services.
 - 6.3.9.11. Information and counselling on maternal nutrition and provision of nutritional support or referrals.
 - 6.3.9.12. Information on and services for early infant male circumcision.

6.3.10. Provide other services at voluntary medical male circumcision service delivery points which should include:

- 6.3.10.1. HTC services and referrals for clients testing HIV-positive.
- 6.3.10.2. TB screening for all clients testing HIV-positive and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.
- 6.3.10.3. Information on HIV prevention, including provision of male and female condoms.
- 6.3.10.4. Advocacy campaigns and targeted social behaviour change communication campaigns to promote male involvement in uptake of SRH and HIV services.
- 6.3.10.5. Family planning information, counselling and provision of contraceptive services.
- 6.3.10.6. Information on and screening of male reproductive health cancers.

6.3.11. Provide a package of services at HIV comprehensive care service delivery points:

- 6.3.11.1. Family planning information, counselling, provision of contraceptives and/or referrals.
- 6.3.11.2. Pregnancy screening services.
- 6.3.11.3. STI screening and treatment services.
- 6.3.11.4. TB screening and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.
- 6.3.11.5. Information about rights of people living with HIV and AIDS, including sexual reproductive and health rights (SRHR).
- 6.3.11.6. Information about re-infection and provision of male and female condoms.
- 6.3.11.7. Provision of key population-sensitive services such as provision of lubricants to MSM.
- 6.3.11.8. Provision of information and services on EMTCT.
- 6.3.11.9. Screening services for cancers of the reproductive system.
- 6.3.11.10. Comprehensive SGBV services.

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- 6.3.11.11. Information on and services for safe legal abortion and post-abortion care.
 - 6.3.11.12. Nutritional counselling and provision of, or referral for, nutritional commodities including nutritional supplements.
 - 6.3.11.13. Information on and referrals for economic strengthening or livelihood interventions and programmes.
 - 6.3.11.14. Information on, provision of, and referrals for orphans and vulnerable children and youth (OVC&Y) care and support services.

6.3.12. Provide the following services at nutrition care service delivery points:

- 6.3.12.1. Maternal nutrition interventions alongside HIV information, HTC and EMTCT.
- 6.3.12.2. Infant and young child feeding interventions, together with information on EMTCT.
- 6.3.12.3. Nutrition screening with early infant diagnosis for HIV-exposed children.
- 6.3.12.4. Early childhood development (ECD) services or referrals for HIV-positive children with delayed developmental milestones.
- 6.3.12.5. Nutritional care and support, including supplements for HIV-positive clients.
- 6.3.12.6. Screening for TB and the provision of and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.
- 6.3.12.7. Screening for hepatitis B and C and provision of information on hepatitis B vaccine.

6.3.13. Integrate the following package of services during provision of safe, legal abortion and post-abortion care services:

- 6.3.13.1. HTC services and referral for clients testing HIV-positive.
- 6.3.13.2. TB screening for all clients testing HIV-positive and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.
- 6.3.13.3. Information on HIV prevention, including provision of male and female condoms.
- 6.3.13.4. STI information, screening and treatment.
- 6.3.13.5. Information on and provision of male and female condoms.
- 6.3.13.6. Family planning information, counselling, provision of contraceptives and/or referrals.
- 6.3.13.7. Services and counselling on SGBV.
- 6.3.13.8. Information on and screening for cancers of the reproductive system.

6.3.14. Provide the following services in female and gynaecology wards:

- 6.3.14.1. Information on and screening for cancers of the reproductive system.
- 6.3.14.2. HTC and referrals for clients testing HIV-positive.

- 6.3.14.3. Integrated comprehensive post-abortion care with HIV-prevention information and services.
- 6.3.14.4. Family planning information, counselling, provision of contraceptives and/or referrals.
- 6.3.14.5. TB screening for all clients testing HIV-positive and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.
- 6.3.14.6. Information, screening and treatment for STIs.

6.4. Minimum Standards at Community Level

Integration at community level is critical in creating a demand for SRH and HIV services at facility level. In addition, the Minimum Standards at this level will focus on addressing negative cultural practices which hinder access to and utilization of SRH and HIV services, while at the same time seeking to promote positive cultural practices. The following is a list of Minimum Standards that each Member State will ensure are provided at this level:

- 6.4.1. Provide integrated community SRMNCH and HIV outreach services, including community-based care for people living with HIV and AIDS and community-based distribution of contraceptives, HIV-prevention services, antenatal care services, HTC, and family planning. Examples of outreach services are outlined below.

Integrated SRMNCH and HIV outreach services:

- Family planning
- Antenatal care
- Post-natal care
- HTC Services
- Services for under-fives
- Prevention of mother-to-child transmission
- Outpatient services

- 6.4.2. Develop and integrate community-based psychosocial support for vulnerable children and people living with HIV with SRH information and nutritional support.
- 6.4.3. Integrate community-based OVC&Y programmes with comprehensive sexuality education and other adolescent and youth reproductive health services.
- 6.4.4. Develop and implement integrated community-based nutrition and HIV services, including nutritional screening and provision of nutritional supplements.
- 6.4.5. Provide immunization outreach services integrated with information on EMTCT and tracing of HIV-exposed infants for early infant diagnosis.

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- 6.4.6. Provide integrated SRH and HIV social behaviour change communication interventions at community level.
 - 6.4.7. Provide integrated community case management with EMTCT services and other relevant HIV and AIDS interventions.
 - 6.4.8. Establish and provide SRH and HIV integrated community-based youth- and adolescent-friendly services.
 - 6.4.9. Implement tested community mobilization interventions on male involvement.
 - 6.4.10. Implement community mobilization and advocacy strategies against child marriages and teenage pregnancies.
 - 6.4.11. Integrate community-based TB case tracing with information and referrals for HTC.
 - 6.4.12. Develop and implement an advocacy, communication and social mobilization strategy to create a demand for SRH and HIV services and programmes.
 - 6.4.13. Develop and implement strategies within school settings at all levels (from ECD to universities) to ensure provision of CSE and other SRH services as per the Ministerial Commitment on CSE and SRH Services for Adolescents and Young People in Eastern and Southern Africa.
 - 6.4.14. Develop strategies that ensure transfer of SRH and HIV information from one generation to another.
 - 6.4.15. Integrate SRH and HIV approaches into cultural and traditional rites of passage, with a focus on passing on information, including accessing services, to adolescents and youth.
 - 6.4.16. Implement interventions for parents, guardians and teachers to ensure their support and involvement in the provision of comprehensive sexuality education and other SRH and HIV services to children, adolescents and youth.

6.5. Minimum Standards for Adolescent and Youth-Friendly Sexual and Reproductive Health Level

- 6.5.1. Undertake a rapid assessment to identify enablers as well as barriers experienced by adolescents and youth in accessing SRH and HIV services, such as age of consent.
- 6.5.2. Information and counselling on pregnancy and provision of pregnancy testing services.
- 6.5.3. Provide age-appropriate family planning information, counselling and contraceptive services or referrals to adolescent-friendly service providers.
- 6.5.4. Provide age-appropriate information and HIV-prevention services, including provision of male and female condoms.
- 6.5.5. Provide HTC information and services.
- 6.5.6. Provide services for HIV-positive adolescents including psychosocial support and treatment.
- 6.5.7. TB screening and management of those testing positive for TB as per the Harmonized Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region.

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- 6.5.8. Provide information on and services for the prevention and management of obstetric fistula among teenage mothers, including early recognition of complications and ensuring access to quality care by a skilled birth attendant.
 - 6.5.9. Provide STI information, screening and treatment services.
 - 6.5.10. Provide comprehensive SGBV services.
 - 6.5.11. Provide information and services for safe legal abortion and post-abortion care.
 - 6.5.12. Provide voluntary medical male circumcision for adolescents and youth.
 - 6.5.13. Provide CSE and other SRH and HIV services in the education systems at all levels.
 - 6.5.14. Integrate and ensure provision of CSE, SRH and HIV services in activities and programmes targeting out-of-school adolescents and youth.
 - 6.5.15. Provide information about EMTCT and services to adolescents and youth living with HIV.
 - 6.5.16. Link HIV-positive youth and adolescents to economic strengthening and livelihood interventions, such as those for OVC&Y.
 - 6.5.17. Provide information and counselling services on drug and substance abuse.
 - 6.5.18. Provide focused antenatal care services for adolescent girls and young women who are pregnant.
 - 6.5.19. Provide targeted post-natal care services for eligible adolescents and youth.
 - 6.5.20. Provide quality antenatal and obstetric care for all pregnant adolescents and young girls.
 - 6.5.21. Put in place systems to ensure the provision of sustainable and cost-effective sanitary pads to girls and young women unable to access sanitary pads.
 - 6.5.22. Train health workers on value clarification and attitude change to ensure provision of SRH and HIV services devoid of stigma and discrimination, especially for adolescent and youth MSM and sex workers.
 - 6.5.23. Provide training to parents and other adults who are responsible for adolescents and youth on adolescent and youth sexual and reproductive health rights.
 - 6.5.24. Enforce or enact new laws on zero tolerance to gender-based violence against adolescents and youth.
 - 6.5.25. Develop systems to ensure provision of or referrals for social protection, economic strengthening and livelihood interventions for vulnerable adolescents and youth.
 - 6.5.26. Develop policies and laws which focus on preventing teenage pregnancies.
 - 6.5.27. Develop national and community systems for the provision of economic and social support for teenage mothers.
 - 6.5.28. Enact and enforce laws that ban child marriages.
 - 6.5.29. Develop systems to ensure provision of or referrals for alternative means of income to impoverished families to discourage marrying off children for economic gain.

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- 6.5.30. Develop targeted social behaviour change communication interventions to address the sociocultural factors that contribute to child marriages and teenage pregnancies.

6.6. Cross-cutting Minimum Standards

These Minimum Standards address the issues that cross-cut the other four levels of policy, systems, facility and community. Under the cross-cutting Minimum Standards, Member States will be required to:

- 6.6.1. Undertake rapid assessments at policy, systems, facility and community levels to understand the entry points, opportunities and gaps for SRH and HIV integration.
- 6.6.2. Undertake rapid assessments on the opportunities, gaps and barriers on access to SRH and HIV services by key populations.
- 6.6.3. Implement collaborative interventions with the justice system, including working with the police to address issues of gender-based violence, and especially SGBV.
- 6.6.4. In collaboration with other stakeholders, develop innovative Member State specific interventions to address economic-related structural factors among vulnerable groups that hinder access to integrated SRH and HIV services.
- 6.6.5. Develop strategies to ensure the involvement of adolescents and youth in the design, implementation, monitoring and evaluation of SRH and HIV interventions.
- 6.6.6. Develop strategies that support SRH and HIV integration into national youth movements and in government departments and units.
- 6.6.7. Develop innovative interventions for male involvement in SRH and HIV services.
- 6.6.8. Develop strategies and interventions for integration of SRH and HIV and other relevant communicable and non-communicable diseases.
- 6.6.9. Develop innovative strategies and approaches to ensure public-private partnerships in the promotion and provision of integrated SRH and HIV services.

7.0. Implementation of the Minimum Standards

These Minimum Standards identify the buy-in, effective coordination, allocation of budgets and availability of strong health systems by Member States as preconditions for effective implementation. Ministers of Health from Member States and those responsible for HIV and AIDS will oversee the implementation of these Minimum Standards. This section outlines key steps for effective integration, roles and responsibilities of different stakeholders and financing mechanisms, as well the monitoring and evaluation of the implementation of these Minimum Standards.

7.1. Key steps for Implementation of the Minimum Standards

This section outlines the steps to be followed by Member States to ensure the effective implementation of the Minimum Standards. These steps are not prescriptive and may vary based on the existing level of integration of each Member State. The steps involve dissemination of the Minimum Standards to stakeholders for buy-in and their adoption and operationalization through integration into Member States national policy documents, guidelines, strategies and budgets. It is essential for Member States to conduct a national rapid assessment for SRH and HIV integration, to ensure an understanding of opportunities, entry points and gaps to be addressed for effective integration at policy, systems, facility and community levels. Based on this assessment, Member States will develop appropriate strategies and establish the required infrastructure and systems for integration.

Essential steps for effective integration:

- Domesticate the Minimum Standards
- Disseminate the Minimum Standards
- Ensure their buy-in from stakeholders
- Conduct rapid assessment on integration
- Develop strategies, including necessary policies to ensure integration
- Ensure national coordination for integration
- Implement and scale up.

7.2. Stakeholders' Roles and Responsibilities

7.2.1. SADC Secretariat

The SADC Secretariat will coordinate the overall implementation and monitoring of these Minimum Standards and ensure harmonization across the region on behalf of the Ministers of Health. Specific responsibilities will include:

- Dissemination and popularization of the Minimum Standards to stakeholders at regional and international levels.
- Advocating for the implementation and domestication of the Minimum Standards in the region in line with commitments made by Member States.
- Facilitating training, skills transfer and the documentation and dissemination of best practices in relation to integration across the SADC Member States.
- Coordinating partners around resource mobilization and technical support in the region.
- Mobilization of resources for regional coordination of the implementation of the Minimum Standards.
- Monitoring and documenting the progress of Member States in the implementation of the Minimum Standards.

7.2.2. Member States

The role of the Member States will be to:

- Ensure national HIV and SRH programmes take a multi-sectoral approach and involve relevant departments, ministries and stakeholders in the public and private sectors.
- Identify and coordinate partners to support the implementation of the Minimum Standards at national, sub-national and community levels.
- Develop detailed financial plans and mobilize resources both in-country and externally to support the implementation of the Minimum Standards.
- Ensure the buy-in of Ministers of Health and other relevant Ministries, such as Education and Youth, and domesticate the Minimum Standards into national frameworks, policies, strategies and budgets.
- Ensure Ministers of Health and other relevant Ministries, such as Education and Youth, develop systems for implementation, monitoring and evaluation of the integrated response.
- Report on the progress of the implementation of the Minimum Standards to the SADC Secretariat on an annual basis.
- Document best practices and participate in regional forums for the dissemination of best practices and lessons learned.

7.2.3. Other Stakeholders

Other stakeholders include United Nations agencies, bilateral donors and development partners, local and international non-governmental organizations, community- and faith-based organizations, the private sector, and research and training institutions. Their roles will be as follows:

- Provide technical support to the SADC Secretariat and Member States for the implementation, monitoring and evaluation of the Minimum Standards.
- Popularize, advocate for and promote the recognition and prioritization of these SADC Minimum Standards at national, regional and international levels.

- Support resource mobilization for the implementation of the Minimum Standards at regional and national levels.
- Participate in the provision of integrated SHR and HIV services at facility and community levels.
- Conduct operations research and document and disseminate emerging best practices on integration.

7.3. Financing Mechanisms

Implementation of these Minimum Standards may require additional financial resource allocations by each Member State and/or the reallocation of resources from other programmes. Funding for the activities required to meet the Minimum Standards will be allocated within the national budget of each Member State. To ensure adequate financing for the implementation of the Minimum Standards, Member States shall ensure:

- Costed plans for integration are developed in collaboration with other stakeholders, including civil society organizations, United Nations agencies and development partners.
- Member States' and donor's funding is aligned with the costed plans for the provision of integrated SRH and HIV services.
- Mapping of funding opportunities for integration is conducted and a resource mobilization plan developed, including the reallocation of funds from vertical programmes.
- Buy-in from both HIV and SRH units and departments for the purposes of aligning existing funds within the two streams for integrated service delivery.

7.4. Monitoring and Evaluation

Implementation of these Minimum Standards by Member States as well as at the regional (SADC) level will need to be monitored and evaluated to identify progress, lessons learned, and gaps and challenges that need to be addressed. These will be used to inform programme improvement as well as for scaling up SRH and HIV integration. In support of the 'one monitoring and evaluation system', the Minimum Standards will be integrated into the existing system.

7.4.1. Monitoring and Evaluation at Member State Level

Monitoring and evaluation at Member State level will focus on the implementation of the Minimum Standards as outlined in the broad areas of policy; systems; facility; adolescent and youth sexual reproductive health; and community, as well as cross-cutting Minimum Standards. For purposes of monitoring and evaluation, Member States will review, adopt and contextualize the compendium of indicators already developed by the global SRH/HIV Integration Steering Group and adapt them to regional needs. In ensuring effective monitoring and evaluation, Member States will:

- Review, contextualize and adopt the already developed compendium of indicators for SRH and HIV integration.
- Collect information on the broad areas of the Minimum Standards on an annual basis and prepare an annual report.
- Hold annual meetings with all relevant stakeholders within existing mechanisms for stakeholder participation and consultation to monitor progress.
- Develop plans for multi-sectoral supportive supervision.

- Share data and other relevant information and report progress to the SADC Secretariat on an annual basis.
- Use evidence and available data for the improvement of policies and systems at Member State level.

7.4.2. Monitoring and Evaluation at SADC Regional Level

Participants in the Regional Validation Consensus meeting held in Johannesburg between September 16 and 18, 2014, agreed to adopt the existing SRH and HIV integration monitoring and evaluation framework, namely, the SRH-HIV Compendium Indicators and Tools.⁶³ This framework provides a menu of indicators that can be used for SRH and HIV integration at different levels. For the purposes of monitoring and evaluating progress in integration at the SADC level, this Minimum Standards document adopts three indicators from the framework:

- (a) Percentage of service delivery points providing HIV services that are delivering an SRH ‘marker service’⁶⁴ to clients;
- (b) Percentage of service delivery points providing SRH services that are delivering an HIV ‘marker service’ to clients; and
- (c) Percentage of service delivery points routinely providing general health services that are delivering an SRH and an HIV ‘marker service’ to clients.

Details on the measurement of the three indicators are outlined in the compendium document.

In addition, the Secretariat will track progress through routine reporting, documentation and technical support, and supervision visits to the Member States. Monitoring progress will mainly involve collating data from Member States’ annual reports as well as a review of SADC Secretariat supportive supervision reports. The Secretariat will prepare regional reports and annual review meetings to discuss implementation progress and share lessons across Member States.

Five years from the date of their joint approval by SADC Ministers of Health and those responsible for HIV and AIDS, the Minimum Standards will be reviewed and subsequently revised, as needed, to ensure the Minimum Standards remain relevant and in line with new developments and technologies.

⁶³ IPPF, UCSF, UNAIDS, UNFPA, WHO. (2014). SRH-HIV Compendium Indicators and Tools.

⁶⁴ The HIV ‘marker service’ is HIV testing and counselling; the SRH ‘marker service’ is modern contraceptive services.

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