

Linking Sexual and Reproductive Health and HIV

Gateways to integration

a case study from Rwanda

A glimpse of the future: eliminating
new HIV infections among children
and keeping their mothers alive



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The purpose of the case study

The purpose of this case study is to illustrate how an integrated, comprehensive approach to delivering an elimination of mother-to-child transmission of HIV (eMTCT) programme has been operationalized in practice. It focuses particularly on how an HIV programme can be delivered through a sexual and reproductive health platform and the community.

The case study uses the experience of Rwanda to demonstrate what is possible. It is hoped that the promising practices and the lessons learnt, within this case study will provide readers with new and alternative ideas about how they might re-orientate aspects of their own operational practice related to eMTCT.

This case study also provides stakeholders with an advocacy tool and an educational resource that serve to provide further support for the implementation of *The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*.

The purpose of the film

A short film – *Glimpse of the future: Eliminating new HIV infections among children in Rwanda and keeping their mothers alive* – has been produced to complement the case study. Filmed in Rwanda, it provides an account of the eMTCT programme described in this case study through the eyes of Rwandan clients, health providers, programme managers, and policy makers. A set of questions, which can be used to facilitate discussion on the film, can be found on page 33.

Intended audience

The case study is written for:

- healthcare professionals working at a service delivery level;
- programme managers and health advocates working in the area of public health;
- educators, trainers and facilitators who are developing the capacity of health workers in the area of eMTCT;
- health policy advisors working within, for example, a Ministry of Health or Social Development; and
- representatives from the donor community working in the areas of health and development.





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Executive summary

This case study – *A glimpse of the future: eliminating new HIV infections among children and keeping their mothers alive* – illustrates how a comprehensive approach to the elimination of mother-to-child transmission of HIV (eMTCT), following the framework provided by *The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive (The Global Plan)*¹ can be operationalized in practice.

In May 2011, Rwanda's First Lady, Jeannette Kagame, launched the country's national eMTCT initiative.² Government leadership and commitment to the process, along with the active involvement of local, regional and international partners led to the development of *The National Strategic Plan for Elimination of Mother to Child Transmission of HIV in Rwanda (2011–2015)*, released in February 2012.

Together with this national political commitment, this case study identifies a number of key interventions at the policy, systems and service delivery level being undertaken in Rwanda that are enabling the country to eliminate new HIV infections and keeping mothers alive. They include:

At the policy level

- 1. Local political commitment:** The country's national political commitment to eMTCT is replicated at a district level. All 30 health districts have developed eMTCT plans from the national plan and these have been endorsed by their respective district authority.
- 2. Health insurance:** A policy mechanism that Rwanda introduced in 1998 and scaled up in 2004 is a community-based health insurance scheme. Based on their level of income, each member of the scheme contributes the equivalent of US\$3–\$11 per year and pays just 10% of the usual fee when accessing services. Fee waivers exist for the poorest and most vulnerable. Ninety-seven percent of the population are covered by the scheme.

At the systems level

- 3. An integrated health system approach:** At a health systems level the eMTCT programme is well integrated into the country's existing maternal, newborn and child health (MNCH) services. This harmonization not only improves the quality of services delivered to clients, for example, by reducing the need for multiple clinical visits to different health facilities, but ultimately contributes to significant reductions in mother-to-child transmission rates and maternal mortality.
- 4. Secondary health posts:** With 40% of the country's health facilities being supported by faith-based organizations³ in which modern contraceptive methods are not made available to clients, the Ministry of Health has established a complementary health facility alongside the faith-based one. Referred to as secondary health posts, clients opting for a modern family planning (FP) method in the faith-based facility are referred directly to the adjoining secondary health post. There they are able to access the necessary FP counselling and commodities.
- 5. Task shifting:** Shifting (delegating) tasks from one cadre of trained professionals (such as physicians) to other staff who previously were not accorded such tasks, is another of the solutions that the country has adopted to meet the growing demand for HIV treatment and care⁴ and the requirements of the eMTCT strategy. By embracing such an approach, Rwanda has trained nurses to, for example, initiate patients onto first line antiretroviral therapy (ART) and identify and manage the side effects.⁵
- 6. On-site staff mentoring:** The provision of on-site mentorship by a team of doctors and nurses, stationed at each primary care level facility for at least two weeks at a time, not only enables the local health teams to familiarize themselves with the implementation of new national guidelines around, for example, treatment as prevention and Option B+, but also supports the processes of quality improvement and assurance.



Service delivery level

- 7. Community health workers:** The eMTCT strategy in Rwanda is supported by a cadre of 60,000 community health workers (CHWs) who provide a critical link between community members and the local health facilities. Not only do the CHWs motivate pregnant women and their partners to attend antenatal and postnatal care services, provide basic health education (including advocating for the non-discrimination of people living with HIV in the local community), and provide a community-based FP service but they also play an active role in recording vital events in each household.
- 8. Adolescent sexual and reproductive health and rights (SRHR):** 67% of Rwandan's are less than 20 years old and the first outcome of the country's eMTCT strategy calls for the scale up of existing HIV education initiatives which provide for targeted and comprehensive sexual and reproductive health (SRH) and HIV education, counselling and skills-building services. Whilst there is a clear focus on providing youth-friendly education and services to young people, this is not confined to health facilities but also focuses on creating a positive approach to comprehensive sexuality education within the home and school environment.
- 9. Male involvement:** Rwanda is internationally recognized for its leadership in the arena of male involvement in eMTCT. For example, worldwide, the proportion of pregnant women attending ANC whose male partner was also tested was 5% in 2008; in Rwanda, by contrast, the proportion was 84% in 2011.⁶ The support given by both district and national government officials to the importance of having male partners accompany their partner to their first ANC consultation (at least), along with the invitation that is sent by the health professional to an absent partner (requesting he attend the next ANC consultation of his partner), have now entrenched the male partner's attendance at the first ANC consultation as a social norm.
- 10. Rights-based approach:** The Government of Rwanda has affirmed that living with HIV should not constitute a barrier or an obstacle to accessing services – be these health services, access to education or legal support, economic opportunities and/or social protection.⁷ Supporting the SRHR of women living with HIV is an important part of *The Global Plan* and has particular relevance to preventing unintended pregnancies. The Rwandan eMTCT plan follows this as it strongly embodies the adoption of a rights-based approach that emphasizes the SRH and human rights of all people regardless of HIV status. This is illustrated in one of the six principles on which the plan is based:

“ The delivery of eMTCT interventions should safeguard standard human rights, including the right to safe and confidential services, and autonomy to make informed decisions regarding reproductive health and treatment options. The strategy emphasizes the sexual, reproductive and human rights of all people including women and men living with HIV as well as the rights of marginalized populations such as sex workers, migrants, men who have sex with men, etc.”

PRINCIPLE 5, NATIONAL STRATEGIC PLAN FOR EMTCT IN RWANDA (2011–2015).⁸

Abbreviations

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ARV	antiretroviral
ART	antiretroviral therapy
CHW	community health worker
eMTCT	elimination of mother-to-child transmission of HIV
FP	family planning
GBV	gender-based violence
HIV	human immunodeficiency virus
IATT	Interagency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children
ICAP	International Center for AIDS Care and Treatment Programs
IPPF	International Planned Parenthood Federation
MNCH	maternal, newborn and child health
PEARL	peer educator for adherence, referral and linkages
PMTCT	prevention of mother-to-child HIV transmission
PSI	Population Services International
RBC	Rwanda Biomedical Centre
RRP+	Rwanda Network of People Living with HIV/AIDS
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	voluntary counselling and testing
WHO	World Health Organization

Section 1
Introduction to eMTCT



Introduction to eMTCT

Global attention has for some time focused on the *prevention* of mother-to-child transmission of HIV (PMTCT) as an essential and cost-effective means of preventing new HIV infections in infants.⁹

Building on past progress of country-led national PMTCT programmes, there is global consensus that the world must now strive towards the *elimination* of new HIV infections among children by 2015 and keeping their mothers alive. Significantly this commitment to maternal health recognizes that HIV is the leading cause of death among women of reproductive age and contributes to maternal mortality.

These commitments are laid out in *The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive (The Global Plan)* which has two global targets. By 2015:¹⁰

1. Reducing the number of new HIV infections among children by 90%; and
2. Reducing the number of AIDS-related maternal deaths by 50%.

A note on terminology

There has been a shift in terminology from the term **preventing** mother-to-child transmission of HIV to **eliminating** mother-to-child transmission (eMTCT). An explanation about the latter term and some guidance about how it ought to be used in a sensitive manner are provided in Annex 1 of this publication.

The implementation framework of *The Global Plan* is as follows:

Prong 1

Prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care (ANC), postpartum and postnatal care and other health and HIV service delivery points, including working with community structures.

Prong 2

Providing appropriate counselling support, and contraceptives, to women living with HIV to meet their unmet needs for family planning (FP) and spacing of births, and to optimize health outcomes for these women and their children.

Prong 3

For pregnant women living with HIV, ensure HIV counselling and testing and access to the antiretroviral (ARV) drugs needed to prevent HIV infection from being passed on to their babies during pregnancy, delivery and breastfeeding.

Prong 4

HIV care, treatment and support for women and children living with HIV and their families.

This strategy provides the foundation on which country-level action plans for eMTCT are developed and costed. Importantly, such policies and plans should promote the integration of eMTCT with SRH programmes, such as maternal, neonatal and child health (MNCH), FP, gender-based violence (GBV) and sexually transmitted infection (STI) services.

The overall aim and description of the four prongs and their respective targets is outlined in Figures 1a and 1b.

FIND OUT MORE

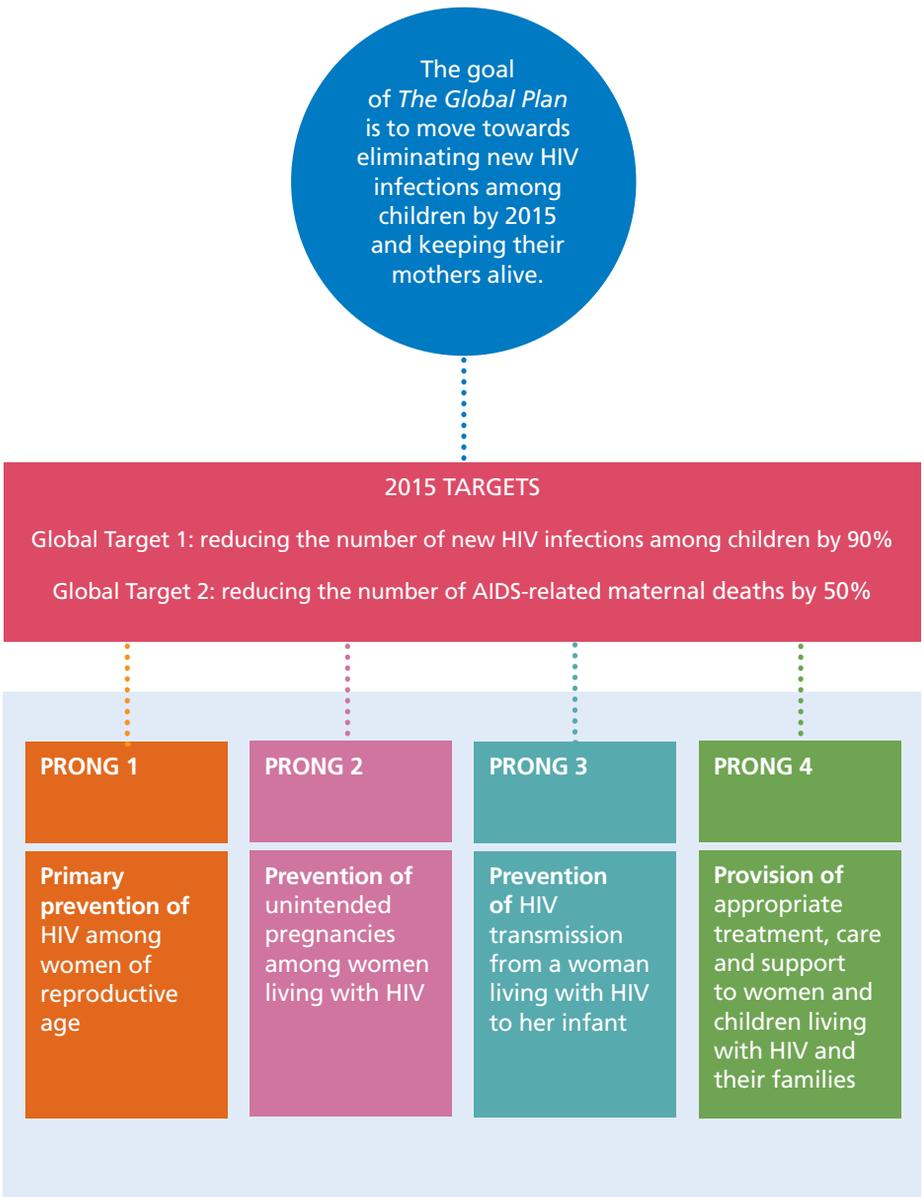
The Global Plan

You can access *The Global Plan*, find out what progress is being made in reaching the global targets, and review some countries' eMTCT plans on the following websites:

- *The Global Plan* website: www.zero-hiv.org
- The Interagency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers, and Children (IATT) website: www.emtct-iatt.org

The Global Plan also has a blog at: www.zero-hiv.org/category/blog

Figure 1a: The four-pronged strategy and the targets of the comprehensive approach to the eMTCT



KEY FIND OUT MORE

How to scale up the four prongs of comprehensive eMTCT

You can find a list of the key guidance documents for each of the four prongs, along with an annotated bibliography of these documents in:

IATT (2012) *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015. In support of the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.*

Section 3: Related programming guidance (Table 1) and Annex 2: Annotated bibliography of supporting policy and programming guidance in this publication lists and describes these guidance documents.

This document can be downloaded from: www.srhhivlinkages.org or www.emtct-iatt.org

Figure 1b: The four-pronged strategy and the targets of the comprehensive approach to eMTCT



* Targets taken from *The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.*

PRONG 3

PREVENTION OF HIV TRANSMISSION FROM WOMEN LIVING WITH HIV TO THEIR INFANTS



Related activities

- HIV testing and counselling for pregnant women
- ART for pregnant women and mothers living with HIV and their infants
- Safe delivery techniques
- Counselling on infant feeding
- FP counselling

PRONG 4

PROVISION OF APPROPRIATE TREATMENT, CARE AND SUPPORT TO WOMEN AND CHILDREN LIVING WITH HIV AND THEIR FAMILIES



Related activities

- Early infant diagnosis
- Paediatric ART and on-going counselling
- Clinical care and ART to support the mother's health and protect the child's on-going health and development
- Information on nutrition, HIV and SRHR issues, and psycho-social support related to legal and welfare issues

Targets for 2015*

Reduce mother-to-child transmission of HIV to 5%.

90% of mothers receive perinatal ART or prophylaxis.

90% of breastfeeding infant-mothers pairs receive ART or prophylaxis.

Target for 2015*

Provide 90% of pregnant women in need of ART for their own health with life-long ART.

Table 1: Rwanda – vital statistics at a glance

Estimated population (2012)	10,537,222 ¹³
Adult population aged 15–49 years (2012)	5,370,933 ¹⁴
Life expectancy at birth (2009)	Men: 57 ¹⁵ Women: 60 ¹⁶
Total fertility rate (2010)	4.6 ¹⁷
Crude birth rate – births per 1000 population (2002)	41.2% ¹⁸
Number of ANC visits (2010)	98% receive ANC from a skilled provider, most commonly from a nurse or medical assistant (94%) ¹⁹ 38% of women had an ANC visit by the time of their fourth month of pregnancy, as recommended ²⁰ 35% received the recommended four or more ANC visits ²¹
Births attended by skilled birth attendants (2010)	69% ²²
ARV coverage of pregnant women (2011)	89% ²³
HIV prevalence rate in adults aged 15–49 (2010)	3% (adults) ²⁴ 3.7% (women) and 2.2% (men) ²⁵
Estimated number of people (all ages) living with HIV (2011)	211,502 (192,396–235,5260) ²⁶
Estimated number of adults aged 15 years and over living with HIV (2011)	185,746 (169,535–206,786) ²⁷
Estimated number of HIV-positive pregnant women (2011)	10,297 ²⁸
Estimated deaths due to AIDS (2011)	6,048 (4,916–7449) ²⁹
Estimated number of people receiving ART (2011)	96,123 ³⁰ (91% of HIV-positive individuals eligible for ART are receiving treatment) ³¹
Estimated number of adults in need of ART (2011)	109,866 (103,292–118,614) ³²
Percentage of young people aged 15–24 who used a condom the last time they had sex (2010)	Male: 66% ³³ Female: 42% ³⁴
Percentage of men aged 15–19 who had first sexual intercourse by 15 years (2010)	13.3% ³⁵
Percentage of men aged 20–25 who had first sexual intercourse by 15 years (2010)	8.8% ³⁶
Percentage of women aged 15–19 who had first sexual intercourse by 15 years (2010)	4.8% ³⁷
Percentage of women aged 20–25 who had first sexual intercourse by 15 years (2010)	2.8% ³⁸
Unmet need for FP	19% ³⁹
Contraceptive prevalence rate (2010)	45% ⁴⁰
Contraceptive prevalence rate amongst sexually active unmarried women aged 15–49 years (2010)	41% ⁴¹

Section 2

Building on the legacy of PMTCT in Rwanda



Building on the legacy of PMTCT in Rwanda

Rwanda established its first pilot PMTCT site in Kigali, the capital of the country, in 1999.⁴² Over the next decade the Ministry of Health progressively extended the coverage of its PMTCT programme so that by 2010 there were 382 sites offering services to prevent mother-to-child transmission of HIV.⁴³

Over this national scale up period the PMTCT programme was gradually integrated into the country's existing MNCH services.

“ Programmes to eliminate HIV infection among children and keep mothers alive are integrated into routine maternal and child health services in 80% of our facilities. Health workers are trained to provide such services, and clients save time and effort.”

DR AGNES BINAGWAHO, MINISTER OF HEALTH, REPUBLIC OF RWANDA, 2012⁴⁴

At present, there are 467 sites offering PMTCT services, available in 94.5% of the health facilities providing MNCH services.

As well as increasing coverage, the PMTCT programme in Rwanda has shown some impressive results:

- The acceptance rate of HIV testing among pregnant women in ANC increased from 89% in 2005 to 98.3% in June 2010. Of the women who were tested during this period, 99.4% received their HIV test results.⁴⁵
- With the introduction of a set of recommendations that encourage greater male involvement in PMTCT, an aspect of which includes the requirement that male partners be present at the first ANC visit, the uptake of HIV testing by male partners in ANC increased from 32.5% in 2005 to 84.35% in 2011.⁴⁶
- The proportion of HIV-positive women who delivered in a health facility increased from 70% in 2005 to 95% in 2011.⁴⁷
- The proportion of exposed infants who received ART prophylaxis increased from 47.2% in 2007 to 96.2% in 2011.⁴⁸

Although it cannot be attributed to the PMCT programme alone, HIV prevalence among pregnant women in ANC decreased from 4.8% in 2005 to 1.7% in 2011.⁴⁹



LINKING THIS CASE STUDY TO THE GLOBAL PLAN

National actions

“National leaders will build a vibrant coalition between the HIV and maternal, newborn and child health constituencies around the goals of eliminating new HIV infections among children by 2015 and keeping their mothers alive ... and promote greater synergies and the strategic integration of prevention of mother-to-child HIV transmission programmes and maternal, newborn and child health programmes, as well as family planning services.”

The Global Plan, 2012: 16

To date, the national scale up of the PMTCT programme has been guided by the principles and desired outcomes of the country's national strategic plans for HIV.⁵⁰ The *National PMTCT Scale up Plan (2007–2012)*, preceded the development of the eMTCT plan. The 2011 national PMTCT technical guidelines were revised to accommodate the country's adoption of Option B+.⁵¹ Option B+ is one of the three PMTCT ARV programme options currently recommended by WHO. It involves providing life-long, triple ARVs to all HIV-positive pregnant women, regardless of their CD4 count. Since April 2012, Option B+ has begun to be rolled out nationally.

Accelerating the implementation of eMTCT

In May 2011, Rwanda's First Lady, Jeannette Kagame, launched the country's national eMTCT initiative.⁵² After the public launch, the Rwanda Biomedical Center (RBC) and other local, regional and international partners in PMTCT initiated the development of a national plan to provide a framework to accelerate the implementation of eMTCT.

The eMTCT plan was developed over a period of three months with the active involvement of a range of stakeholders including: subject experts in a number of technical working sub-groups; district health workers; representatives from other government institutions; and networks of people living with HIV.

Released in February 2012, *The National Strategic Plan for Elimination of Mother-to-Child Transmission of HIV in Rwanda (2011–2015)*, aims to reduce the overall population based mother-to-child transmission rate to 2% at 18 months by 2015. In line with *The Global Plan* framework, the country's eMTCT plan is comprehensive as it involves all four prongs of eMTCT.

One of the key components of this planning process was the assessment by key stakeholders of the current PMTCT programme performance as well as the identification of related challenges, gaps and bottlenecks. The assessment also aimed to provide evidence-based strategic guidance for priority interventions to achieve the goal of elimination of new HIV infections in children and keeping their mothers alive.⁵³

FIND OUT MORE

WHO guidelines on the use of ART within eMTCT programmes

- The WHO document *Programmatic Update: Use of Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants* (WHO, April 2012) provides a summary of the current WHO guidance on the use of ART in eMTCT programmes.

The document describes the three options that are currently available for HIV-positive pregnant women and their infants (Option A, B and B+) and highlights some of the benefits and programmatic, operational and clinical implications associated with each option.

- The toolkit *Expanding and Simplifying Treatment for Pregnant Women Living with HIV: Managing the Transition to Option B/B+* (IATT, WHO, UNICEF, March 2013) is a collection of assessment tools and checklists that describe the considerations to be taken into account when transitioning to Option B/B+.

These documents can be downloaded from: www.emtct-iatt.org

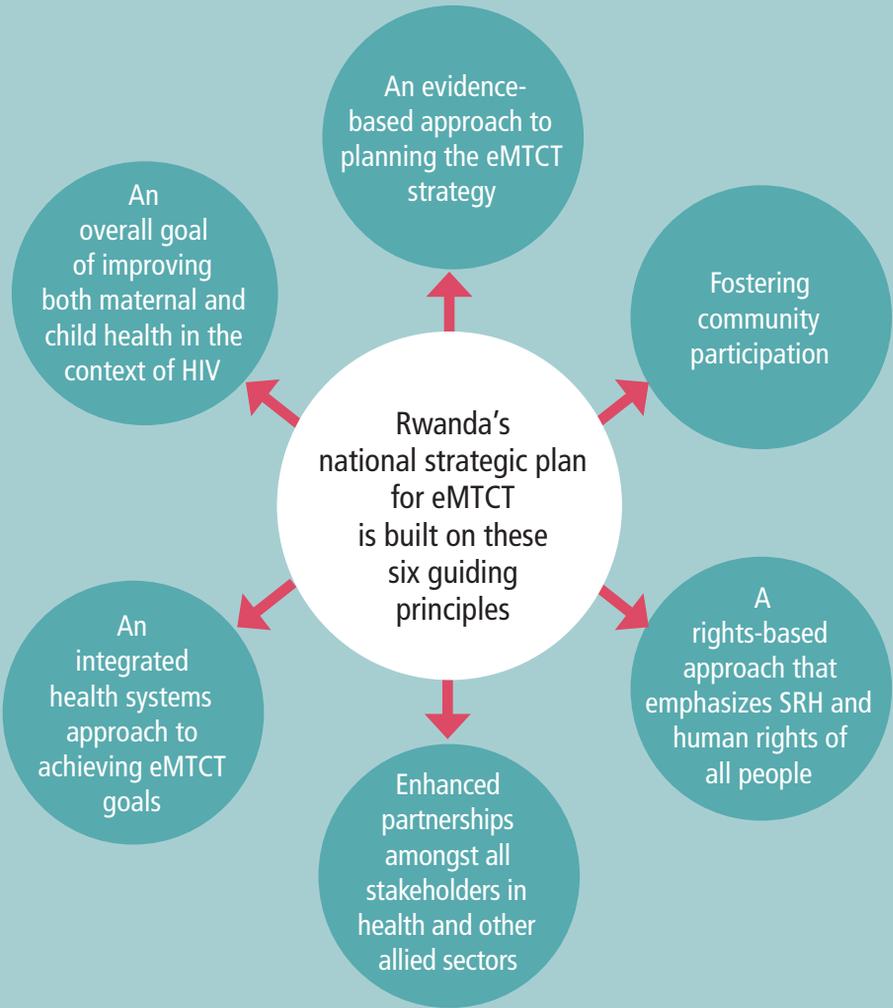
LINKING THIS CASE STUDY TO THE GLOBAL PLAN

Leadership priorities

“Being accountable: Country and community ownership is essential when decisions are made about how to optimize synergistic and mutually beneficial programmes. Reliable data represent the basis for mutual accountability for governments and partners and to the people that need, use and benefit from the services.”

The Global Plan, 2012: 15

Figure 2: Rwanda's national strategic plan for eMTCT and its six guiding principals



Section 3

Breathing life into the eMTCT strategy

In order to highlight how aspects of the country's national strategic plan for eMTCT has been able to articulate the various principals and elements of *The Global Plan*, this section is divided into three parts and describes how key aspects of the Rwandan eMTCT plan has been operationalized at a policy, systems and health service delivery level.



AT A POLICY AND STRATEGIC LEVEL

1 Local level political commitment supports the development of district-based eMTCT plans

“One of the things that makes the PMTCT programme so successful in Rwanda is the high level of political commitment at all levels: from the central level down to the health facility level and in turn to the community level. We have strong commitment from the government side but also from our supporting partners and donors. There is also a high level of co-ordination amongst all of these partners.”

DR PLACIDIE MUGWANEZA, ACTING DIRECTOR, HIV PREVENTION UNIT, RWANDA BIOMEDICAL CENTER

The country's national political commitment to eMTCT is replicated at a district level, where, following the development of the national eMTCT strategy, each of the 30 health districts were tasked with developing their own eMTCT plans. To date, all 30 of the districts have plans in place until 2015 – all of which have been endorsed by their respective district authority.

2 Decentralized decision-making and performance-based financing and contracting

After the 1994 genocide, Rwanda re-adopted the district health model as a way of re-building the health system. This decentralized model of governance has afforded the 85% of Rwandans who live in rural agricultural communities greater access to health care⁵⁴ and local level stakeholders the opportunity to engage with district health authorities and health service providers about local priorities.

Two of the mechanisms through which this participatory decision-making is done are through the country's performance-based financing mechanism and the *Imihigo* (performance contracts). Under *Imihigo*, district mayors, governors and ministers sign six-month performance contracts

with the President of the Republic. These contracts focus on priority areas and include specific outputs, indicators, and targets,⁵⁵ which are used to monitor the progress of programmes and improvements in service quality at the district and sub-district levels. Indicators related to eMTCT are regularly incorporated into these performance-based financing and contracting processes.

“As an example, if we realize that the community is not interested in PMTCT and we only have 20% of couples coming to ANC and getting tested, we set a target for the district (let us say of 80% by the end of the year). That becomes part of the Mayor of this district's performance-based contract with the President. We then all focus on reaching this target: we set an action plan and mobilize the community, we coordinate activities, we insure that there is an efficient supervision process in place (for our health workers) and we also get the community involved – because all of our targets are first agreed to at a village level, and there after at a cell and a sector level before being formalized into the district's and the Mayor's performance-based contract.”

DR GEORGETTE MUTABAZI, DISTRICT PROGRAMME CO-ORDINATOR, RUBAVU

Following an independent assessment, districts are then financed, and public servants paid on the basis of their performance in reaching their targets.

Another mechanism that Rwanda introduced in 1998–2000 and scaled up in 2004, was the community-based health insurance scheme, the *Mutuelle de Santé*. It targets more than 97% of the population, providing basic services and helps people share the risk of having to pay in full for treatment at village and district levels. Based on their level of income, each member of the scheme contributes the equivalent of US\$3–\$11 per year and pays a 10% fee for each illness episode. Fee waivers exist for the poorest and most vulnerable – with these costs being subsidized by the Government of Rwanda or development partners.⁵⁶



LINKING THE CASE STUDY TO THE GLOBAL PLAN

Resource mobilization actions

“Exploring innovative financing mechanisms.

Countries will be encouraged to explore innovative financing mechanisms to support the resource gaps that they identify. These could include investments in national health insurance financing schemes, national levies and public-private partnerships.”

The Global Plan, 2012: 20

AT A SYSTEMS LEVEL

1 Making the link: integrating the delivery of HIV and SRH, including MNCH services

Achieving the targets for improving maternal health and eMTCT requires linking the HIV and SRH responses. Programming for prongs 1 and 2 of the comprehensive eMTCT strategy requires effectively integrating SRH (i.e. MNCH, FP, GBV, STIs) and HIV services while jointly addressing health system bottlenecks, and ensuring a supportive policy environment respecting human rights.⁵⁷

“ We try to have all services together – all in one facility. In the beginning we had separate voluntary counselling and testing (VCT), PMTCT and ART programmes. But now we want, by the end of this year [2012], to have all these services [VCT, PMTCT, ART] and all the surrounding services, including FP and STI services, all in one service – that is one of the country targets... it is what we call ‘all in one’: to have all services at one point of care.”

DR SABIN NSANZIMANA, HEAD OF HIV/AIDS, STI AND OBBI DIVISION, RWANDA BIOMEDICAL CENTRE

To support such integration, the Ministry of Health has focused on two key strategies:

1. The integration of FP and HIV services

The rationale for such integration has long been apparent as sexually active women are at risk of both unintended pregnancies and HIV.⁵⁸ The integration is bi-directional: so, for example, a woman coming into a health facility for an FP consultation would automatically be offered information and services related to HIV, and a woman coming into a health facility seeking HIV information, testing and/or care would be offered FP counselling and information on contraceptive methods available, including education on the importance of dual protection and safer conception options for clients desiring a pregnancy.

The vision of the FP and HIV integration process is to ensure that clients receive both FP and HIV services in the ‘same place’ (i.e. within a single facility), from the ‘same service provider’ (i.e. by a health professional who has been trained to provide both types of service) and at ‘the same time’ (i.e. within a single consultation).

In those instances where modern contraceptive methods are not available to clients (for example, in health facilities managed by a faith-based organization), the Ministry of Health has established a complimentary mechanism to facilitate a client’s access to FP. Referred to as *secondary health posts* the Ministry of Health has set up an adjoining health facility which provides the necessary FP counselling and FP commodities. Clients opting for a modern FP method in the faith-based facility are referred to the respective secondary health posts for their preferred FP methods.

With 40% of the country’s health facilities being supported by faith-based organizations⁵⁹, the establishment of secondary health posts was considered an important intervention by the Ministry of Health to ensure that prongs 1 and 2 of the comprehensive eMTCT strategy could be fully realized in the catchment areas of these facilities.

“ The Ministry of Health has developed an agreement with these churches and the local administration has now built a secondary health post near the health facility [that is] managed by the Catholic Church. These secondary health posts provide some services – such as modern FP methods – that the clients cannot get at the primary health post managed, for example, by the Catholic Church.”

DR ANICET NZABONIMPA, IN-CHARGE: FP AND HIV INTEGRATION PROGRAMME, MINISTRY OF HEALTH



LINKING THE CASE STUDY TO THE GLOBAL PLAN

Country implementation action

“Strengthen synergies and integration fit between HIV prevention and treatment and related health services to improve maternal and child health outcomes. Countries will promote integration between HIV services for pregnant women and maternal, newborn and child health, family planning, orphans and vulnerable children, and other relevant programmes and services in order to expand the coverage of HIV services, increase access, strengthen linkages and referrals, improve quality and optimize the use of resources.”

The Global Plan, 2012: 26

2. Harmonization of MNCH with the HIV response

The Ministry of Health has actively promoted an integrated and harmonized response to HIV and MNCH initiatives at both a national and district level. Therefore, comprehensive eMTCT services have been integrated into the MNCH services offered in all public health centres, dispensaries and hospitals – and a minimum package of eMTCT services has been integrated into health posts that offer ANC.

By integrating eMTCT into other MNCH services, the Ministry aims to improve and harmonize the delivery of health services to the client, reduce multiple clinical visits and ultimately contribute to significant reductions in mother-to-child transmission rates and maternal mortality.

2 Task shifting: one of the solutions to address shortages of human resources in HIV treatment and care

“Task shifting helped a lot. Before the training of nurses in ARV prescription, it was difficult because every HIV-positive person had to look for a doctor. The task shifting reduced the workload of doctors and the time patients had to wait. Moreover, it shortened the distance patients had to walk because (before) everyone had to go from a health centre to the hospital, now ARVs can be prescribed at the health centres.”

MR DANANY NDUNGUTSE, PMTCT MANAGER, RUBAVU HEALTH CENTRE

In resource-limited settings such as Rwanda, significant healthcare worker shortages contribute to weakening the country's attempts to provide accessible, quality healthcare for all. Given the limited number of professional healthcare workers and the increasing number of people on or needing ART and requiring long-term care, task shifting – or the delegation of healthcare tasks from one cadre of trained professionals (such as physicians) to other staff who previously were

not accorded such tasks – is one of the solutions that the country has adopted to meet the growing demand for HIV treatment and care.⁶⁰

In line with WHO global recommendations and national guidelines on task shifting, Rwanda has developed a set of guidelines to manage the redistribution and expansion of HIV-related responsibilities and tasks among its healthcare workforce.⁶¹

By adopting this strategy, Rwanda has trained nurses to conduct some activities that were previously only offered by doctors, among them are: first line ART initiation, follow up of people living with HIV or HIV-exposed clients, early identification of therapeutic failure in clients on ART, identification and management of side effects, STIs and tuberculosis screening, and use of new client files and registers.⁶²

The Ministry is confident that along with other health systems strengthening strategies, supervised task shifting can support the robust implementation of Option B+.

“Task shifting was a solution that we looked at when we saw that we only have a few doctors who cannot reach all health centres to provide antiretrovirals. So we trained nurses; 500 nurses are now able to provide ARVs, they are able to prescribe first line ARVs and do simple follow up of WHO staging and opportunistic infections. So those nurses can do a very good job in the implementation of Option B+.”

DR SABIN NSANZIMANA, HEAD OF HIV/AIDS, STI AND OBBI DIVISION, RWANDA BIOMEDICAL CENTRE



LINKING THE CASE STUDY TO *THE GLOBAL PLAN*

Country implementation action

“Enhance the supply and utilization of human resources for health.

Through policy and regulatory reform, including task-shifting and task-sharing, countries will develop and implement a plan that addresses shortages of qualified health professionals including schemes for recruiting, training, deploying and retaining health care workers ...”

The Global Plan, 2012: 26

3 An on-site mentorship programme to support primary care health workers deliver ART services effectively

To accompany the process of task shifting, the Ministry of Health has established a team that provides on-site support and mentorship to healthcare workers in both the urban, peri-urban and rural areas of the country. Comprised of a team of doctors and nurses, the team ensures that the expertise and experience they have is shared with local healthcare workers at a primary care level throughout the country. Stationed for at least two

weeks with a local healthcare team, the mentorship team is able to supervise the work of the local healthcare workers and provide support to them as they manage more complicated HIV and ART clients. The provision of this on-site, direct and integrated supervision not only enables the local healthcare teams to familiarize themselves with the implementation of new national guidelines (for example, around Option B+), but also supports the processes of quality improvement and assurance.

The ultimate aim of the mentorship programme is to ensure that high quality eMTCT services are provided to clients across the country.



FIND OUT MORE

Integrating eMTCT into MNCH services

You can find more information about this topic in the following publications:

- Stone-Jimenez, Maryanne, Bisola Ojikutu, Mulamba Diese, and Cassandra Blazer (2011) *Technical Brief: Integrating Prevention of Mother-to-Child Transmission of HIV Interventions with Maternal, Newborn, and Child Health Services*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

This publication can be downloaded from: www.aidstar-one.com

- IATT (2012) *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015. In support of The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.*

This publication can be downloaded from: www.srhivlinkages.org or www.emtct-iatt.org

AT A SERVICE DELIVERY LEVEL

Many of the interventions described in the Rwandan national strategic plan for HIV have both a clinical health facility-based aspect and a community-based aspect. Rather than seeing the interventions in the two settings as discrete, the strategy adopted by the national strategic plans links them to ensure a 'continuum of intervention' from the health facility to the community.⁶³ The country's eMTCT strategy reflects this ideal and specifically acknowledges the importance of integrating different models of service delivery in the operationalization of the eMTCT strategy (see Figure 3).

1 On the frontline: the role of community healthcare workers in Rwanda's eMTCT programme

“Our health system is now well established but we also have another strength: that is our community. We really appreciate the contribution of our community... (and within that) we have an

organized community – of community health workers. This is a team of 45,000 people that can make things happen... we count on them to reach all women in the households (of their) villages – and say to them please go to the health centre and be tested, go to the health centre to check on your pregnancy...”

DR SABIN NSANZIMANA, HEAD OF HIV/AIDS, STI AND OBBI DIVISION, RWANDA BIOMEDICAL CENTRE

Community health workers (CHWs) can promote increased demand for and facilitate access to and utilization of, services related to eMTCT. For example, as an extension of the health services they are able to provide some of the basic services, and through close contact with the community, can also inform health service managers about how to better meet the needs of their clients.⁶⁵ In addition, being members of the local community CHWs have the potential to positively influence social norms and practices that support, for example, the uptake of HIV counselling and testing or that serve to reduce HIV-related stigma and discrimination, and encourage greater male partner involvement in

Figure 3: Community and health actors and systems⁶⁴



LINKING THE CASE STUDY TO THE GLOBAL PLAN

Community actions

“Communities will maximize community assets. Community leaders will ensure that policies and programmes are relevant to each local environment and that all community resources and assets are engaged, including midwives, mentor mothers and other women living with HIV, peer educators and community health workers.”

The Global Plan, 2012: 16

Community health workers as agents of change

Robert Kananga is a 53 year old father and husband who works as a volunteer community health worker (CHW) in the small town of Gakenke, approximately 55 kilometres north of Kigali, the capital of Rwanda. He lives with his family in a simple two-roomed dwelling just off the town's busy main road which is bustling with commercial activity. The larger of the two rooms, which Robert uses for his consultations with community members, is cool and peaceful. A wooden box, bearing his name, is stored neatly in the corner of the room. It is the only outward sign that Robert is a CHW.

Elected by the local community in 2007 and trained by the Ministry of Health, he works in close partnership with a female CHW. Together they are called the *Agent de Santé Binômes* (the male and female community health workers) and focus on child health. A third CHW, referred to as the *Agent de Santé Maternelle* focuses specifically on maternal health and provides dedicated support to pregnant women

and newborns. Together the CHW team support the community health programmes of the local clinic and district.

They meet their dedicated supervisor at the clinic, along with the CHWs from the neighbouring villages, on a monthly basis. It is at these meetings that the CHWs report on their activities (for example, how many newly pregnant women they have referred to the health facility), share the challenges they are facing and are provided with follow-up training.

When asked why he became a CHW, Mr Kananga said:

"Before the Genocide, there was no such a system and it was really difficult. It was always a big problem to take children to the health centre. I am among the first generation of community health workers and we realize that it is really helpful. The community chose me because they judged me competent, and now I came to like what I am doing because I can see a positive impact it has on the community. There are no more situations where someone can get sick and stay at home without any medical care."

the SRHR of their partner. Similarly they can also raise awareness about the availability of various eMTCT interventions, provide ART literacy and adherence support, reduce the risk of loss to follow-up and provide home-based care.

In 2008, Rwanda adopted a National Community Health Policy⁶⁶ to guide and strengthen the provision of community-based health services within the country. The scale up of the existing CHW programme was a critical component of this policy. At present there are 60,000 CHWs working at a village level across the country.

Each village has one male and one female CHW and one other CHW who focuses specifically on maternal health.

Collectively they are responsible for between 50–150 households, and together with the CHWs in adjoining villages are supervised by, and report to, a health worker at the local health centre. The CHWs work as volunteers. Following on from their initial training they are provided with additional training as new services are gradually introduced into the package of care they offer community members.

The country's eMTCT plan recognizes communities as essential partners for eMTCT and has outlined a variety of roles and responsibilities for CHWs and community-based organizations (such as associations of people living with HIV, NGOs, faith-based organizations) across the plan's four key outcome areas.



LINKING THE CASE STUDY TO THE GLOBAL PLAN

Community actions

"Community leaders will identify solutions. Community leadership is also vital to tackle the many complex psychosocial issues (including stigma and discrimination) faced by pregnant women living with HIV that limit their access to or retention in health services that could benefit them and their children."

The Global Plan, 2012: 16

As the country's national community health policy notes:

“Community health workers form the link between the health centres and the community, serving as the mouthpiece and ears of the health service at the community level. They know the communities well as they live and work among them, and they are often respected individuals.”⁶⁷

Alongside their regular child and maternal health activities, the CHWs provide specific support to the eMTCT programme by:

- Informing community members about the services that are available at the local health centre and ensuring that they are accessible to community members. These include HIV counselling and testing, the treatment of STIs and opportunistic infections, FP and reproductive health counselling, and the availability of ART and support groups for people living with HIV;
- Increasing awareness of community members about the advantages of FP and providing FP counselling, condoms, contraceptive pills, injectable contraceptives and cycle beads;
- Motivating pregnant women to attend antenatal and postnatal care visits at the health centre, including accompanying women to these consultations;
- Sensitizing men to ensure they provide the necessary support to their pregnant partner in being able to attend these consultations;
- At the request of the clinic, following up on women who have missed one of their antenatal or postnatal care appointments and encouraging them to attend their consultations;
- Working in collaboration with traditional birth attendants, sensitizing women on safe motherhood and ensuring that pregnant women reach the health facility for safe delivery services;
- Facilitating educational and behaviour change communication sessions with individuals, families and groups on issues related to SRH – along with providing health education on other issues such as tuberculosis, malaria, childhood infections, water-borne diseases and malnutrition;
- Providing support and counselling to people living with HIV, including ART adherence support;
- As part of their support of the integrated management of childhood illnesses programme, the expanded programme on immunizations, and the community-based nutrition programme, identifying when a child requires clinical or rehabilitation assistance and encouraging the early referral of a child to the health centre for further management;
- Informing community members about the importance of not stigmatizing and discriminating against those living with HIV within the community;
- Advocating that community leaders stay informed about the key health issues in the district and are motivated to get involved and provide leadership in prevention, care and mitigation activities.

CHWs also play an active role in the community based health information system by recording basic data on each household within their village. For example, they are responsible for keeping records of the under-fives, of women between the ages of 15–49 years, of vital events (such as pregnancies), and of maternal deaths and under five mortality.

FIND OUT MORE

Community participation in eMTCT

You can find more information about this topic in this publication:

IATT (2012) *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015. In support of The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.*

This section is particularly relevant: **Strategy 2: Strengthen Community Engagement.**

This document can be downloaded from: www.srhivlinkages.org or www.emtct-iatt.org

“ Improved communication between (the) health care system and community actors will increase the sense of ownership of the population (of) the health care services and its utilization of these services.”

RWANDA NATIONAL STRATEGIC PLAN FOR HIV AND AIDS (2009–2012:49)

2 Upholding adolescent sexual and reproductive health and rights

The first outcome of the country's eMTCT strategy calls for the scale up of existing HIV education initiatives that provide for targeted and comprehensive SRH and HIV education, counselling and skills building services that can be implemented through multiple strategies in different settings. Identified settings include health facilities, non-health settings (such as schools, youth-friendly centres, work places and faith-based settings), and through community-level activities (such as community gatherings and outreach activities to groups at risk such as sex workers).⁶⁸

In the country's eMTCT plan special emphasis is placed on including information that addresses the specific vulnerabilities and SRH needs of young women and girls.

The Minister of Health, Dr Agnes Binagwaho, notes in her preface to the national *Adolescent Sexual Reproductive Health and Rights Policy Strategic Plan (2011–2015)*⁶⁹ with "sixty-seven percent of Rwandans being less than 20 years old, these young people are the adults of tomorrow who will be forming and determining the social and economic development of the country." In accordance with the commitment that the Government of Rwanda made at the International Conference on Population and Development (1994), to make SRHR services "available, accessible, acceptable and affordable" to young people, this is a commitment that the Ministry is more than willing to uphold.

Recognizing the need of young people to access sexuality education and related health services in order to reduce, for example, their HIV risk and prevent an unintended pregnancy or an unsafe abortion, the adolescent SRH programme within the Ministry of Health targets young people between the ages of 10–24 years.

“ All the services are targeted to that age range so whoever is in need of such services in the community, for example – family planning, or education about sexual and reproductive health – can go to a health facility or a youth-friendly centre – and the health care providers have been trained to provide these services to young people.

We [place] an emphasis on educating young people about their rights within the health services. This really helps, we believe, in reducing unsafe abortions amongst teenagers, and makes them feel comfortable about coming to use such services like family planning and delivery at the health facility”.

DR DIANE MUTAMBA, IN-CHARGE: ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAMME, MINISTRY OF HEALTH

Providing SRHR related education and services to young people is not confined to health facilities alone: the programme also focuses on creating a positive approach to comprehensive sexuality education within the home and school environment.

“ We have been working at trying to break the cultural barrier where parents were not comfortable talking about sexuality education at home. We believe that education first starts at home and we have been working on sensitizing parents and caregivers to start talking about sexuality at the earliest age possible [with their children].

We have also incorporated sexual health education into the formal school curriculum. Teachers were used to talking about reproductive health but never talked about sexual health. We now have trained teachers to talk and teach about sexuality in the formal school education.”

DR DIANE MUTAMBA, IN-CHARGE: ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAMME, MINISTRY OF HEALTH

The above interventions are based on the principles and commitments the Government of Rwanda has made to honour the SRHR of young people and to provide youth-friendly SRH services to adolescents and young adults.

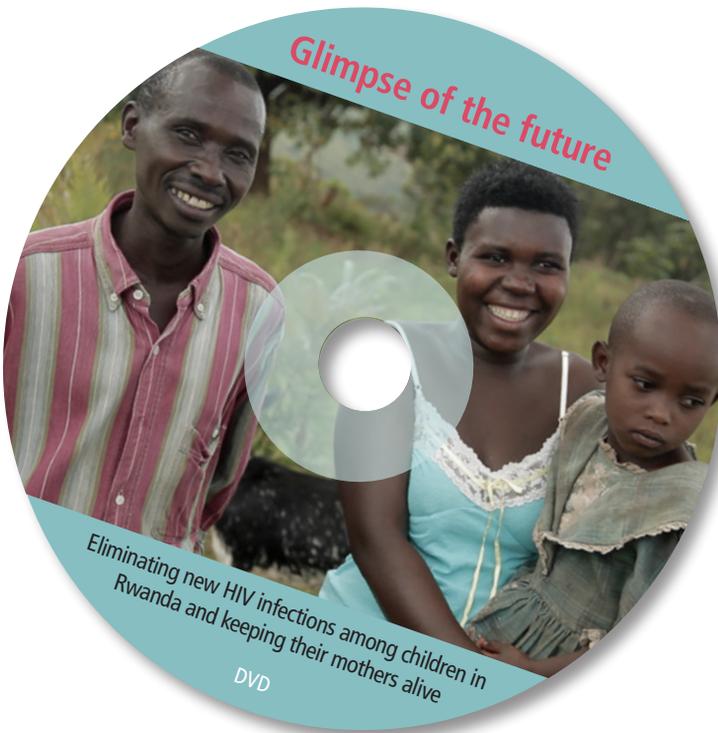
3 Raising awareness about eMTCT through popular forms of communication

As *The Global Plan* emphasizes, eliminating new HIV infections among children and keeping their mothers alive will require widespread public support. Community members are informed about the health services available, to eliminate mother-to-child transmission through their dialogue and engagement with CHWs and facility-based healthcare workers. The Ministry of Health has also produced a range of information, education and communication materials to communicate the message.

The Ministry of Health has supported the development of a web-based

documentary about eMTCT: *VIH/sida mere-enfant: appel à l'action!* (Preventing mother-to-child transmission of HIV/AIDS is possible!).⁷⁰

More recently, and as a complement to this publication, a short film *Glimpse of the future: Eliminating new HIV infections among children in Rwanda and keeping their mothers alive* was produced. The film provides an account of various components of the eMTCT programme through the eyes of Rwandan clients, health providers, programme managers and policy makers. The film aims to provide stakeholders with an advocacy tool and an educational resource that will serve to provide further support for the implementation of *The Global Plan*.



LINKING THE CASE STUDY TO *THE GLOBAL PLAN*

Communication priorities

A communication campaign is required to mobilize couples to access quality-assured comprehensive HIV services and access to antenatal care for women. Such mobilization can create demand for services, reduce the barriers to access and ensure that women stay in care to obtain the full benefit of services.”

The Global Plan, 2012: 21

A health promoting environment for young people

It's Saturday morning and a noisy game of volleyball is taking place on the concrete court outside Kabuga Youth Centre, which is competing with the sound of music blaring from large black speakers in the main hall. A couple of hundred young people are hanging around watching the game and twenty or so are sitting in the health centre waiting to see the counsellor for an HIV test or for FP services.

The youth centre is in the small town of Kabuga, 25 kilometres east of Kigali and supports between 200 and 400 young people between the ages of 15 and 24 every day. As well as coming to the centre to play sports and socialize, the youth-friendly health clinic on site provides VCT, FP and pregnancy tests. All the services are provided confidentially and in a stigma-free and non-judgemental manner.

The youth centre also runs a number of peer education programmes where young people, who have been trained in communicating messages about HIV and SRH, go to the community to provide information and encourage their peers to make use of the health clinic and the activities that are associated with it.

Mr Deo, the co-ordinator of the centre, says that young people are welcomed to the centre and along with participating in the games and entertainment activities that are on offer, they benefit from the centre's HIV counselling and testing and peer-education programmes:

"In those two services, we teach [the young people] about HIV and AIDS, reproductive health, family planning, and income-generating activities."

A close working relationship is maintained with the local health centre where clients are referred for clinical examinations and then encouraged to return to the youth centre for follow-up SRH counselling, health education and to engage with their peers in a health promoting environment.



4 Encouraging male participation in ANC consultations

Rwanda is internationally recognized for its leadership in the arena of male involvement in eMTCT. For example, worldwide, the proportion of pregnant women attending ANC whose male partner was also tested was 5% in 2008; in Rwanda, by contrast, the proportion in 2011 was 84%.⁷¹

Apart from the strong support that district and community leaders, the local CHWs and the healthcare workers themselves express in relation to the importance of a man accompanying his partner to the clinic for their first ANC consultation, a range of other systems have been put in place to guarantee the active engagement of men in the eMTCT process. For example,

- An invitation letter is given to a woman who comes to her first ANC consultation without her partner. She is expected to present this letter to her partner following her visit to the health facility so he accompanies her at her next appointment. In many instances CHWs will assist the facility-based healthcare workers to ensure that partners do in fact receive such invitation letters and, if possible, commit to attending the next ANC consultation.
- A *pair-educateur* (male peer educator) is present in some health centres. The *pair-educateur* provides immediate support to the male partners (who have tested HIV-positive during an ANC consultation) and accompanies clients who require ART to the local ART facility in the event that it is not provided for male partners within the same facility.

The support given by both district and national government officials to the importance of male partners accompanying their partner to an ANC consultation, along with the use of the partner invitation letters and the

verification of information about absent partners by CHWs, is underpinned by the now entrenched social norm for men to attend ANC with their partners.

During her first ANC visit, a pregnant woman, and ideally her partner too, participate in a group education session and receive some basic information on a spectrum of SRHR and HIV-related issues such as FP, birth spacing, nutrition, safe delivery care, HIV, STIs and issues related to gender and SRHR. HIV counselling and testing is then routinely offered to all pregnant women and their partners and the tests results are given on the same day.

Couples counselling and strengthened post-test counselling is another important component of the first ANC visit in Rwandan health centres, and something which is also considered to have contributed to the high uptake of HIV counselling and testing amongst men and their greater involvement in the eMTCT programme.

“ Every couple coming for ANC or PMTCT (they are combined in one service here), is counselled before getting any services. Sometimes the topic of the counselling is family planning ... When we talk to them together it is better because the man gets time to know and accept the family planning and he doesn't think that it is the woman who is bringing new things to the couple. Even at the general consultation, family planning is the first public talk they get.”

NURSE, GAKENKE HEALTH CENTRE

“ To learn about our HIV status together is good. The advice we receive in the couple counselling is more effective than the advice I can receive alone. It reduces the suspicion between us and reinforces our relationship. The advice we get helps us know how to behave afterwards – and it doesn't matter whether we are HIV-negative or not.”

CLIENTS AT AN ANC CONSULTATION, GAKENKE HEALTH CENTRE

LINKING THE CASE STUDY TO THE GLOBAL PLAN

Principles for success

“... efforts must be taken to secure the involvement and support of men in all aspects of these programmes and to address HIV- and gender-related discrimination that impedes service access and uptake as well as client retention.”

The Global Plan, 2012: 8

Irrespective of the HIV status of the couple, the post-test counselling session provides an important opportunity for the health worker to provide focused information to the couple about their health during the pregnancy and thereafter. Issues discussed with couples in the first (and subsequent ANC sessions) include:

- The benefits and use of condoms during the pregnancy to prevent HIV and other STIs, and the need to consider, in the later part of the pregnancy, future contraceptive use – particularly the use of dual protection.
- The importance of keeping ANC appointments and the role that the male partner can play in securing the health of his partner and unborn baby during this period.
- The risk of HIV sero-conversion during pregnancy and breastfeeding and the need for re-testing every three months if one or both partners are HIV-negative.
- Adherence to ARVs and the treatment regime that will be followed to prevent HIV transmission to the baby.
- Nutritional counselling and support, including counselling about infant feeding options.
- Advice about planning for the birth, including the encouragement of a health facility delivery.
- The facility- and community-based structures that are in place to support disclosure, manage HIV-related

stigma and discrimination and obtain psychosocial support in living positively with HIV.

Apart from the couples counselling that is provided, other clinical services like STI and tuberculosis screening and management are also provided in the first consultation.

For women who have tested HIV-negative, considerable attention is given to putting in place strategies that aim to prevent sero-conversion during pregnancy: these include ensuring that an HIV-negative woman – and ideally, her partner – return to the health centre every three months during her pregnancy to get re-tested and receive follow-up prevention counselling and related commodities.



KEY FIND OUT MORE

Male involvement in eMTCT

You can find out more about the benefits of male involvement and strategies to promote male involvement in eMTCT in the following publications:

- IATT (2012) *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015. In support of The Global Plan toward the elimination of new HIV infections among children by 2015 and keeping their mothers alive.*

The following section of this publication is particularly relevant: **Strategy 3: Promote Greater Involvement of Men.**

This document can be downloaded from: www.srhivlinkages.org or www.emtct-iatt.org

- Report on the *Sub-Regional Consultation to Discuss Strengthening Male Involvement in the Elimination of Mother-to-Child Transmission of HIV*. Held in Kigali, Rwanda, 24–26 August 2011.

The report can be downloaded from: www.who.int/reproductivehealth/topics/linkages/male_involvement_PMTCT.pdf

5 Treatment as prevention: providing support to sero-discordant couples

Results announced by the United States National Institutes of Health show that if person living with HIV adheres to an effective ART regimen, the risk of transmitting the virus to their uninfected sexual partner can be reduced by 96%⁷² as well as having health benefits for the person with HIV.⁷³ Thus WHO guidelines recommend that for couples where only one partner is HIV-positive, offering ART to the HIV-positive partner, regardless of his/her own immune status (CD4 count), will reduce the likelihood of HIV transmission to the HIV-negative partner.⁷⁴ In line with this, the current Rwandan HIV national guidelines suggest that “any HIV-positive sex partner in a discordant couple is eligible for ART regardless of their CD4 count and clinical stage”.⁷⁵

“ In the case where we do have discordant couples ... we have a programme that focuses on reducing HIV transmission within the family...we know that the existing efforts of (promoting) condoms and (educational) messages are not enough so what we have added in, recently, is to treat the positive partner in discordant couples with antiretrovirals ... So we think that with those combined efforts of message, condom, treatment and good follow up with counselling we will end up reducing infections from the positive member of the partner and end by up contributing to the eMTCT goals – because that is the family, that is the baby that we want to protect.”

DR SABIN NSANZIMANA, HEAD OF HIV/AIDS, STI AND OBBI DIVISION, RWANDA BIOMEDICAL CENTRE

Importantly, where appropriate, the option of treatment as prevention is introduced within the context of HIV testing and couples counselling.

6 Continuity of care

The longitudinal HIV care and treatment of all clients that have been part of the eMTCT programme is supported by CHWs in the local communities. Working together, the CHWs and staff at health centres encourage women to keep their postpartum and postnatal care appointments. They also help clients access the information and support that is available about, for example, infant feeding, vaccinations and HIV testing, growth monitoring and FP (including the use of dual protection) and ART adherence.

7 Supporting the sexual and reproductive rights of women living with HIV

One of the three overarching results that the *Rwandan National Strategic Plan (2009–2012)* set out to achieve was to establish that “people infected and affected by HIV have the same opportunities as the general population”.⁷⁷ As such, the Government of Rwanda has affirmed that living with HIV should not constitute a barrier or an obstacle to accessing services – be these health services, access to education or legal support, economic opportunities and/or social protection.

The Rwandan eMTCT plan reflects the adoption of this rights-based approach by ensuring that it was one of the six guiding principles on which the plan is built.

FIND OUT MORE

Treatment as prevention

Treatment as prevention is a term used to describe HIV prevention methods that use ART for people living with HIV to decrease the chance of HIV transmission independent of CD4 cell count.⁷⁶ Thus, importantly for eMTCT, lowering viral load with ARV drugs contributes not only directly to preventing onward HIV transmission to infants (prong 3), but also to primary prevention of HIV (prong 1) within sero-discordant relationships.

More information about treatment as prevention can be accessed from the following set of guidelines:

WHO (2012) *Guidance on couples HIV testing and counselling, including antiretroviral therapy for treatment and prevention in serodiscordant couples: recommendations for a public health approach.*

This document can be downloaded from: http://whqlibdoc.who.int/publications/2012/9789241501972_eng.pdf or from: www.srhhiwlinkages.org

“ The delivery of eMTCT interventions should safeguard standard human rights, including the right to safe and confidential services, and autonomy to make informed decisions regarding reproductive health and treatment options. The strategy emphasizes sexual, reproductive and human rights of all people including women and men living with HIV as well as the rights of marginalized populations such as sex workers, migrants, men who have sex with men, etc.”

PRINCIPLE 5, NATIONAL STRATEGIC PLAN FOR EMTCT IN RWANDA (2011–2015)⁷⁸

Supporting the SRHR of women living with HIV is an important part of *The Global Plan* and has particular relevance to prong 2. In operationalizing this rights-based approach, the Rwandan eMTCT plan specifically aims to protect the SRHR of women living with HIV by:

- Ensuring that quality, integrated HIV and FP services are accessible in all health public health facilities and that women living with HIV are provided with information and counselling on their reproductive rights and their fertility options and intentions. Importantly, the benefits of FP, the ways in which unintended pregnancies can be prevented, and decision-making around a full range of contraceptive options – based on the client’s preference, also form part of these comprehensive FP consultations.
- Linking HIV and FP services delivered at health facilities to local, community based initiatives such as those facilitated by CHWs and village leaders that support, for example, awareness-raising on male partners’ joint responsibility in practicing safer sex and FP, and in providing appropriate referrals and on-going FP support to women living with HIV.
- Providing support to the Rwanda Network of People Living with HIV (RRP+) and the Peer Educators for Adherence, Referral and Linkages (PEARL) programme – an initiative developed by the International Center for AIDS Care and Treatment Programs (ICAP) and Columbia University. The PEARL programme is facilitated by peer educators living with HIV, the majority of whom are women, selected from amongst the membership of RRP+. The programme, by working at a community level alongside the CHW programme, aims to improve the adherence of clients living with HIV enrolled in different programmes (such as eMTCT and adults and infants on ART). It also aims to strengthen the referrals and linkages between the formal health facilities, community-based organizations and local villages or neighbourhoods and improve the overall uptake by the community of services offered by the facilities such as ANC, HIV counselling and testing, FP, etc.⁷⁹ The peer educators do this by conducting home visits, facilitating training and counselling sessions at a grassroots level and accompanying their clients to facilities when required.



LINKING THE CASE STUDY TO THE GLOBAL PLAN

Principles for success

“Women living with HIV at the centre of the response.

National plans for eliminating new HIV infections among children and keeping their mothers alive must be firmly grounded in the best interests of the mother and child. Mothers and children must have access to optimal HIV prevention and treatment regimens based on latest guidelines.

Women living with HIV must also have access to family planning services and commodities. The process of developing and implementing programmes must include the meaningful participation of women, especially mothers living with HIV to tackle the barriers to services and to work as partners in providing care.”

The Global Plan, 2012: 8

Ensuring that SRH and HIV-related services are provided to people living with HIV in a non-stigmatizing and non-discriminating environment is also an important principle for the Ministry of Health.

“As Rwandans, we know that we don't have to stigmatize HIV-positive people, it is taught at healthcare facilities and on radios... We all know many HIV-positive persons, we live with people that are HIV-positive and share (our lives) with them ... At this health centre HIV-positive people are not stigmatized, for example this room is the waiting room for people coming for an HIV test, and there is no stigma because we don't know who is positive or negative. And (even after that) nurses don't separate HIV-positive people from other people, we all get services together.”

NURSE, GAKENKE HEALTH CENTRE

8 Monitoring the implementation of the eMTCT strategy

The monitoring of the country's eMTCT strategy and the progress made toward reaching the eMTCT targets is implemented through a variety of mechanisms. These include follow up of the programme's routine data that are reported by health facilities on a monthly basis, quarterly eMTCT co-ordination meetings at the district level and the implementation of a cohort study that will follow pregnant women living with HIV and their infants – until 24 months of age.

FIND OUT MORE

Sexual and reproductive health and rights of women living with HIV and providing non-discriminatory services to people living with HIV

You can find out more about the greater involvement of people living with HIV in eMTCT and some guidelines on how to provide non-discriminatory eMTCT services to people living with HIV in the following publications:

- IATT (2012) *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015. In support of The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.*

The following sections of this publication are particularly relevant: **Strategy 4: Engage organizations of people living with HIV; Strategy 5: Ensure non-discriminatory service provision in stigma-free settings; and Annex 2: Annotated bibliography of supporting policy and programming guidance.**

This document can be downloaded from: www.srhhivlinkages.org or www.emtct-iatt.org

- GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS (2009) *Advancing the Sexual and Reproductive Health and Rights of People Living with HIV.*

This document can be downloaded from: www.srhhivlinkages.org

LINKING THE CASE STUDY TO THE GLOBAL PLAN

Communication priorities

“Reducing stigma and discrimination faced by women and children living with HIV

Women living with HIV often face stigma and discrimination while accessing health and social welfare services: this limits the impact of services, thus reducing the outcomes of care. Reducing stigma and discrimination is also vital to empowering and giving leadership to women living with HIV for them to demand access to and manage HIV-related services for themselves and their children.”

The Global Plan, 2012: 21

STORIES FROM THE FIELD

"Now I feel great, and proud to be called Mama Keza"

Chantal and Emmanuel met at the health facility where they both receive their ART medication and are provided with on-going clinical care. They have a one year old child who sits with them listening and breastfeeding whilst they are being interviewed.

Their present joy and contentment as a family is very different to what Chantal and Emmanuel experienced when they were first diagnosed HIV-positive.

Despite having support and understanding from her family, when Chantal first learned as a young woman that she was HIV-positive she felt "depressed and hopeless" and had feelings of "unworthiness" within her.

"When this happens to you, you feel so depressed and ask yourself why couldn't this wait until when I am an adult or a mother?"

Emmanuel's experience was similar: also close to his family, he too felt "depressed" when he learnt he was HIV-positive:

"I had a small amount of soldiers [CD4 cells] protecting me, only 26 out of the thousand a normal person should have. So I decided to forget about getting married."

The young couple talk about two turning points in their lives: the first being the encouragement and support they received from the health workers and the second, finding one another and getting married.

As Emmanuel recalls:

"The doctors comforted me and showed me ways to feel better with my condition and assured me that I would feel young and strong again and nobody would know that I was sick."

As Chantal remembers:

"When I learned that I had HIV, they told me that it was not the end of the world. Then I started feeling a little bit easy. They advised me to visit the hospital regularly ... [The healthcare workers] helped us ... they welcomed us, taught us, and explained to us that being infected is not dying. The health counsellors also [helped us] with their home visits [which] did comfort us."

The second turning point was meeting one another, getting to know one another and inviting friends and family to their wedding – and, importantly, deciding to have a baby:

"At the hospital, we told them that we want to have a baby, and they said it was a good thing (and that we must) follow their instructions. I got pregnant and I was taking my medicine every day. So when I was three months pregnant I came with my husband to the hospital [for ANC] ... and now I feel great and proud to be called Mama Keza."

Their joy is apparent, and their advice clear:

"If someone has HIV and has never been to the hospital, I would urge that person to go to the hospital so that they can get the proper care and so life goes on Do not be afraid, go get tested. If you are infected, it is not the end of the world, talk to doctors, ask their advice, don't isolate yourself."



Annex 1: Note on terminology

This case study makes use of some key terms that are elaborated and defined below:

The elimination of mother-to-child transmission of HIV⁸⁰

There has been a shift in terminology from preventing mother-to-child transmission of HIV to eliminating such transmission as reflected in the global targets 2011–2015 of *The Global Plan*. This is the terminology used in the case study. However, people living with HIV have indicated that the term 'elimination' of mother-to-child transmission is problematic as it fails to recognize that HIV is not just a virus but is part of people's lives, affecting how the community relates to them on every level.⁸¹

Particularly when used alone, the word 'elimination' is also perceived to be derogatory, since, if taken out of context, without qualifying terms, it can seem to connote an end to the lives of people living with HIV.

The term 'elimination' can:

- evoke fear and be disempowering for people living with HIV;
- prevent people from accessing necessary services and, subsequently, from being able to prevent transmitting HIV to their child, if these services are associated with the term; and
- be understood to mean eliminating women living with HIV or infants living with HIV in order to eliminate mother-to-child transmission.⁸²

Furthermore, women living with HIV have recently advocated for the terminology 'comprehensive prevention of vertical transmission' to replace 'mother-to-child transmission', believing that focusing on the event, rather than the persons involved removes the onus, blame and guilt for transmission of HIV to the baby solely from the mother.

This simple change in term from 'mother-to-child transmission of HIV' turns the focus away from women being 'vectors of transmission'. Women find the term 'comprehensive prevention of vertical transmission' less accusatory and more conducive to male involvement; it also has the potential to increase access to services.⁸³ This viewpoint also prefers the term 'stopping' or 'ending' vertical transmission instead of 'elimination', which *"can be perceived as threatening to one's existence and, if taken out of context and without qualifying terms, can evoke fear and be disempowering for people living with HIV."*

The document *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015* also makes clear that the term 'elimination' should not be used alone, as a shorthand or as a slogan. *"Stakeholders must carefully consider choice of terminology in programming to ensure definitions are clear, not normative, clouded in ambiguity or value laden. This document uses the term 'elimination of mother-to-child transmission' or 'eMTCT', never 'elimination' on its own."*⁸⁴

The synergies, linkages and integration of SRH and HIV

One of the overarching principles of *The Global Plan* is that of leveraging synergies, linkages and integration for improved sustainability. *The Global Plan* recommends that national plans must leverage opportunities to strengthen the synergies with existing programmes for HIV, maternal health, newborn and child health, FP, orphans and vulnerable children, and treatment literacy.⁸⁵

The idea of linking SRH services with HIV services is obviously an important part of this principle. In delineating the full scope of a linked SRH and HIV response a distinction has been made between linkages and integration.⁸⁶ Agreed definitions are as follows:

Linkages

The bi-directional synergies in policies, programmes, services and advocacy between SRH and HIV. It refers to a broader human rights-based approach, of which service integration is a subset.⁸⁷

Integration

Refers to different kinds of SRH and HIV services or operational programmes that can be joined together to ensure, and perhaps maximize collective outcomes. This would include referrals from one service to another, for example. It is based on the need to offer comprehensive and integrated services.⁸⁸ This means, in terms of service delivery, the organization and management of health services to ensure that people get the care they need, when they need it, in ways that are user-friendly and that achieve the desired results and while providing value for money.⁸⁹

FIND OUT MORE

HIV and SRH linkages

You can find out more about the benefits of such linkages and the key actions to link SRH and HIV at the policy, systems and service delivery levels in the following resources:

IATT (2012). *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015. In support of The Global Plan toward the elimination of new HIV infections among children by 2015 and keeping their mothers alive.*

The following section of this publication is particularly relevant: **Strategy 1: Link SRH and HIV at the policy, systems and service delivery levels.**

This document can be downloaded from: www.srhivlinkages.org or www.emtct-iatt.org

Annex 2: Discussion questions to accompany the film

Below is a series of questions that could be used to facilitate a discussion on the film *Glimpse of the future: Eliminating new HIV infections among children in Rwanda and keeping their mothers alive* with healthcare workers, programme managers and health advocates working in the area of HIV and sexual and reproductive health.

It is hoped that these questions will serve to both encourage participants to refer back to and read aspects of the corresponding written account of the Rwandan case study and also to identify what more they need to find out about in *The Global Plan* and the strategies used in its implementation.

Discussion questions

1. In the opening sequence of the film the narrator talks about “*The Global Plan*”. Do you know what plan the narrator is referring to here, and if so, what its two main global targets are?
.....
2. There are four prongs that make up a comprehensive approach to the elimination of mother-to-child transmission of HIV (eMTCT) and to keep mothers alive. As you watch the film, make sure you:
 - List and describe each of the four prongs that make up a comprehensive eMTCT approach; and
 - List some of the activities that are currently being implemented in Rwanda in relation to each of the four prongs......
3. Are there other activities related to any one of the four eMTCT prongs that are being implemented in your own setting that were not mentioned in this film? Make a list of these additional activities.
.....
4. One of the strategies that was highlighted in this film was that of involving men in the first antenatal care visit. What is your opinion of this strategy? Could this strategy be successfully operationalized in your own setting? Discuss why and why not.
.....
5. One of the interviewees notes that living with HIV ought not to limit one’s rights or freedom. What are the sexual and reproductive health and rights of women living with HIV?
.....
6. What are some of the things that community- and facility-based health workers can do to ensure they provide good quality and non-discriminatory eMTCT services to people living with HIV?
.....
7. What role do you think community leaders can play in supporting eMTCT? Consider this in relation to your own work context and/or local setting.
.....
8. In Rwanda, community-based health workers have an important role to play in supporting the eMTCT strategy. What kinds of activities do you think lay health workers, such as community health workers, can play in supporting eMTCT?
.....
9. Where would you find more detailed information about *The Global Plan*, the progress that is being made toward reaching the global targets and what policies, plans and strategies various countries have put in place to support eMTCT?
.....
10. What did you find particularly inspiring from this film?
.....

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This case study provides a 'glimpse of the future' by identifying a number of key interventions taking place in Rwanda that are enabling the country to move towards successfully eliminating mother-to-child transmission of HIV.

Following the framework provided by *The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, this case study illustrates how a comprehensive approach to the elimination of mother-to-child transmission of HIV and reducing maternal mortality can be operationalized in practice.

