**Web Annex H. Analysis guidance for human rights, gender equality and community engagement in validation**

**Table of Contents**

[Purpose 1](#_Toc128394434)

[Introduction 2](#_Toc128394435)

[Shared principles 2](#_Toc128394436)

[*Do no harm* 2](#_Toc128394437)

[*Meaningful inclusion* 3](#_Toc128394438)

[*Transparency and equality* 3](#_Toc128394439)

[Step-by-step: Understanding the process for validation 3](#_Toc128394440)

[**Step 1: Engage the community** 3](#_Toc128394441)

[**Step 2: Completing the assessment tool** 4](#_Toc128394442)

[**Step 3: Gathering key documents and stakeholder information** 4](#_Toc128394443)

[**Examining laws, regulations and policies** 4](#_Toc128394444)

[**Examining practice and the lived experiences of women** 5](#_Toc128394445)

[**Step 4: Identify gaps, risks and concerns in law, policy and practice through a collaborative multi-stakeholder consultation** 5](#_Toc128394446)

[**Frequently Asked Questions** 6](#_Toc128394447)

[**Step 5: After the analysis and report** 8](#_Toc128394448)

[Section-by-section: Understanding the requirements 9](#_Toc128394449)

[**Section 1: Ending criminalization of HIV, syphilis and HBV** 9](#_Toc128394450)

[**Section 2: Ensuring voluntary testing and treatment** 9](#_Toc128394451)

[**Section 3: Ensuring informed consent** 10](#_Toc128394452)

[**Section 4: Eliminating coercive practices including involuntary sterilization, contraception or abortion**  11](#_Toc128394453)

[**Section 5: Ensuring confidentiality** 13](#_Toc128394454)

[**Section 6: Ensuring equality and non-discrimination** 14](#_Toc128394455)

[**Section 7: Ensuring accessibility and quality of women-centred healthcare services** 14](#_Toc128394456)

[**Section 8: Addressing gender-based violence** 15](#_Toc128394457)

[**Section 9: Engaging and being accountable to communities** 16](#_Toc128394458)

[**Section 10: Ensuring access to justice** 17](#_Toc128394459)

[Focus group discussion guide 19](#_Toc128394460)

# Purpose

This step-by-step guide is meant to guide the national assessment for validation of elimination of vertical transmission of HIV, syphilis and hepatitis B virus (HBV) in the area of human rights, gender equality and community engagement (HR GE CE). This annex supports the National Validation Committee to gather evidence using the focus group discussion guide in this annex and the *Human rights, gender equality and community engagement assessment and verification tool*, provided for in Web Annex G. Further, this annex provides guidance on synthesizing the data collected for reporting in the initial validation report. The *Report template for initial validation or Path to Elimination* is available in Web Annex C.

# Introduction

In the course of the National Validation Committee (NVC)’s work to gather evidence and prepare the initial validation report, it is essential to maintain a high degree of collaboration with, and input from, the community to assess the situation of human rights, gender equality and community engagement. A collaborative process of information-gathering and analysis supports the i) building of the capacities of governments to deliver on their human rights obligations, and ii) building the capacity of communities to claim their health rights. Thus, the process:

* empowers women as rights holders
* strengthens diverse women’s participation in national efforts that reflect their realities and rights
* creates a platform for dialogue and consensus around priorities and ways forward
* provides vital information and feedback from women who use health care services on how to improve programme and service quality; and
* strengthens the enabling environment for prevention of vertical transmission efforts

A successful assessment may ultimately require allowing different community groups to complete the tool and independently analyze findings and then reach consensus about the issues and findings through a facilitated multi-stakeholder consultation. The recommended steps for completing the HR GE CE assessment are outlined in the *Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus*. It is important to also consider that the nature of the issues under assessment can be very sensitive and involve risk for both individuals and health workers responding to the assessment questions. A well-managed process creates a safe space for individuals to come forward to share insights or raise concerns on sensitive or challenging issues.

# Shared principles

Drawing on public health principles and evidence-based good practice, it is recommended to follow these fundamental principles throughout the assessment process:

## *Do no harm*

In any efforts to engage and collaborate with women around sensitive topics including HIV status, human rights violations and experiences of inequality, the principle of “do no harm” must be adhered to. The process must make provisions to ensure, at a minimum[[1]](#footnote-2):

1. Safety, privacy and confidentiality of all participants.
2. No harm or retaliation against individual or organizational participants or members of the assessment team.
3. Availability of gender and culturally-sensitive services and sources of support, remedy and redress for individuals reporting human rights violations.
4. Mechanisms and strategies to reduce any possible distress caused by the data collection.

## *Meaningful inclusion*

Validation processes should be conducted in line with the Greater Involvement of People Living with HIV[[2]](#footnote-3), a guiding principle that calls for the active and meaningful participation of people living with HIV in the inception, development, implementation, monitoring and evaluation of policies and programmes. Networks of women living with HIV and organizations supporting women with HIV, syphilis and HBV must be meaningfully engaged as early in the process as possible. The selection of who to engage in the national validation process should, as much as possible, be led by these networks and organizations and their engagement should not be tokenistic.

## *Transparency and equality*

The process of data gathering with the community should be collaborative, fair and transparent. Adequate and equitable time and support for preparation must be afforded to plan the process. The community should be empowered to select their own representatives, paying attention to principles of gender equality, inclusiveness, and diversity and propose methods of participation in the process. These organizations should be provided with financial and technical support, if needed, to independently gather evidence, analyze issues and provide recommendations for consideration by the NVC.

# Step-by-step: Understanding the process for validation

The HR GE CE Assessment in Web Annex G compiles a set of minimum information required to review whether programmes to prevent vertical transmission have been carried out in a manner which meets international human rights standards and promotes gender equality, and are therefore eligible for validation of EMTCT of HIV, syphilis and/or HBV.

Involving individuals and organizations with human rights and gender equality expertise, including community stakeholder and human rights practitioners, will also be essential to ensure the correct analysis of issues, and importantly, to ensure that where human rights concerns or violations and underlying gender inequalities are identified, there are appropriate strategies to address these violations, including safety for groups and individuals reporting rights abuses and facilitation of accountability pathways.

## **Step 1: Engage the community**

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| **As a general rule, the schedule of the validation process should be announced well in advance to a wide range of stakeholders so that they can prepare their contributions to the process.** |

As outlined in the *Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus*, the National Validation Committee should gather evidence for the validation assessment in a collaborative and consultative manner, involving all key stakeholders. This should include robust participation from organizations representing women who use healthcare services, including networks of women living with HIV or HBV, networks of key populations, organizations working on sexual and reproductive health and rights and other women’s organizations, throughout the validation process.

The engagement of networks of women and civil society to provide expertise and input can occur in a variety of ways, including through focus groups, stakeholder interviews or independent reports to feed into the national assessment (see Step 3).

## **Step 2: Completing the assessment tool**

The focus group discussion guide is a printable tool at the end of this document which can be used to collect qualitative information on the situation of HR GE CE in a country. Web Annex G provides an assessment tool which may be used to compile and analyze information on the 10 issue areas for HR GE CE.

During the assessment process outlined in the *Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus*, additional HR GE CE issues may be identified that may not be directly contemplated by the tool. These issues are no less important and may be incorporated into and considered in the process of assessment. However, the validation review is not a substitute for a comprehensive and ongoing human rights, gender equality and community engagement monitoring and evaluation process, which is normative and beyond the scope of validation for elimination of vertical transmission.

## **Step 3: Gathering key documents and stakeholder information**

In some cases, law, policy and standard operating procedures that guide specific interventions may not align with what is happening in the programmes or what women are experiencing when they seek or use health services. Examining laws, regulations or policy alone is not enough to determine whether the programme meets human rights standards and ensures gender equality.Understanding how these laws are practiced allows for the identification of rights concerns and gaps in implementation, and helps a country make progress to address these issues.

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| **The assessment process must understand both existing laws, regulations and policy ANDwhat is happening in practice.** |

### **Examining laws, regulations and policies**

The first step to ensure that current sexual and reproductive health care, maternal health care and prevention of vertical transmission efforts comply with validation requirements is to examine the relevant:

* Laws – (e.g. national healthcare laws, criminal laws, gender equality non-discrimination laws)
* Regulations – (e.g., Ministry of Health rules)
* Policies - (e.g. informed consent procedures)

A desk review should be conducted to gather information and evidence in response to the specific questions outlined in this tool. It should include a review of:

* national constitutions
* HIV laws, health care laws, criminal codes, patients’ rights charters, and other relevant laws
* judgments from international, regional, and national courts
* country reports to human rights bodies such as to CEDAW, CESCR and the HRC
* shadow reports submitted to the treaty monitoring bodies by nongovernmental organizations
* shadow reports submitted to the validation process
* grey literature including relevant reports from civil society
* concluding observations and recommendations from National Human Rights Institutions other relevant bodies
* national program policies and standards of care
* health care system circulars, training updates, and
* Global AIDS Monitoring and its National Commitments and Policy Instrument (NCPI)

This list of sources is not exhaustive. Each of the sub-sections in Annex G also offers specific suggestions for where relevant data can be found.

### **Examining practice and the lived experiences of women**

Women who use prevention of vertical transmission services are uniquely positioned to provide valuable insight into their experiences accessing services. This information is essential to determine the extent to which human rights, gender equality and community engagement standards are met in practice.

The tools may include:

* Consultations and focus group discussions with and led by women living with HIV, and HBV, and women who access antenatal care services, including women from key populations and groups in situations of vulnerability or marginalization.
* Stakeholder interviews with:
	+ key government and state officials, including from the Ministry of Health and ministries for women, children and gender equality, as well as officials with human rights, gender equality and community engagement functions, for example the human rights desk at the ministry of health, ombudsperson, bureau of gender affairs and others.
	+ HIV and vertical transmission programme managers and health services providers, including nurses and midwives.
	+ civil society organizations, including organizations of and advocates for women living with HIV, young people living with HIV, and women’s groups.
* Independent reports can also be a valuable tool for the National Validation Committee to gain information about specific aspects of human rights, gender equality and community engagement practices. The submission of independent reports after the completion of the initial validation report by the National Validation Committee requires a specific and guided process in order to be fair and transparent. In all cases, the safety and security of human rights advocates must be protected and they should be supported to provide their submission confidentially.

## **Step 4: Identify gaps, risks and concerns in law, policy and practice through a collaborative multi-stakeholder consultation**

The data collection tool may be completed by many different stakeholders engaged in the process, and thus requires the National Validation Committee to synthesize findings. To do so, it is recommended to conduct a multi-stakeholder consultation with key stakeholders from the community.

**Importantly, throughout the validation process, there must be sufficient opportunities for networks of women with HIV and HBV, civil society and human rights groups to engage directly with the National Validation Committee.**

The muli-stakeholder consultation should aim to address each of the 10 topics in the assessment tool. For each topic, the discussion should help examine both policy and practice - together aiming to answer three overarching questions:

* Do the programmes and interventions respect, promote and fulfil human rights?
* Do the programmes and interventions meaningfully engage women with HIV, syphilis or HBV?
* Do the programmes and interventions promote gender equality?

As you review the responses to the questions you should seek to:

* **Identify gaps in policy and law.**
	+ Are the laws or policies identified in the assessment in place and operational?
	+ Does the substance of the policy reflect and meet the goals outlined in the purpose – for example to protect confidentiality?
	+ Are there any conflicts in policy and law?
* **Identify gaps and risks in practice.**
	+ Have communities identified any concerns?
	+ Are there monitoring reports from NGOs or reports submitted to CEDAW or other treaty bodies that identify any human rights concerns, relevant challenges with gender equality or challenges for communities seeking to self-organize or participate in national policy spaces?
	+ Does the Ministry of Health or programmes to prevent vertical transmission monitor and seek feedback from service users? What does that feedback show in terms of the experience of women accessing services?
	+ In assessing the available information have you identified any gaps in policy or practice which are resulting in human rights problems?
* **Identify efforts to respond to or remedy these human rights concerns.**
* Understand whether there any additional human rights, gender equality or community engagement issues in policy or raised by communities that don’t fall into one of the 10 issue areas outlined in the tool.
	+ Understand how those additional concerns have been addressed.

The National Validation Committee should seek to portray the answers to the above questions in the initial validation report.

The Regional Validation Committee (RVC), in the course of validating the initial report by the NVC and considering their recommendation for validation, may also consider the following questions:

* Whether additional information is required to understand the policy or practice?
* Do any of the gaps affect the recommendation to validate for elimination?
* What are the proposed recommendations for the country to respond to the gaps or human rights, gender equality or community engagement issues?

### **Frequently Asked Questions**

**What are the circumstances that could pose a risk to validation of elimination of vertical transmission in the area of HR GE CE?**

There are several issues that pose risks for validation. ‘Red flags’ to be considered when assessing a country’s eligibility for validation include if the country:

1. criminalizes HIV or syphilis exposure and transmission
2. mandates testing or treatment of HIV, syphilis or HBV
3. does not have a law, policy or regulation that protects patient confidentiality and confidentiality around HIV status
4. does not have informed consent policies or evidence of lack of informed consent in practice in PMTCT or maternal health settings
5. has recent reports of coercive or forced sterilization, contraception, abortion or forced Caesarian that have occurred within the last 3 years or that remain unaddressed in policy
6. has recent reports of human rights violations within prevention of vertical transmission or related healthcare settings
7. does not have a mechanism for reporting rights violations, accountability, and remedies for violations of human rights
8. does not have a policy addressing gender-based violence in health care settings
9. has policy or regulatory restrictions or restrictive practices that limit access to family planning or sexual and reproductive health
10. does not have a mechanism for community engagement

A country may have a ‘red flag’ or not fully meet a requirement and still be eligible for validation if they demonstrate efforts or progress to resolve the issues. For example, the Regional Validation Committee and the Global Validation Advisory Committee might wish to recommend the country for validation with specific recommendations to make progress in the HR GE CE area.

**What to do if human rights violations are identified during the validation assessment?**

Where human rights violations are identified by individuals or organizations within the validation assessment process, the individual concerned should be supported with information on how to report complaints or receive redressal and provided contact information of HR groups and CSOs that can provide assistance. Strict confidentiality should be adhered to in the interview process.

**Only one or two people identified a human rights violation. Is it necessary to include it in the report?**

Research or analysis based on peoples’ experiences of the health system is a key part of the assessment and all reported rights violations must be taken seriously for a deeper understanding of the situation and whether there has been any attempt to remedy it. Even one report of a human rights violation is worthy of further attention, investigation and consideration, and should be properly handled within the country’s existing reporting and redressal systems.

For the validation report, information on violations reported to national or other systems and how these have been dealt with should be time-bound to the period of assessment for validation. The Regional Validation Committee and Global Validation Advisory Committee may take the view that even one report of a human rights violation during the period of assessment could indicate that more individuals utilizing the services are experiencing similar rights violations and will seek to understand whether the issue is widespread or systemic.

Questions which the RVC and GVAC will consider, and which should be addressed in the initial validation report, include:

* Is the healthcare system currently aware of this problem?
* What steps have been taken to eliminate the practice and to ensure effective remedy to the individuals affected?
* How has the community been involved in responding to the problem?
* What remedy does the community seek?

**What to do if we discover human rights concerns that have occurred outside the validation assessment time period?**

If human rights concerns occurred outside the validation assessment time period, the issue is still is worthy of further attention, investigation, and consideration. As some of the material from human rights treaty body mechanisms may be more than five years old due to longer reporting cycles, it would be important that the National Validation Committee go back to the most recent Committee on the Elimination of Discrimination against Women (CEDAW) report and follow up on its recommendation under HIV/right to health.

Sharing examples of how the Ministry of Health has taken steps to realize its duty to respect, protect and fulfil human rights, gender equality and community engagement can support the analysis. However, although experiences from before the period of validation review can be informative and the woman should still be connected to redressal options, the focus for determining eligibility for validation remains on the current systems and recent experiences within the programmes.

**How can we measure progress?**

Progress in the response to the gaps identified through the assessment process can be measured via practical progress commitment from the country to make needed reforms, including a timeline, with specific steps articulated.

Key Questions to understand progress:

1. Has the action plan to address the rights violations been developed jointly with impacted communities and other human rights experts?
2. Has the Ministry of Health or other duty bearers demonstrated commitment to making the reforms?
3. Have the interventions achieved demonstrated shifts in policy or law or demonstrated shifts in practice?

## **Step 5: After the analysis and report**

Once the National Validation Committee has completed the analysis following the multi-stakeholder consultation and prepared the initial validation report, the Regional Validation Committee and Global Validation Advisory Committee may follow-up on identified areas where there are gaps in policy or practice and propose recommendations for improvement.

# Section-by-section: Understanding the requirements

## **Section 1: Ending criminalization of HIV, syphilis and HBV**

**CONTEXT**

A growing global consensus backed by empirical studies confirm that the criminalization of exposure and transmission of HIV, Syphilis and Hepatitis B is ineffective, discriminatory, runs counter to public health goals and is doing more harm than good. Fear of prosecution discourages the demand for HIV testing, interferes with adherence to treatment and does not support efforts to prevent new HIV infections. To ensure an effective, sustainable response to HIV that is consistent with human rights obligations criminalizing HIV, Syphilis and Hepatitis B, including sentence enhancements and to amend or repeal any law that explicitly or effectively criminalizes any aspects of vertical transmission of HIV, syphilis and HBV, including breastfeeding.

**PURPOSE**

This section seeks to understand if there are any laws that criminalize or punish people for not disclosing their status, or potentially exposing others to, or transmission of HIV, syphilis, or HBV and whether there have been any arrests, prosecutions or other forms of punishment on this basis.

**SUGGESTED SOURCES FOR ANALYSIS**

* National criminal laws or codes
* National health care laws or HIV laws and regulations
* Reports from the Ministry of Justice, prosecution office or other law enforcement authorities
* Reports from community-led monitoring processes
* Reports from civil society and networks of women living with HIV and/or other health advocates

UNAIDS Global AIDS Reporting on National Commitments and Policies Instrument (NCPI)

**GUIDANCE FOR ANALYSIS**

If a country has any law or regulation that explicitly provides for criminalization of HIV or syphilis or HBV and/ or if there have been increasing arrests, prosecution or sentencing of people based on these laws in the past 3 years, that country’s eligibility for validation or maintenance will remain at risk until progress can be demonstrated to ensure that law has been repealed or amended. Criminal liability for transmission of HIV, syphilis, or HBV under existing criminal law must be restricted to exceptional circumstances where a person acts with specific intent to transmit HIV, syphilis, or HBV and actually does so. Information must be obtained from communities of women who use services to prevent vertical transmission, including networks of women living with HIV and HBV, to establish that exposure, non-disclosure or transmission of HIV, syphilis or HBV is not criminalized or otherwise punished in practice.

**REFERENCES AND FURTHER READING**

* [Oslo Declaration On HIV Criminalisation](file:///Users/sophiebrion/Documents/ICW%20GLOBAL%202021/WHO%20VALIDATION/HUMA%20RIGHTS%20GUIDANCE%20DOC/%E2%80%A2%09https%3A/www.hivlawandpolicy.org/sites/default/files/Oslo_declaration.pdf)
* [Expert consensus statement on the science of HIV in the context of criminal law](https://doi.org/10.1002/jia2.25161)
* [UNICEF, WHO, UNAIDS White paper: Going the “Last Mile” to EMTCT](https://library.unaids.org/wp-content/uploads/2020/08/1-EMTCT-Whitepaper-EN-WEB-hi-res.pdf)
* [UN Joint Statement on Ending HIV-related Discrimination in Healthcare Settings](https://www.who.int/gender-equity-rights/knowledge/ending-discrimination-healthcare-settings/en/)
* [Report of the Global Commission on HIV and the Law](https://hivlawcommission.org/report/) and [Supplement](https://hivlawcommission.org/supplement/)
* [UNAIDS Guidance](https://www.unaids.org/sites/default/files/media_asset/20130530_Guidance_Ending_Criminalisation_0.pdf)
* [UN ESCR General Comment No 22](http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQejF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3Ylzg)

## **Section 2: Ensuring voluntary testing and treatment**

**CONTEXT**

Voluntary HIV, syphilis and hepatitis testing and treatment is the foundation of a rights-based and people-centered approach to prevention of vertical transmission. Mandatory, compulsory or testing and treatment that are either conducted without the person’s informed consent or coerced in exchange for access to other services or benefits represent violations of the human right to bodily integrity. There is no public health justification for compulsory testing. Programs that utilize routine provider-initiated testing must include an opt-out policy for testing and must still obtain informed consent. Voluntary testing that is accompanied by pre and post counselling is most effective in reaching public health goals including adherence to treatment.

WHO recommendations and good practice statements for creating an enabling environment for HIV testing services:

* HIV testing must be voluntary. All people being tested should be made aware of their right to refuse testing, and they must give informed verbal consent to be tested. Mandatory or coercive HIV testing is never appropriate.
* Countries are encouraged to examine their age-of-consent policies and consider revising them to reduce age-related barriers to HIV services and to empower providers to act in the best interest of the adolescent.

**PURPOSE**

This section seeks to understand whether testing and treatment for HIV, syphilis and HBV is voluntary. This means that all women are given the information they need to make an autonomous choice including on any risks and benefits and alternatives they may have and are provided with an option to decline the test or treatment without consequences.

**SUGGESTED SOURCES FOR ANALYSIS**

* National Laws including health, labour, travel and immigration laws
* Ministry of Health policies and training curricula on HIV, syphilis, HBV
* Data from community feedback mechanisms or community-led monitoring processes
* Reports from networks of women living with HIV and/ or other health advocates
* Interviews with service providers and women using the services
* UNAIDS Global AIDS Reporting on National Commitments and Policies Instrument (NCPI)

**GUIDANCE FOR ANALYSIS**

If a country has any law or policy that calls for mandatory testing or treatment for HIV, syphilis or HBV for any population that country’s eligibility for validation or maintenance will remain at risk until progress can be demonstrated to ensure that policy or law has been revised. While the laws and policies may prohibit mandatory testing or treatment, if there are any reports of people routinely experiencing compulsory testing or treatment the country should not be validated until measures have been taken to ensure that testing and treatment is voluntary and that women are counselled on the benefits of testing and treatment and informed that they have the right to opt out. Information must be obtained from communities of women who use services to prevent vertical transmission, including networks of women living with HIV, to establish if this is the practice.

**REFERENCES AND FURTHER READING**

* [Consolidated Guidelines on HIV Testing, WHO 2019](https://www.who.int/publications/i/item/978-92-4-155058-1)
* [International Guidelines on HIV/AIDS and Human Rights.](https://www.ohchr.org/EN/Issues/HIV/Pages/InternationalGuidelines.aspx)

## **Section 3: Ensuring informed consent**

**CONTEXT**

All women, indeed all people, have a right to informed consent for any and all medical interventions including for testing, treatment, family planning, and maternal health interventions. Informed consent is a legal, ethical and professional requirement grounded in the rights to bodily autonomy, privacy and health. Obtaining informed consent supports people-centered care. Involvement in decision-making by obtaining informed consent has documented benefits for the well-being of individuals. Securing informed consent has specific requirements, including capacity, the provision of “adequate and understandable information in a form and language understood by the patient.” Women must be informed fully about the risks and benefits of any/all procedures or tests and any alternatives available to them, they must be given adequate time to consider this information; and that they have the right to refuse any test or treatment without fear of ill treatment, stigma or retribution from healthcare providers. Women’s bodily autonomy must be respected in all decision-making including discussions of family planning options, birth options and choices, and infant testing and feeding options.

**PURPOSE**

This section seeks to understand whether women’s prior, voluntary and informed consent to any medical procedure or intervention is a requirement provided for in law and policy and whether, in practice, women are routinely asked for their prior, voluntary and informed consent before any medical procedure or intervention is undertaken.

**SUGGESTED SOURCES FOR ANALYSIS**

* National laws or regulations such as health care laws or HIV laws which require informed consent
* Ministry of Health or programme level policy requiring informed, voluntary consent
* Patient’s Rights Laws or Charters
* Data from community feedback mechanisms or community-led monitoring processes
* Reports from networks of women living with HIV and/ or other health advocates
* Interviews with service providers and women using the services
* UNAIDS Global AIDS Reporting on National Commitments and Policies Instrument (NCPI)

**GUIDANCE FOR ANALYSIS**

To meet the requirement for validation, the country must have policies and procedures that require health care providers to obtain prior, voluntary and informed consent including for testing, treatment, and any medical procedures or interventions. The informed consent policy must specifically provide for elements of informed consent as outlined above. Information must be obtained from communities of women who use services to prevent vertical transmission, including women living with HIV, to establish if this is the practice.

**REFERENCES AND FURTHER READING**

* [Integrating Human Rights and Women's Health Competencies for Practice](file:///Users/eszter/Library/Containers/com.apple.mail/Data/Library/Mail%20Downloads/389B991A-1991-437D-AD0D-DA467744B706/%E2%9D%8F%09https%3A/www.figo.org/news/integrating-human-rights-and-womens-health-competencies-practice)
* [Informed Consent and Shared Decision Making in Obstetrics and Gynecology](https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology)
* Universal Declaration of Human Rights
* International Covenant on Civil and Political Rights
* ICPD Programme of Action
* UNESCR Gen. Comment No. 14, The Right to the Highest Attainable Standard of Health

## **Section 4: Eliminating coercive practices including involuntary sterilization, contraception or abortion**

**CONTEXT**

All women including those living with HIV have rights to bodily integrity, to decide whether or not to found a family and to choose the number and timing of those children. As such women living with HIV including women from key and other vulnerable populations must be able to freely choose from the available contraceptive options autonomously and without coercion. Coercive or forcible practices such as mandatory contraception for any population, for example migrant women, or recommendations or advice or requirements for abortion based on HIV status or key population membership status or forced or coerced sterilization all constitute violations of women’s human rights. Coerced sterilization, or sterilization that has been compelled in exchange for incentives such as loans or cash payments; or access to nutrition or other services or supports or a denial of these services or that is a result of persuasion via unequal power dynamics, misinformation, exaggeration of the risks of HIV transmission, or that occurs during labor or childbirth or as a result of abuse or discrimination constitute recognized forms of unlawful coercion and represent violations of human rights. The United Nations High Commission on Human Rights and UNAIDS have also highlighted concerns about the use of forcible and coercive measures in the context of prevention of vertical transmission and in particular the counterproductive outcome of coercive measures in terms of meeting public health goals.

The International Federation of Gynecology and Obstetrics’ Guidelines on Female Contraceptive Sterilization sets out international best practice guidelines to ensure women’s autonomy and informed consent and includes clarity that “No woman may be sterilised without her own previously given informed consent, with no coercion, pressure, or undue inducement by healthcare providers or institutions.” Further the guidelines are clear that a woman’s “informed decision must be respected, even if it is considered liable to be harmful to her health.” FIGO Guidelines also make clear that consent should not be a condition to access to any treatment, care, support, benefit or ‘when women may be vulnerable, such as when requesting termination of pregnancy, going into labor or in the aftermath of delivery.’

**PURPOSE**

This section seeks to understand whether women experience force or coercion (through pressure or incentives), to undertake involuntary sterilization, contraception, abortion or other interventions such as caesarian section.

**SUGGESTED SOURCES FOR ANALYSIS**

* National Laws
* Ministry of Health Policy and Procedures
* National Human Rights Institutional reports
* Data from community feedback mechanisms or community-led monitoring processes
* Reports from networks of women living with HIV and/ or other health advocates
* Interviews with service providers and women using the services
* Stigma Index Reports and other CSO reports

**GUIDANCE FOR ANALYSIS**

To meet the requirement for validation the country must have laws and/or policies in place that prohibit forcible or coercive practices including contraception, sterilization and abortion and reflect international standards on elective caesarian section. If there are any reports in the past 3 years of forced or coerced sterilization, contraception, abortion or other interventions such as caesarian section among women with HIV, syphilis or HBV that country will not be eligible for validation. Reports of forcible or coercive practices even from a single woman must be investigated and the country must demonstrate that measures have been instituted to ensure accountability and to stop the practice. Women who may have experienced these human rights violations must have access to justice and remedy. Information must be obtained from communities of women who use services to prevent vertical transmission, including networks of women living with HIV, to establish if this is the practice.

**REFERENCES AND FURTHER READING**

* [An interagency statement Eliminating forced, coercive and otherwise involuntary sterilization](https://www.who.int/reproductivehealth/publications/gender_rights/eliminating-forced-sterilization/en/)
* [International Federation of Gynecology and Obstetrics’ Guidelines (FIGO Guidelines)](https://www.researchgate.net/publication/51569357_Female_contraceptive_sterilization_FIGO_Committee_for_the_Ethical_Aspects_of_Human_Reproduction_and_Women%27s_Health)
* [HIV and the Law: Risks, Rights & Health', Global Commission on HIV and the Law Final Report.](http://www.hivlawcommission.org/resources/report/FinalReport-Risks%2CRights%26Health-EN.pdf)
* [Office of the United Nations High Commissioner for Human Rights & Joint United Nations Programme on HIV/AIDS (UNAIDS), International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version para. 96 (2006).](http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf.)
* International Covenant on Economic, Social and Cultural Rights Article 12

## **Section 5: Ensuring confidentiality**

**CONTEXT**

All people have a right to confidentiality and privacy when it comes to information about their health. In the context of women living with HIV, ensuring the confidentiality and privacy regarding HIV status is a critical tool to reduce stigma and discrimination and to support women to mitigate and manage risks of violence in their lives. Additionally, protecting the confidentiality and privacy of women living with HIV builds trust and supports women to feel safe and comfortable accessing prevention of vertical transmission services supporting treatment adherence. Privacy is both a legal and an ethical concept. The legal concept refers to the legal protection that has been accorded to an individual to control both access to and use of personal information. Privacy provides the overall framework within which both confidentiality and security are implemented. Privacy protections vary between jurisdictions and are defined by law and regulations.”

**PURPOSE**

This section seeks to understand the policies, practices, systems and training that ensure that information about patients (including women with HIV, syphilis or HBV) is kept private and confidential.

**SUGGESTED SOURCES FOR ANALYSIS**

* National law requiring confidentiality or protecting HIV status from disclosure by health care providers and others
* Ministry of Health or programme level policy providing for confidentiality of HIV status and/ or for protections of privacy
* Ministry of Health confidentiality and privacy training curricula
* Data from community feedback mechanisms or community-led monitoring processes
* Reports from networks of women living with HIV and/ or other health advocates
* Interviews with service providers and women using the services

**GUIDANCE FOR ANALYSIS**

To meet the requirements for validation a country must have policies, procedures, systems and training in place for health care providers to ensure patients’ privacy and confidentiality. These protections must be applied to all patients, including women with HIV, syphilis or HBV or women from key or vulnerable populations including migrant women and women in prison and other closed settings. Any reports of violations of this right should be investigated and the country must demonstrate that measures have been instituted to improve confidentiality and privacy practices and ensure accountability for breaches of confidentiality and privacy. Women who may have experienced a violation of their right to privacy must have access to justice and remedy. Information must be obtained from communities of women who use services to prevent vertical transmission, including networks of women living with HIV, to establish if practices are in place to ensure patients’ privacy and confidentiality.

**REFERENCES AND FURTHER READING**

* [International Guidelines on HIV/AIDS and Human Rights,](https://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf)
* Article 17 of the International Covenant on Civil and Political Rights

## **Section 6: Ensuring equality and non-discrimination**

**CONTEXT**

Discrimination can have particularly profound effects on efforts to eliminate the vertical transmission of HIV. Women who have faced discrimination or who perceive or expect HIV-related stigma in health-care settings may be less likely to access prenatal and postnatal treatment and care. Where they do access such care, they may be deterred from using HIV services. Discrimination is a human rights violation prohibited by international human rights law and most national constitutions. It exacerbates risks and deprives people of their rights and entitlements, fueling the HIV epidemic.

**PURPOSE**

This section seeks to understand if all women can access healthcare, including sexual and reproductive health services, equally and without any discrimination, including those from key populations, no matter what their race/ethnicity, age, HIV or health status, marital status, sexual orientation, gender identity, religion, economic status and other status such as disability or national origin.

**SUGGESTED SOURCES FOR ANALYSIS**

* National laws including the Constitution, civil code, health care, HIV and gender equality laws
* Ministry of Health or programme level policy and training curricula on non-discrimination and equality
* Patient’s Rights Charter
* Data from community feedback mechanisms or community-led monitoring processes
* Reports from networks of women living with HIV and/ or NGO’s and health advocates
* Interviews with service providers and women using the services
* UNAIDS Global AIDS Reporting on National Commitments and Policies Instrument (NCPI)

**GUIDANCE FOR ANALYSIS**

To meet the requirement for validation, the country must have laws, policies and procedures in place that guarantee that all women have equal and non-discriminatory access to health care services, including sexual and reproductive health care. Supporting information to establish equal and non-discriminatory practice must be obtained from communities of women who use services to prevent vertical transmission, including networks of women living with HIV and HBV.

**REFERENCES AND FURTHER READING**

* Technical Note for Sustainable Development Goals, [indicator 5.6.1](https://unstats.un.org/sdgs/metadata/files/Metadata-05-06-01.pdf)
* Commission on Crime Prevention and Criminal Justice (CCPCJ) [resolution 26/2](https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_26/CCCPJ_Res_Dec/CCPCJ-RES-26-2.pdf) on "Ensuring access to measures for the prevention of mother-to-child transmission of HIV in prisons"
* [UNICEF, WHO, UNAIDS White paper: Going the “Last Mile” to EMTCT](https://library.unaids.org/wp-content/uploads/2020/08/1-EMTCT-Whitepaper-EN-WEB-hi-res.pdf)

## **Section 7: Ensuring accessibility and quality of women-centred healthcare services**

**CONTEXT**

Why AAAQ: Available (includes affordable), accessible, acceptable, and good quality health care are core components of promoting and protecting people’s right to health. The right to the highest attainable standard of health requires that these four attributes be achieved for all people regardless of gender, religion, immigration status, race, ethnicity and particularly relevant to the HIV response people from key populations, without discrimination. Strategies are needed across health system building blocks to improve the accessibility, acceptability, affordability, uptake, equitable coverage, quality, effectiveness, and efficiency of services for women living with HIV. If left unaddressed, such barriers undermine health interventions and the SRHR of women living with HIV.

**PURPOSE**

This section seeks to understand whether good quality health services including sexual and reproductive health services, prevention of vertical transmission and maternal health care are available, accessible, acceptable, and affordable for all women and what strategies are in place to address challenges and remove barriers.

**SUGGESTED SOURCES FOR ANALYSIS**

* Policies on access to PMTCT services for vulnerable people
* Ministry of Health Training guide, content and schedule
* Ministry of Health or programme level policy providing for aspects of AAAQ
* Stigma Index Reports and other CSO reports
* Data from community feedback mechanisms or community-led monitoring processes
* Reports from networks of women living with HIV and/ or NGO’s and health advocates
* Interviews with service providers and women using the services

**GUIDANCE FOR ANALYSIS**

For a country to be validated it must demonstrate that strategies to improve the accessibility, acceptability, affordability, uptake, equitable coverage, quality, effectiveness and efficiency of services for all women are in place across the health system. Communities of women who use services to prevent vertical transmission, including networks of women living with HIV, must verify accessibility and quality of services.

**REFERENCES AND FURTHER READING**

* Consolidated guideline on sexual and reproductive health and rights of women living with HIV, World Health Organization 2017
* WHO Framework on integrated people-centred health services
* <https://www.who.int/news-room/fact-sheets/detail/quality-health-services>
* <https://www.who.int/health-topics/quality-of-care#tab=tab_1>
* https://www.who.int/servicedeliverysafety/areas/people-centred-care/framework/en/

## **Section 8: Addressing gender-based violence**

**CONTEXT**

Ending all forms of violence against women and girls is among the core commitments for ending the AIDS epidemic by 2030. Progress in reducing the prevalence of intimate partner violence against women is important, as an outcome itself and as a proxy for gender inequality. In the context of prevention of vertical transmission, interpersonal violence against women is both a contributing factor for HIV acquisition and a consequence of infection. Networks of women living with HIV have long reported the devastating impacts of gender-based violence on women’s ability to access and be retained in care. Fear of intimate partner violence may deter women from disclosing their HIV status or seeking treatment. The WHO recommends that “Policies and programmes addressing gender inequality and gender-based violence will help achieve universal targets for HIV prevention, treatment and care. Investment in responses in these areas is an essential part of HIV programming.”

**PURPOSE**

This section seeks to understand the laws, policies and services available to prevent and respond to gender-based violence and how they are integrated into programmes to prevent vertical transmission.

**SUGGESTED SOURCES FOR ANALYSIS**

* National HIV Plan
* Ministry of Health Policies
* National Laws or Plans on Gender Based Violence
* Data from community feedback mechanisms or community-led monitoring processes
* Reports from networks of women living with HIV and/ or NGO’s and health advocates
* Interviews with service providers and women using the services
* National statistics, including Demographic and Health Survey (DHS)

**GUIDANCE FOR ANALYSIS**

To comply with this requirement there must be policies and procedures in place which respond to gender-based violence and make adequate provision for training and sensitization of health care providers and police and judiciary, and for support and safety planning for women Information must be obtained from communities of women who use services to prevent vertical transmission, including networks of women living with HIV, to establish that these supports are available.

**REFERENCES AND FURTHER READING**

* World Health Organization (2021). [Caring for women subjected to violence: a WHO curriculum for training health care providers, revised edition 2021](https://www.who.int/publications/i/item/9789240039803).
* WHO, UNAIDS. Addressing violence against women and HIV/AIDS: what works? Geneva: World Health Organization; 2010 (http://www.who.int/ reproductivehealth/publications/violence/9789241599863/en).
* Fast-Track commitments to end AIDS by 2030. Geneva: UNAIDS; 2016
* https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-7192-4

## **Section 9: Engaging and being accountable to communities**

**CONTEXT**

Global consensus is that community that engaging people living with HIV has many benefits and is essential to the success of the HIV response. There are now many examples of effective strategies to involve community, particularly people living with HIV including in the policy-making process, programme development and implementation, advocacy and community-led service delivery. Engagement and participation of women living with HIV, in particular, in the formulation of health laws, policies, programmes, and monitoring and evaluation (M&E) systems that affect them ensures better, more effective programming and that women living with HIV and syphilis that women get the treatment they need to keep themselves well and their children free from HIV and syphilis. Community engagement is central to improving quality of care. The perspectives of women, their families and communities, on the quality of services influence their decisions to seek care. Engagement of facility service providers with the communities they serve – so that they can understand their expectations, build trust and engage them in the process of delivery – is an essential component for creating demand for and access to quality maternal and newborn services.

**WHO Community Engagement Framework**

Definition of community engagement for quality, integrated, people-centred and resilient health services: Community engagement is a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes.” WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017

**PURPOSE**

This section seeks to understand how communities, in particular, groups representing women using the services to prevent vertical transmission are meaningfully involved in the planning, implementation and monitoring of both policies and programmes.

**SUGGESTED SOURCES FOR ANALYSIS**

* National HIV Plan
* Ministry of Health Policies
* Data from community feedback mechanisms or community-led monitoring processes
* Reports from networks of women living with HIV and/ or NGO’s and health advocates

**GUIDANCE FOR ANALYSIS**

To comply with the requirement of community engagement, countries must demonstrate that they have strategies in place to meaningfully engage women with HIV, syphilis or HBV including women from key populations planning, implementation and monitoring and evidence of where participation has changed policy and practice if available. For example, does the government support and fund any community -led monitoring process, or engage women in decision-making spaces such as technical working groups or provide support for research or advocacy led by women’s groups. Information must be obtained from communities of women who use services to prevent vertical transmission, including networks of women living with HIV to establish implementation of these practices and their effectiveness.

**REFERENCES AND FURTHER READING**

* <https://www.who.int/news-room/fact-sheets/detail/quality-health-services>
* <https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/quality-of-care>
* Consolidated guideline on sexual and reproductive health and rights of women living with HIV, World Health Organization 2017
* Promising practices in community engagement for elimination of new HIV infections among children by 2015 and keeping their mothers alive, UNAIDS 2012
* Communities Deliver The critical role of communities in reaching global targets to end the AIDS epidemic, UNAIDS, Stop AIDS Alliance 2015
* Stronger together: From health and community systems to systems for health, UNAIDS 2016
* [Global Network of Sex Work Projects (2018) ‘Briefing note: Meaningful involvement of sex workers’,](https://www.nswp.org/sites/nswp.org/files/meaningful_involvement_document_en.pdf)

## **Section 10: Ensuring access to justice**

**CONTEXT**

States have an obligation to guarantee that all persons can realise their rights to access justice and to ensure that when people experience violations of their human rights, including sexual and reproductive rights, that they can achieve meaningful and effective remedy. States must ensure that violations of human rights are investigated and that the perpetrators of rights violations are held accountable. States must also ensure that individuals experiencing rights violations can receive meaningful remedies. Appropriate remedies “include, but are not limited to, adequate, effective and prompt reparation in the form of restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition.”

Access to justice includes not only whether individuals can access the courts or legal representation, but the ability of individuals who have had their rights violated to report violations, access informal, non-state justice mechanisms. Ministries of Health should seek to empower individuals and communities to assert their rights and promote accountability as well as an enabling environment that facilitates individuals access to report rights violations, the healthcare system to take action to correct the causes of rights violations.

**PURPOSE**

This section seeks to understand the availability, accessibility and effectiveness of mechanisms or places for women to report and/or press claims for rights violations in health care settings, and obtain timely and effective remedies that prevent the alleged violation or its continuation, or provide adequate redress for violations that have already occurred.

**SUGGESTED SOURCES FOR ANALYSIS**

* National laws including: Health Care, HIV, Civil Codes, Criminal and Human or Civil Rights Laws
* Ministry of Health Policies and Procedures
* National Human Rights Reports
* Data from community feedback mechanisms or community-led monitoring processes
* Reports from networks of women living with HIV and/ or NGO’s and health advocates
* UNAIDS Global AIDS Reporting on National Commitments and Policies Instrument (NCPI)

**GUIDANCE FOR ANALYSIS**

To comply with this requirement the country must demonstrate an accessible and working mechanism where women can safely file complaints about violations of their rights, through which the complaints will be heard and investigated and through which women can access remedy or redress and service providers can be held accountable. Communities of women who use services to prevent vertical transmission, including networks of women living with HIV, must verify that these mechanisms are accessible and effective.

**REFERENCES AND FURTHER READING**

* [UN ESCR General Comment No 22](http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQejF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3Ylzg)
* [UN CEDAW General Recommendation No 33 on Women’s Access to Justice](https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/CEDAW_C_GC_33_7767_E.pdf)
* [Report of the International Task Team on Travel restrictions](https://www.unaids.org/sites/default/files/media_asset/jc1715_report_inter_task_team_hiv_en_0.pdf)
* [Report of the Global Commission on HIV and the Law](https://hivlawcommission.org/report/) and [Supplement](https://hivlawcommission.org/supplement/)

# Focus group discussion guide

**Section 1: Ending criminalization of HIV, syphilis and HBV**

|  |  |  |
| --- | --- | --- |
| **QUESTION** | **RESPONSES** | **SOURCES CONSULTED** |
| 1. Provide details of any laws or regulations during the assessment time period that criminalize or punish people for any of the following:
	1. exposure to;
	2. non-disclosure of; and,
	3. transmission of HIV, syphilis, or HBV.
 |  |  |
| 1. Provide details of any laws or regulations during the assessment time period that provide for increased sentencing or punishment based on HIV status, if any.
 |  |  |
| 1. Provide details of arrest, prosecution or punishment of any women for transmission, exposure to, or non-disclosure of HIV, syphilis, or HBV during the assessment time period, if any.
 |  |  |

**Section 2: Ensuring voluntary testing and treatment**

|  |  |  |
| --- | --- | --- |
| **QUESTIONS** | **RESPONSES** | **SOURCES CONSULTED** |
| 1. Provide details of laws and policies in place during the assessment time period that explicitly prohibit mandatory (or compulsory) testing\* or treatment of pregnant women for HIV, syphilis and HBV? Please share the relevant policy or law.
 |  |  |
| 1. Is testing or treatment mandatory:
	1. during pregnancy?
	2. for certain groups of women? (please specify which groups)
	3. for certain jobs? (please specify which ones)
	4. as a pre-condition before marriage?
	5. Is it a pre-condition for a work, study or resident permit?
 |  |  |
| 1. Provide information on the training of services providers on ensuring voluntary testing or treatment for HIV, syphilis and HBV, if any. Please describe whether the training covers the following aspects:
	1. the process of testing or the diagnosis
	2. the available services depending on the results or the proposed treatment
	3. the risks and benefits of testing or treatment
	4. alternative treatments with their risks and benefits
	5. the risks and benefits of declining treatment
	6. the option to refuse testing or treatment without consequences
 |  |  |
| 1. Provide details of any reports or community feedback regarding mandatory testing or treatment of pregnant women for HIV, syphilis and HBV occurring during the assessment time period, if any.
 |  |  |

**Section 3: Ensuring prior, voluntary and informed consent**

|  |  |  |
| --- | --- | --- |
| **QUESTIONS** | **RESPONSES** | **SOURCES CONSULTED** |
| 1. Provide details on laws and policies in place during the assessment time period that guarantee prior, voluntary and informed consent from women undergoing any medical procedure or intervention?\*

*\*Consider all settings and services including public and private maternal and child health, family planning, sexual and reproductive health, HIV etc.*  |  |  |
| 1. Provide details of policies and standard operating procedures in place during the assessment time period to ensure that the process for obtaining prior, voluntary and informed consent to any medical procedure or intervention include:
	1. accurate and unbiased information in an understandable form and language
	2. the risks and benefits of any/all procedure or tests and any alternatives available to them
	3. adequate time to consider this information
	4. right to refuse any test or treatment without retaliation
 |  |  |
| 1. Can adolescents get tested for HIV, syphilis or HBV without prior parental permission?
	1. If so, at what age?
	2. Are there any options or circumstances for adolescents below the age defined in national laws and policies to consent on their own? Please provide details.
 |  |  |
| 1. Provide details of any reports of violations of informed consent from women including those from key populations and adolescents and/or reports of third-party authorization requirements from spouse, partner or parent during the assessment time period, if any.
 |  |  |

**Section 4: Eliminating coercive practices including involuntary sterilization, contraception or abortion**

|  |  |  |
| --- | --- | --- |
| **QUESTIONS** | **RESPONSES** | **SOURCES CONSULTED** |
| 1. Provide details on laws and policies in place during the assessment time period regarding the prohibition of coercive practices such as forced, coerced and otherwise involuntary sterilization, contraception, and/or abortion, if any.
 |  |  |
| 1. Please describe the policy in place during the assessment time period on elective Caesarian Section, including its application for women with HIV, syphilis or HBV.
 |  |  |
| 1. Provide details of any reports during the assessment time period of involuntary sterilization, contraception, abortion and/or other medical procedures?
 |  |  |
| 1. If there have been reports of force or coercion during the assessment time period, please describe what measures or interventions have been put in place to prevent ongoing practice and respond to these human rights violations?
 |  |  |

**Section 5: Ensuring confidentiality of health information**

|  |  |  |
| --- | --- | --- |
| **QUESTIONS** | **RESPONSES** | **SOURCES CONSULTED** |
| 1. Provide details on laws and policies in place during the assessment time period that guarantee the confidentiality and privacy of patients’ information, such as their HIV status, if any.
 |  |  |
| 1. Provide details of the systems for the protection of data privacy and confidentiality and training provided to health care providers on these issues, including around voluntary partner notification.
 |  |  |
| 1. Provide details of any reports from women during the assessment time period of violations of the right to privacy and confidentiality by health care providers, if any.
 |  |  |

**Section 6: Ensuring equality and non-discrimination**

|  |  |  |
| --- | --- | --- |
| **QUESTIONS** | **RESPONSES** | **SOURCES CONSULTED** |
| 1. Provide details of laws and policies and relevant legal frameworks, in place during the assessment time period that guarantee women’s equal access to health care (including sexual and reproductive health care, prevention of vertical transmission services, and maternal health care) without discrimination. Specifically, provisions that guarantee:
	1. Gender equality
	2. Non-discrimination based on health status, including HIV, syphilis or HBV
	3. Non-discrimination based on economic and social status
 |  |  |
| 1. Are there provisions that guarantee access for specific populations (i.e. the law or policy includes a non-discrimination reference):
	1. Migrant or trafficked women
	2. Refugees
	3. Sex workers
	4. Women who use drugs
	5. Transgender people
	6. Lesbian, bisexual or queer women
	7. Women in prison/detention centers
	8. Adolescent or young women
	9. Unmarried women
	10. Indigenous women
	11. Women from religious or ethnic minorities
	12. Women with disabilities
 |  |  |
| 1. Please describe the practices and any other measures in place during the assessment time period to ensure equality and non-discrimination in accessing healthcare, including training of health care workers. Please provide details of relevant documents, if any.
 |  |  |
| 1. Are there any policies or procedures in place during the assessment time period which require:
	1. prior authorization by a male relative/husband for a woman to access sexual and reproductive healthcare, medical examination or treatment, including access to contraceptives or abortion?
	2. parental authorization for adolescents\*’ access to sexual and reproductive healthcare, medical examination or treatment, including access to contraceptives or abortion?
 |  |  |
| 1. Provide details of any community feedback or reports of women with HIV or syphilis or HBV being denied equal access to healthcare services during the assessment time period.
 |  |  |

**Section 7: Ensuring accessibility and quality of women-centred healthcare services**

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| --- | --- | --- |
| **QUESTIONS** | **RESPONSES** | **SOURCES CONSULTED** |
| 1. What is the furthest that women have to travel for ANC/PMTCT services?
 |  |  |
| 1. What other health services are integrated in settings offering prevention of vertical transmission (PMTCT)?
	1. family planning?
	2. STI prevention & treatment, including for syphilis?
	3. HIV testing and treatment services, including early infant diagnosis?
	4. HBV testing and treatment services?
 |  |  |
| 1. What fees or costs must women pay to access ANC or PMTCT services?
 |  |  |
| 1. In facilities offering PMTCT services, have there been stock-outs or shortages of medicines or diagnostics (for HIV, syphilis, HBV) during the assessment time period? Please describe.
 |  |  |
| 1. In facilities offering PMTCT services, have there been any shortages of trained health care workers during the assessment time period?
 |  |  |
| 1. What guidance is given to mothers living with HIV on infant feeding options?
 |  |  |
| 1. What birth method is recommended for pregnant women living with HIV?
 |  |  |
| 1. What counselling or psychosocial support is provided for women who test positive for HIV, syphilis or HBV? Please provide details.
 |  |  |
| 1. Please describe any barriers to access for these populations of women and what interventions are in place to support women to access services:
	1. Migrant women
	2. Refugees
	3. Sex workers
	4. Women who use drugs
	5. Transgender people
	6. Lesbian, bisexual or queer women
	7. Women in prison/detention centers
	8. Adolescent or young women
	9. Unmarried women
	10. Indigenous women
	11. Women from religious or ethnic minorities
	12. Women with disabilities
 |  |  |
| 1. Provide details from any reports of stigma or discrimination during the assessment time period?
 |  |  |
| 1. Please provide details on how health care workers are trained in human rights issues, including
	1. What is the range of topics covered?
	2. How many hours of training are provided on these topics?
 |  |  |

**Section 8: Addressing gender-based violence**

|  |  |  |
| --- | --- | --- |
| **QUESTIONS** | **RESPONSES** | **SOURCES CONSULTED** |
| 1. Provide details of laws and policies in place during the assessment time period that prohibit and/or provide protection from violence against women and girls, including those from key populations.
 |  |  |
| 1. Do services to prevent vertical transmission include interventions or have linkages with services for women experiencing violence such as resources, referrals, safety planning, counselling and care? If so, please describe the available supports and policies.
 |  |  |
| 1. Provide details of trainings provided to health care providers on gender-based violence during the assessment time period.
 |  |  |
| 1. Provide national plans of action and/or policies for prevention of violence and provision of services and support to survivors of violence against women.
 |  |  |

**Section 9: Engaging and being accountable to communities**

|  |  |  |
| --- | --- | --- |
| **QUESTIONS** | **RESPONSES** | **SOURCES CONSULTED** |
| 1. Does your country have any policies, guidelines or strategies in place during the assessment time period to ensure community engagement, including the meaningful involvement of women living with HIV, syphilis or HBV in the planning, implementation and monitoring of programmes to prevent vertical transmission?
 |  |  |
| 1. Describe the opportunities for communities of women using services to prevent vertical transmission to be meaningfully involved in the planning, implementation and monitoring of national policies, guidelines and programmes during the assessment time period.
 |  |  |
| 1. Does the annual PMTCT progress report include input and analysis from civil society and community, including women living with HIV and key populations?
 |  |  |
| 1. Please describe mechanisms in place during the assessment time period for collecting the feedback of women who use services to prevent vertical transmission, including women from key populations, and how this feedback is used to improve the quality of these services.
 |  |  |

**Section 10: Ensuring access to justice**

|  |  |  |
| --- | --- | --- |
| **QUESTIONS** | **RESPONSES** | **SOURCES CONSULTED** |
| 1. Please provide details of mechanisms or fora/processes that are available to women to report human rights abuses and to press claims for rights violations in health care settings? Please describe:
	1. Accessibility of the process for women, including affordability and language accessibility.
	2. How the process holds service providers accountable for rights violations.
	3. What protections are in place to prevent and address retaliation against women who report violations?
 |  |  |
| 1. Provide details of any reports of rights violations or claims pressed during the assessment time period (if not addressed in another section). For these reports/claims, provide details on the process of investigation; the remedies available to women and any measures taken to prevent future violations (how service providers were held accountable and, any resulting policy changes).
 |  |  |
| 1. Are the available remedies for rights violations in healthcare settings timely and effective in that they prevent the continuation of the alleged violation and provide adequate redress?
 |  |  |

1. Adapted from https://www.who.int/publications/m/item/vawg-data-collection-during-covid-19 [↑](#footnote-ref-2)
2. GIPA or the Greater Involvement of People Living with HIV <https://data.unaids.org/pub/briefingnote/2007/jc1299_policy_brief_gipa.pdf> [↑](#footnote-ref-3)