

IPPF Medical Bulletin

IMAP Statement: Linkages: sexual and reproductive health and HIV

Introduction

The importance of linking sexual and reproductive health (SRH) and HIV is now widely recognized. The majority of HIV infections are sexually transmitted or are associated with pregnancy, childbirth and breastfeeding. The risk of HIV transmission and acquisition can be further increased due to the presence of certain sexually transmitted infections (STIs).

In addition, sexual and reproductive ill-health and HIV share root causes, including poverty, limited access to appropriate services and information, gender inequality, cultural norms and social marginalization of the most vulnerable populations. The international community agrees that the Millennium Development Goals will not be achieved without ensuring universal access to both sexual and reproductive health and HIV prevention, treatment, care and support.¹ Recently, there has been increasing awareness of and discussion concerning the possible benefits of linkages between SRH and HIV programmes at the policy, systems, and service delivery levels.²⁻⁵

Consensus has been reached on the need for effective linkages between responses to HIV and SRH, and specific actions recommended to achieve linkages at the levels of policy, systems, and services.⁴⁻¹³ Linkages are a relatively new approach to increasing universal access to SRH and HIV prevention and care, and over the past few years the linkages agenda has gained much momentum. It is important that the process of linking SRH and HIV works in both directions. In other words, SRH-related policies and programmes need to be linked with HIV-related policies and programmes, and vice versa. To date, whilst SRH organizations have attempted to link HIV into their work, many HIV organizations still need to get closer in terms of linking their work to SRH issues. There is still a lack of clarity about terminology and there is currently no globally accepted definition of the terms 'linkages', 'mainstreaming' and 'integration' in the context of sexual and reproductive health and HIV. IPPF – and a number of organizations including UNFPA, UNAIDS and WHO – supports the following definitions:

Linkages: The policy, programmatic, services and advocacy synergies between sexual and reproductive health and HIV.¹⁴

Integration: Refers to different kinds of sexual and reproductive health and HIV services or operational programmes that can be joined together to ensure collective outcomes. This would include referrals from one service to another. It is based on the need to offer comprehensive services.¹⁴

Mainstreaming: Mainstreaming HIV means all sectors and organizations determining: how the spread of HIV is caused or contributed to by their sector, or their operations; how the epidemic is likely to affect their goals, objectives and programmes; where their sector/organization has a comparative advantage to respond in order to limit the spread of HIV and to mitigate the impact of the epidemic, and then taking action.¹⁴

Linkages between core HIV services (prevention, treatment, care and support) and core SRH services (family planning (FP), maternal and child health (MCH), the prevention and management

of STIs, reproductive tract infections, promotion of sexual health, prevention and treatment of gender-based violence, prevention of unsafe abortion and provision of post-abortion care) in national programmes are thought to generate important public health benefits. In addition, perspectives on linkages need to be broad-based, addressing not only the health sector and the direct impact on health, but also the structural and social determinants affecting both HIV and SRH.

Guiding principles

The following seven key principles represent a philosophical foundation and commitments upon which linkages policies and programmes must build:

1. *Address structural determinants.* Root causes of HIV and sexual and reproductive ill-health need to be addressed. This includes action to reduce poverty, ensure equity of access to key health services and improve access to information and education opportunities
2. *Focus on human rights and gender.* The sexual and reproductive rights of all people, including women and men living with HIV, need to be emphasized, as well as the rights of marginalized populations such as injecting drug users, men who have sex with men, and sex workers. Gender-sensitive policies to establish gender equality and eliminate gender-based violence are additional requirements
3. *Promote a co-ordinated and coherent response.* Promote attention to sexual and reproductive health priorities within a coordinated and coherent response to HIV that builds upon the principles of one national HIV framework, one broad-based multi-sectoral HIV coordinating body, and one agreed country-level monitoring and evaluation system (Three Ones Principle)
4. *Meaningfully involve people living with HIV (PLHIV).* Women and men living with HIV must be fully involved in designing, implementing and evaluating policies and programmes and research that affect their lives
5. *Foster community participation.* Young people, key vulnerable populations, and the community at large are essential partners for adequately responding to the described challenges, and meeting the needs of affected people and communities
6. *Reduce stigma and discrimination.* More vigorous legal and policy measures are urgently required to protect PLHIV and vulnerable populations from discrimination
7. *Recognise the centrality of sexuality.* Sexuality is an essential element in human life, the individual, family and community well-being.

Evidence for and benefits of linkages

While much still remains unknown about which linkages will have the greatest impact, and how best to strengthen selected linkages in different programme settings, a recent systematic review of the evidence by the Cochrane Collaboration HIV Review Group¹⁵ yielded a number of vital recommendations for future action. While there is broad consensus that strengthening linkages should be beneficial for clients, only limited evidence has been published regarding feasibility, costs and implications for health systems. This evidence is crucial to sound funding, programmatic, and policy decisions.

In order to capture the most recent innovative linkages initiatives, the review included the standard peer-reviewed and rigorous

evaluation studies, plus 'promising practices'. The following inclusion criteria were used:

Peer-reviewed studies

- Published in peer-reviewed journal (1990-2007)
- Rigorous evaluation study (pre-post or control group)
- Conducted in any setting

Promising practices

- 'Grey' (non-peer-reviewed) literature (1990-2007)
- Some evaluation results reported
- Conducted in resource limited settings only

58 studies met the inclusion criteria, 35 peer-reviewed studies and 23 promising practices, 36 in Africa, 11 UK or USA, 11 Asia, Eastern Europe, Latin America and the Caribbean. Nearly 80% of the promising practices were based in Africa.

Direction of linkages

34 studies integrated HIV services into existing SRH programmes
14 studies integrated SRH services into existing HIV programmes
10 studies integrated HIV and SRH services concurrently

Type of integrated service

The majority of studies included HIV testing as part of the integration; fewer studies evaluated the integration of other HIV services. The average study design rigour score (from 1 to 9) was 3.46 for peer-reviewed articles and 1.0 for promising practices.

39 studies fell into one or more of the following six categories (four studies qualified for more than one setting): Antenatal care (ANC) clinics adding HIV services; HIV counselling and testing centres adding SRH services; FP clinics adding HIV services; HIV clinics adding SRH services; STI clinics adding HIV services; primary health care clinics adding HIV and/or SRH services

Study limitations

Few studies specifically addressed SRH and HIV service integration. None of those directly related to integration were designed specifically to compare integrated services with the same services offered separately, no study measured stigma outcomes, and of the few reporting cost outcomes, only two calculated cost-effectiveness.

Major findings:

1. Despite diverse settings and clients, the majority of studies showed improvements in all outcomes measured, and only a few showed mixed results. Many studies reported an increase or improvement in: access to and uptake of services, including HIV testing, health and behavioural outcomes, condom use, HIV and STIs, knowledge and overall quality of service
2. Linking SRH and HIV was considered beneficial and feasible, especially in FP clinics, counselling and testing centres, and HIV clinics
3. Of the 58 studies analysed, more were conducted in 2000–2007 (65%) than 1990–1999 (35%). This trend was primarily seen in the promising practices; however, it may be due to publication bias as older, unpublished reports may no longer be available
4. There was a slight time trend in directionality of linkages. Earlier studies were more often SRH programmes adding HIV services, later studies usually HIV programmes adding SRH services
5. Both cost-effectiveness studies suggested net savings from HIV/STI prevention integrated into maternal and child health services
6. Nearly three-quarters (71%) of peer-reviewed studies evaluated programmes with only one type of linkage. In contrast, over half (57%) of promising practices evaluated programmes with five or more linkages, while 9% had only one type of linkage. This difference may be due to recent programmes linking SRH and HIV services more comprehensively, or the fact that peer-reviewed studies were often designed to address narrow research questions
7. The few studies reporting cost outcomes were all conducted after 2000. This positive trend may indicate a growing recognition of the importance of addressing HIV from a human rights perspective and intent to scale up linked services

8. Studies reporting health outcomes were evenly distributed across time
9. Interventions which successfully implemented provider training resulted in improved provider knowledge and attitudes, leading to better SRH and HIV service provision.
10. Few studies addressed the following: linked services targeting men and boys; gender-based violence (GBV) prevention; comprehensive SRH services for PLHIV, including unintended pregnancies and planning for safe, desired pregnancies.

Demonstrated benefits

1. Improved access to and uptake of key HIV and SRH services

Many studies reported an increase or improvement in access to and uptake of services, including HIV testing, health and behavioural outcomes, condom use, HIV and sexually transmitted infection (STI), and knowledge.

a. Availability of/access to services

Several studies measured availability of/access to key HIV and SRH services, or commodities and equipment related to providing such services. These outcomes were generally positive.

One study¹⁶ measured availability of/access to information, education and communication (IEC) materials as an expected outcome of the intervention. It was a promising practice and showed a positive effect on availability of/access to family planning methods but a negative effect on availability of/access to other commodities, due to stock-outs of condoms in voluntary counselling and testing (VCT) centres.

Two other studies measured availability of/access to drugs (nevirapine and antiretroviral drugs¹⁷ as an expected outcome, both showed a positive effect. Four studies that measured availability of/access to HIV testing¹⁶⁻²⁰ were positive,¹⁷⁻²⁰ and one negative due to stock-outs of HIV testing kits.¹⁶ No studies measured availability of/access to equipment.

b. Uptake of services

Several studies measured uptake of various services, with generally positive results.

The most commonly measured uptake was of HIV testing services.¹⁸⁻²⁹ Nine were peer-reviewed studies,^{18,19,21,24-29} and three promising practices.^{20,22,23} All showed a positive intervention. While uptake of HIV testing was generally high and seemed to improve with the interventions, testing uptake by partners of female clinic attendees remained low.

Both studies that measured uptake of family planning methods showed positive outcomes:^{16,30} the number of condoms and oral contraceptives distributed,³⁰ and number of VCT clients who chose a family planning method.¹⁶ All three studies that measured uptake of drugs looked at nevirapine uptake: two showed increase, one showed decrease.^{18,28,31} One study measured uptake of IEC materials. It reported that over 9,000 educational books and pamphlets were distributed, which was classified as a mixed effect as there was no comparison group.²³

2. Greater support for dual protection

While many studies reported increases in condom use after the integration of services, the evidence did not demonstrate greater support for dual protection. Increases in condom use were reported in studies in which HIV services were integrated to ANC, when SRH is integrated in HIV clinics and when services are integrated in primary health facilities.

One study measuring dual protection showed that women who received VCT were three times as likely to report dual method use (condoms as well as a hormonal method) compared with women who did not receive VCT.³² The other study showed improvements in dual method use (vaginal chemical barriers and condoms) over time, but did not report the significance of these results nor use the same measure at baseline.³³

3. Improved quality of care

Seven studies reported on quality of services, which included client satisfaction, quality checklists and provider implementation of consultation procedures. Five had a positive effect,^{16,34-37} and two had no effect.^{22,25} The concern in integrating services is that adding

additional work for providers may decrease the overall quality of services. Therefore, the review's finding that quality of services either improved or remained unchanged, but did not decrease, is encouraging.

4. Enhanced programme effectiveness and efficiency

Overall, linking SRH and HIV was considered beneficial and feasible, especially in FP clinics, counselling and testing centres, and HIV clinics. Two cost-effectiveness studies suggested net savings from HIV/STI prevention integrated into maternal and child health services.^{38,39}

Gaps in the evidence

Gaps identified in the evidence review have highlighted key areas for future action and operations research. Few or no studies measured the following anticipated 'linkage' outcomes:²

- Better access of PLHIV to SRH services tailored to their needs
- Reduction in HIV-related stigma and discrimination
- Improved coverage of underserved/vulnerable/key populations
- Better understanding and protection of individuals' rights
- Decreased duplication of efforts and competition for resources
- Mutually reinforcing complementarities in legal and policy frameworks
- Better utilization of scarce human resources for health

Factors promoting or inhibiting effective linkages between SRH and HIV

Those that promote include positive attitudes and good practices among providers and staff; an institutional commitment to ongoing capacity building, the active involvement of the community and government during planning and implementation; the addition of simple and easily applied services which add very limited costs to existing services; the development of a 'stigma-free' environment in which services are provided; the involvement of male partners and engagement of key populations.

Factors that impede or inhibit linkages include a lack of commitment from stakeholders; non-sustainable funding to support increased work on linkages; clinics that are understaffed or have low morale and high staff turnover; lack of capacity development for staff and providers; inadequate infrastructure, equipment, and commodities; women insufficiently empowered to make SRH decisions; cultural and literacy issues; adverse social events including domestic violence; poor programme management and supervision, and stigmatizing attitudes that prevent a wide range of potential clients from utilizing services.

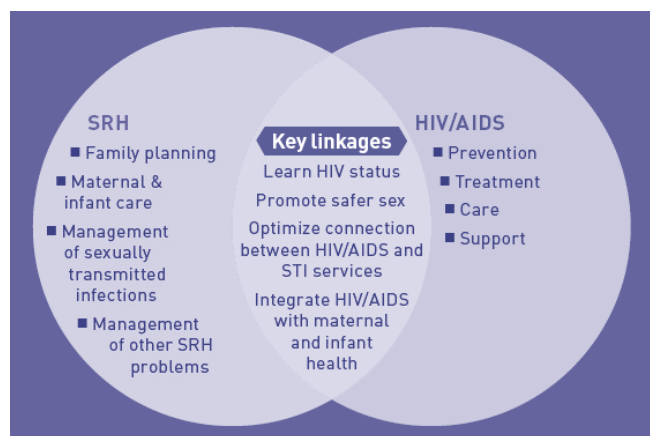
Programmes and services

HIV infection is the predominant sexual health issue facing the world today. HIV, AIDS, sex and reproduction are intimately linked. It is also clear that a comprehensive sexual and reproductive health response to HIV offers one of the most effective routes to reach the many people vulnerable to HIV infection, or those already living with HIV.

Integrating SRH and HIV services recognizes the vital role that sexuality plays in people's lives, and the importance of empowering people to make informed choices about their sexual and reproductive health. There is clear momentum behind efforts to mainstream HIV into sexual and reproductive health and rights responses, and a strong recognition that this programmatic integration is necessary both to achieve SRH goals and respond meaningfully to the HIV epidemic.

The moral and programmatic imperative of bringing the HIV and SRH responses into closer unison is clear. The WHO/UNFPA/UNAIDS/IPPF *Sexual and Reproductive Health and HIV/AIDS: A framework for priority linkages*² highlights some of these strategic programmatic interventions.

The integration of key SRH and HIV services makes 'people sense' for it acknowledges that fragile health systems need to meet people where they are. Whether providing women with family planning services, delivering comprehensive sexuality education for young boys and girls, managing sexually transmitted infections, ensuring access to condoms, or providing antiretroviral treatment, it is critical that sound policies are in place to support



this comprehensive approach that links prevention with care and treatment, and responds to the unique regional and national characteristics of the epidemic. Too often, the verticalization of HIV and SRH programmes (both at the national level and in donor funding priorities) fails to support this logical alignment.

Simultaneously responding to the SRH and HIV challenges could also act as a modality of HIV-related stigma reduction. The roots of this stigma and discrimination run deep. Reducing them means facing and talking openly about issues that include sexuality, drug use, poverty and gender inequality. As the triple combination of ignorance, prejudice, and fear creates a fertile breeding ground for HIV's continued spread, so openness, acceptance, and accessible services are the key to its containment.

Any rejection experienced by an individual because of the stigma attached to HIV, or even the fear of it, is an added challenge posed by the HIV epidemic. Research indicates that service providers themselves can be a source of discrimination – negative reactions from doctors, nurses and health practitioners in various health services have been reported by PLHIV, and deter people from returning. The stigma surrounding HIV frequently overlaps with the stigma faced by certain key populations, making it increasingly difficult to meet their SRH needs.

Efforts to uproot HIV-related stigma and discrimination require the cooperation of all sections of society. The meaningful involvement of people living with HIV in all prevention, care and treatment efforts is a key factor in lessening stigma. The principle of the Greater Involvement of People living with HIV/AIDS⁴⁰ – recognises that their personal experiences can, and should, be used to shape the response to the epidemic. This principle – while frequently mentioned in most national HIV policy documents and strategies^{41,42} – must be activated to ensure that it becomes a sound practice. Involving PLHIV is a key reference point for overcoming the marginalization and isolation that many experience. This is also a step towards protecting the SRH rights of PLHIV and ensuring that they have access to the necessary information, services and support to live long and healthy lives.

The success of many integrated SRH and HIV services rests on the quality of referrals. For services that are not available to the provider, facilitated referrals need to be strengthened to ensure that many of the opportunistic illnesses related to HIV are addressed, including tuberculosis, malaria and hepatitis. There should also be referrals that address other social concerns, such as micro-finance, skills development and access to other forms of psycho-social support.

What can Member Associations do?

1. *Initiate* – in collaboration with other national stakeholders and partners – a *rapid assessment of the status of linkages within the national context*. This assessment should include analysis at policy, systems and service delivery level⁴³
2. Pioneer the *integration of services in areas that currently require further evidence*, such as the integration of SRH and HIV services for PLHIV, including clinical and psychosocial care; contraception and pre-conception planning if pregnancy is desired; gender-based violence reduction and linked services for men and boys
3. Ensure that linkages in *different HIV settings are optimized*. Particular attention should be given to understanding the nature of integrated services in areas of concentrated HIV prevalence among key populations

4. Ensure *effective monitoring and evaluation of programmes* that support linkages between SRH and HIV, and document the key results. This should include the process and modality used to deliver services, feasibility and acceptability of integration among service providers and clients and the cost-benefits of providing integrated services
5. *Advocate for changes* in the following key areas:
 - Funding streams for HIV and SRH programmes should be harmonized to avoid separate allocation of resources for HIV or SRH
 - Health systems delivery should ensure a unified supply of commodities for both HIV and SRH services
 - Laws supporting the criminalization of onward transmission of HIV should be changed, based on non-adherence to key human rights principles
6. *Monitor the implementation of declarations signed by national governments* that relate to the linking of SRH and HIV
7. *Collaborate with and support national HIV organizations* to ensure that the bi-directional aspects of linkages are operationalised⁴⁴
8. Utilize, monitor and document the integration of SRH and HIV services as a *modality of stigma reduction*, to promote greater access and uptake of services, particularly for men and boys, and key populations such as sex workers, men who have sex with men and people who use drugs
9. Facilitate greater understanding of the continuum of care approach towards implementing a linkages agenda. This includes supporting treatment as prevention⁴⁵
10. *Ensure that key HIV services* (including VCT; prevention of mother-to-child transmission (PMTCT); and antiretroviral therapy (ART)) *are integrated with other SRH services* (such as FP, including preconception planning; maternal and child health; prevention and management of GBV; and STI management)
11. *Strengthen linked SRH and HIV responses* in both directions through:
 - a) Stakeholder commitment
 - b) Human resources and planning
 - c) Health provider training
 - d) Client education involvement
 - e) Quality of services
 - f) Infrastructure
 - g) Supply management (including commodity security)
12. *Foster and promote community participation and ownership* in research to ensure that all research on linkages has relevant outcomes for clients
13. *Strengthen collaboration between the SRH and HIV research communities* through the development of a collective linkages agenda
14. *Collaborate with the research community* to evaluate key linkages outcomes, such as health; stigma reduction; cost-effectiveness; and trends in access to services
15. *Develop, adopt, modify and strengthen relevant policies*, HIV and SRH strategic plans and co-ordination mechanisms to foster effective linkages.

Explanatory Notes of selected terms

Bi-directional: Refers to both linking SRH and HIV-related policies and programmes and HIV with SRH-related policies and programmes.

Dual protection: Many sexually active people need dual protection: against both unintended pregnancy and STIs including HIV. Those contraceptives that offer the best pregnancy prevention do not protect against STIs. Thus, condom use for disease prevention is recommended. Condoms used alone can also prevent both STIs and pregnancy if used correctly and consistently, but are associated with higher pregnancy rates than condoms used with another contraceptive method.²

The health sector: Wide-ranging and encompassing public and private health services (including health promotion, disease prevention, diagnosis, treatment and care); health ministries; non-governmental organizations; community groups; and

professional organizations; and institutions that directly input into the health-care system e.g. the pharmaceutical industry and teaching institutions).⁴⁶

HIV and AIDS programmes and policies: This includes HIV counselling and testing, prophylaxis and treatment for PLHIV, home-based care and psycho-social support, positive prevention, HIV prevention for the general population; condom provision for dual protection, PMTCT, and specific services for key populations.

HIV counselling and testing: these form the gateway to HIV prevention, care, treatment and support for persons in need. All HIV testing of individuals must be confidential, only conducted with informed consent (both informed and voluntary) and accompanied by counselling.² Provider-initiated testing and counselling involves the routine offer of HIV testing to all patients in health care settings where HIV is prevalent and ART is available. People retain the right to refuse HIV testing. Client-initiated HIV testing for all people who want to learn their HIV status through VCT remains critical to the effectiveness of HIV prevention. It is essential to promote knowledge of HIV status in any population that may have been exposed to HIV through any mode of transmission.⁴⁷

Key populations: Key populations are those in whom risk and vulnerability converge. HIV epidemics can be limited by concentrating prevention efforts in key populations who can play a key role in responding to HIV. Key populations vary, depending on the context and nature of the local epidemic, but in most places they include men who have sex with men, sex workers and their clients, and injecting drug users.²

Risk and vulnerability: HIV infection is associated with specific risks, including behaviours such as unprotected sexual intercourse or being forced to have sex. Vulnerability to HIV is a measure of an individual's or community's inability to control their risk of infection. In many settings, women – particularly young women – are especially vulnerable to HIV infection as they may be less able than men to avoid non-consensual or coercive sexual relations.^{2,48}

Sexual and reproductive health programmes and policies: This includes FP/MCH/reproductive tract infections (RTIs), promotion of sexual health, prevention and management of gender-based violence, prevention of unsafe abortion and post-abortion care.

PMTCT: Strategies for preventing HIV infections in women and infants include:

- Preventing primary HIV infection among girls and women
- Preventing unintended pregnancies among women living with HIV
- Reducing mother-to-child transmission through antiretroviral drug treatment or prophylaxis, safer deliveries and infant feeding counselling
- Providing care, treatment and support to women living with HIV, and their families.²

Abbreviations and acronyms

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
C&T	Counselling and testing
FP	Family planning
GBV	Gender based violence
HIV	Human immunodeficiency virus
IEC	Information, education and communication
MCH	Maternal and child health
OI	Opportunistic infections
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
VCT	Voluntary counselling and testing

References

A complete list of references can be found in the online issue of the March 2009 *Medical Bulletin*. <http://www.ippf.org/en/Resources/Medical>