

Linking Sexual and Reproductive Health and HIV/AIDS

Background

There is a growing recognition of the connections between sexual and reproductive health (SRH), including family planning (FP), and HIV/AIDS. The majority of HIV infections worldwide are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. In addition, the HIV epidemic and limited access to SRH share root causes—government inaction or restrictions, poverty, gender inequity, harmful cultural practices, inadequate human rights protections, and social marginalization of vulnerable populations. In much of the developing world, one of the few times women and men come in contact with the health system is for SRH services. They come, for example, to get a modern contraceptive method, for antenatal care, to bring their child for vaccinations, or to obtain treatment for sexually transmitted infections (STIs). Many are at risk of HIV infection; some are already infected.

Linking and integrating SRH and HIV services and programs can:

- provide people with health and social services that respond to the realities in which they live;
- help people stay uninfected or healthy if they are HIV-positive;
- strengthen health systems and increase access to health care among women and vulnerable or marginalized groups; and
- contribute to achievement of the vision set out by the International Conference on Population and Development Programme of Action.

Linkages: the understanding of synergies, at the conceptual and strategic levels, that can be created when seeing common approaches to addressing specific health issues.
Integration: the operational, concrete processes of implementing linkages, i.e. how linkages can occur in various forms and at different levels, ranging from referrals to full integration of services or programs.

The purpose of integrated and linked programming and services is to ensure that individuals and households benefit from mutually reinforcing interventions. An integrated approach uses appropriate opportunities to engage the client in addressing her/his broader health and/or social needs besides those that prompted the encounter, ensuring that no opportunities are missed. Referral protocols, referral systems and service networks are key components of linked and integrated services and programs.

Ideally, integration and linkages are bi-directional. SRH→HIV integration maximizes key opportunities for incorporating SRH information, counseling and services, consistent with the capacity and appropriateness of the setting, as an integral part of HIV services. Likewise, HIV→SRH integration maximizes the opportunities for integration of HIV information, VCT and referral for care and treatment as an integral part of SRH services. Features of integration in either direction include: information and education, health monitoring (e.g. history-taking, risk assessment and physical exam), treatment or services (may include referral and/or provision of medications or contraceptives) and linking to appropriate community-based services.

Examples of Integration & Linkages

- Home-based care workers offer woman information and referral for contraception when they make antiretroviral (ARV) drug follow-up visits
- Couples coming for FP counseling are offered HIV testing
- Women use FP clinics as a point of entry for HIV care
- People living with HIV are given information about their SRH
- FP services are offered to HIV-positive women to reduce mother to child transmission of HIV
- Young people are given comprehensive information and tools to prevent HIV and unwanted pregnancy
- Woman undergoing abortion care are offered FP counseling and referrals to voluntary counseling and testing (VCT)

Current Status of Evidence Base

The evidence-base for integration of SRH and HIV services/programs is beginning to emerge. Few randomized trials and well evaluated pilot projects or field studies have been conducted. Although currently there are limited data on the benefits of integration, the integration literature is nevertheless rich; themes emerging from this literature include:

- Integration is valued by clients and providers;
- HIV-associated stigma plays a significant role in both client-provider interactions and in community contexts;

- It is a widely held belief that clients have the right to make informed decisions and to have access to complete, accurate information;
- Providers may be hesitant to provide integrated services due to their own biases;
- As care and treatment becomes more accessible and people's health improves, women and men living with HIV become more sexually active;
- Many HIV-positive women would like to have children or more children; in addition, those on ARVs may see a return to higher fertility; and
- Women often carry the burden of knowing their HIV status as a proxy for men's status and frequently hold the responsibility for a couple's contraceptive needs.

Reproductive Rights & PLHIV

People living with HIV (PLHIV) must be able to exercise their reproductive rights, and must have the information and means to engage in safer sex and to make informed choices about whether and when to have children or use contraception. All methods of contraception can be appropriate for women living with HIV. It is important to recognize that the SRH-related rights of PLHIV and other key vulnerable groups including sex workers, injecting drug users, men who have sex with men, and youth, are no different from those rights of people who are not directly affected by HIV. Nevertheless, the rights of PLHIV are often overtly and flagrantly violated by archaic laws, policies and harmful cultural practices. SRH care for PLHIV is often characterized by a narrow range of services, poor integration with other HIV services, low quality of care, high levels of stigma and discrimination, and limited access, particularly by vulnerable groups.

Challenges Moving Forward

- Evidence demonstrating the effectiveness and cost-effectiveness of linking and integrating SRH and HIV/AIDS is needed. Several dozen studies are currently ongoing.
- Efforts to operationalize linkages and integration of SRH and HIV services and programs are fundamentally inhibited by distinct funding streams and reporting requirements.
- Funding for FP and other SRH programs has been eclipsed by the vast sum being directed to HIV programs, as well as conditionalities imposed by some funders (e.g., the global gag rule).
- Efforts to link and integrate must be tailored to the local context.
- The root causes of the HIV epidemic and poor SRH are long-standing systematic problems that are difficult to address.
- Limited knowledge by HIV and SRH providers on how to link and integrate services.
- Risk of additional strain on health care providers already overextended by staffing shortages in weak health systems.
- Comprehensive SRH care for PLHIV is a low priority for most countries with high HIV rates because of competition for resources, and stigma and discrimination of the sexual rights of PLHIV.
- Limited political commitment/leadership and involvement of women, PLHIV, and representatives from key vulnerable populations.
- Integration efforts suffer from social and cultural inhibitions, as well as individual values and attitudes that make open and honest dialogue about HIV prevention difficult, and that stigmatize and discriminate against PLHIV, those perceived to be infected, and marginalized and vulnerable groups.

Key components for successful and sustainable integration

- Enabling legislative & policy environment
- Adequate resources & systems (financial, human, infrastructure, supplies)
- Participatory processes involving stakeholders & key actors
- Appropriate monitoring & evaluation systems

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