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Linking sexual and reproductive health (SRH) and HIV programs

Impact → Disease incidence rate (HIV and other STIs), unintended pregnancy rate

Outcome → Improved access to und uptake of health services, reduced HIV related stigma, improved coverage of underserved and marginalized population groups, enhanced quality of care, decrease duplication of efforts, effectiveness and efficiency gains.

A Background

The importance of linking HIV and sexual and reproductive health (SRH) programs and services is widely recognized and there is agreement on the need to ensure universal access to both SRH services and HIV prevention, treatment and care in order to achieve Millennium Development Goals (Kennedy et al., 2010). Evidence suggests that linkages and cooperation of respective departments at policy level as well as the integration and linkage respectively between HIV and SRH services are likely to improve quality and effectiveness of health services, increase client satisfaction, reduce sexually transmitted infections (STI) and HIV-related stigma and expand the reach of services to underserved and nontraditional clients (Church & Meyhew, 2009).

While the benefits are widely acknowledged, linkage strategies have been defined and four priority areas for linkages have been proposed (WHO, UNFPA, IPPF-HIV, UNAIDS,2005), notable paucity of evidence is apparent with regard to the efficacy and efficiency of strengthening SRH and HIV linkages and integrating services (Kennedy et al., 2010; Church & Mayhew, 2009; Gruskin et al., 2007). This evidence sheet seeks to synthesize available evidence on the potential benefits and the efficacy of linkage and integration strategies, focusing on the four priority areas defined by WHO, UNFPA, IPPF-HIV, UNAIDS (2005) and asks whether there is sufficient evidence to support German Development Cooperation (GDC) interventions in this field.

Key findings

a) Evidence suggests that linking SRH and HIV services is generally beneficial and feasible, especially in family planning clinics, HIV counseling and testing centres and HIV clinics.

b) While HIV/SRH linkages and service integration strategies indicate positive results, few rigorous evaluations exist. Evidence is particularly lacking on the impact of integrated services on health, social and behavioral outcomes. Reliable cost-effectiveness data further remain scarce and do not permit to draw firm conclusions on the cost-effectiveness of service integration.

c) There is sufficient evidence to suggest that linking HIV and SRH at policy, systems and service level improves access to and uptake of services, enhances overall service quality and improves HIV and STI knowledge. Integration of HIV counseling and testing (C&T) into maternal and child health (MCH) was shown to be particularly effective and evidence further suggests that C&T uptake significantly increases when integrated into MCH in antenatal care settings.

d) Linkage should be targeted at the following priority areas: Learn HIV status and access services, optimize connections between HIV and SRH services, integrate HIV with maternal and infant health, promote safer and healthier sex.

B Definitions

Dual protection: Refers to strategies that provide protection from both unwanted pregnancy and STIs, including HIV (Gruskin et al., 2007), through the use of condoms alone, or combined with other methods (dual method use).

Integration: Refers to how different kinds of SRH and HIV services or operational programs can be joined together to ensure and perhaps maximize collective improved outcomes (IAWG for SRH & HIV Linkages, 2010).

Linkages: Refers to bi-directional synergies in policy, programs, services and advocacy between HIV and SRH (IAWG for SRH & HIV Linkages, 2010).

C Approaches

C1 Learn HIV status and access services

In an attempt to provide a setting where both VCT and other routine SRH services such as antenatal care, STI treatment and family planning (FP) services are readily accessible benefits have been attributed to offering voluntary counseling and testing (VCT) services geared towards the needs of key populations (Komatsu et al., 2011). In this regard, VCT is considered an important entry point to other HIV services, including prevention of mother-to-child-transmission (PMTCT), prevention and management of HIV related diseases, and social support. Moreover it is assumed that HIV and SRH linkages as well as related service integration schemes make VCT more accessible to traditionally underserved population groups.

A review on the effectiveness, optimal circumstances, and best practices for strengthening SRH and HIV linkages by WHO, UNFPA, IPPF-HIV, UNAIDS, UCSF (2009; n=58[1]; LMIC) found **increased HIV Counseling & Testing (C&T) uptake when C&T was integrated into MCH in ANC settings** (n=16) and **improved access to VCT and increased HIV C&T uptake, when integrating HIV, STI and FP services into services offered at primary health care clinics** (n=10). The latter especially applied if point-of-care tests were offered. The integration of services at this level was further shown to increase the number of pregnant women who learned their HIV status at first ANC visit, and evidence also suggests that the uptake of nevirapine among women living with HIV increased (WHO, UNFPA, IPPF-HIV, UNAIDS, UCSF, 2009). With regard to integrated service delivery options, an assessment of the impact of routine antenatal HIV testing for preventing mother-to-child transmission of HIV (PMTCT) in urban Zimbabwe indicates comparative advantages of **'opt-out' rather than 'opt-in' approaches to HIV-testing in ANC settings** (Chandisarewa et al., 2007).

C2 Promote safer and healthier sex

HIV shares many aspects with other STIs, including modes of transmission, behavioral factors, potential control measures and root causes, including poverty, gender inequality and social marginalization of the most vulnerable populations (IAWG for SRH & HIV Linkages, 2010). HIV and SRH programs therefore generally focus on the same target groups and target behaviors and further promote similar messages and services (WHO, 2010). While non-barrier contraception rather than condoms have been promoted as a first-line method of protection against unwanted pregnancy (Berer, 2004), condoms are currently the only devises that protect against both STIs, including HIV, and unintended pregnancies and therefore feature in HIV and SRH programs. Program linkages are accordingly expected to increase the uptake of such dual-protection contraceptive options and are hence assumed to make an important contribution to the prevention of HIV and other STIs as well as to FP strategies.

A systematic review on the efficacy of HIV and SRH linking strategies by Kennedy et al. (2010) identified 10 peer-reviewed articles based on studies in which **condom use was predominantly shown to increase**. In this regard, a **behavioral intervention for HIV positive women, VCT for male STI clinic attenders, VCT for women attending antenatal or pediatric clinics and the provision of different SRH and HIV services to commercial sex workers showed positive effects**. The remaining 3 studies showed mixed or no effects on condom use. These results are confirmed by the WHO, UNFPA, IPPF-HIV, UNAIDS, UCSF (2009; n=58; LMIC) review, further suggesting that the increase is observed in sexually active women rather than in men. Evidence from South Africa confirms the positive impact of service integration on condom use and shows that the group exposed to full service integration (VCT into FP services) was significantly more likely to report always using a condom, testing of a partner and ever having had an HIV test (Mullick et al.,2006).

Although evidence on the impact of SRH/HIV linkages and service integration on health outcomes remains scarce (Church & Mayhew, 2009; WHO, UNFPA, IPPF-HIV, UNAIDS, UCSF, 2009), evidence from a systematic review of the evidence for interventions linking SRH and HIV by Kennedy et al (2010; n=35; LMIC) suggests that the promotion of safer and healthier sex by means of **linkages at the policy, systems and service level contributes to reduce HIV and other STI incidence rates**. In this regard, HIV incidence was shown to decrease after introducing VCT in combination with treatment for other STI in a mobile clinic (Sherr et al., 2007) and providing VCT to women recruited from prenatal and paediatric clinics along with an HIV educational video, free condoms, group discussion and spermicide (Allen et al., 1992). A randomized controlled trial (RCT) of an intervention consisting of four weekly interactive group sessions emphasizing female empowerment, HIV risk behaviors, condom use skills and supportive networks among HIV positive women in the US showed a decline in gonorrhea and chlamydia incidence (Wingood et al. 2004). With regard to the impact of service integration on health outcomes, it has been suggested that the promotion of FP for HIV positive women in integrated service settings can reduce pediatric HIV by

[1] Including peer-reviewed studies and promising practices.

preventing unwanted pregnancies (Sweat et al., 2004). Post-test rates of gonorrhea reinfection were further shown to be lower than pre-test rates after offering HIV C&T to STI clinic attenders (WHO et al., 2009) .

C3 Optimize the connections between HIV and SRH services

In an effort to make better use of scarce resources, avoid further fragmentation of health systems, improve quality of health service provision and comprehensively respond to the health service demands of HIV and SRH, the optimization of connections between HIV and SRH services has been identified as a priority area for linkages.

A systematic review of evidence by WHO, UNFPA, IPPF-HIV, UNAIDS, UCSF (2009; n=58; LMIC) examined linkages between the services and suggests that **linking SRH and HIV is beneficial and feasible, especially in FP clinics, HIV counseling and testing centers (C&T), and HIV clinics**. In this regard, the authors refer to benefits related to STI screening and general SRH service uptake among women living with HIV when integrating SRH services into HIV clinics. The integration of SRH services into HIV C&T clinics and its progressive extension in scope was shown to increase the uptake of FP services by HIV positive women and at the same time dramatically increase the number of clients being tested for HIV. Also the integration of HIV services into FP services was shown to be feasible, improve outcomes and does not seem to increase waiting times, drive away 'conventional' FP clients or decrease quality of FP services (WHO, UNFPA, IPPF-HIV, UNAIDS, UCSF, 2009; Dehne et al., 2000).

In fact, it was shown that the optimization of **linkages between the services improves provider knowledge and attitudes and thereby enhances the overall quality of both SRH and HIV service provision** (WHO et al., 2009). This is confirmed by a systematic review assessing the effectiveness, optimal circumstances and best practices for strengthening linkages between FP and HIV interventions by Spaulding et al. (2009; n=16; LMIC) attributing the observed service quality improvements to better interpersonal communication and counseling skills among service providers that received training in the context of service integration, which underlines the **importance of ongoing capacity building to promote effective SRH/HIV linkages**, as indicated by WHO, UNFPA, IPPF-HIV, UNAIDS, UCSF (2009). Evidence further suggests that the **integration of services has a positive impact on client satisfaction**. In this regard, none of the studies included in a review on the effectiveness of FP services in delivering STI and HIV prevention and care by Church & Mayhew (2009; n=44; LMIC) reported negative impacts. Considering the limitations of data reflecting client satisfaction, which is often subject to courtesy bias, especially when collected at the service site, caution must, however, be exercised in interpreting these findings.

A range of different models of integrated service delivery were proposed, involving integration at provider and facility level as well as referral models (Church & Meyhuw, 2009). Evidence suggests that few countries have achieved significant scale-up of integrated service provision (Dickinson et al., 2009; Druce & Nolan, 2007), which Church & Meyhuw (2009) relate to general health system weaknesses. In this regard the authors indicate that successful program improvements were only achieved when sufficient time was taken to establish and support integrated service delivery and modify procurement, reporting and other necessary systems. Several authors further point at the **need to determine appropriate linkage strategies and integration modalities** based on a consideration of epidemiological factors (e.g. generalized or concentrated HIV epidemics), the structure and organization of health services, the maturity of HIV, AIDS and SRH programs and the contraceptive prevalence rate of the respective contexts as there is no blueprint for integration and linkages (Druce et al., 2006; Dehne et al., 2000; WHO, UNFPA, IPPF-HIV, UNAIDS, UCSF, 2009; Vassall et al., 2011).

C4 Integrate HIV with maternal and infant health

In generalized HIV epidemics, antenatal care, child health care and FP are the most important health services for the implementation of provider-initiated HIV testing and counseling (PITC) (Gruskin et al., 2007). A review article on the contribution of SRH services responding to HIV by Askew & Berer (2003; LMIC) in this regard suggests that the **integration of VCT into maternal and child health (MCH) is particularly effective** as these services are now relatively accessible to the majority of the population and further reach a target group, which is not easily reached through conventional HIV prevention strategies. In this regard, it was shown that directionality of integration has important implications. Anecdotal evidence reviewed by Gruskin et al. (2007; LMIC) suggests that **HIV services should be integrated into existing SRH services as the institutional structures tend to be more solid and the services are positively perceived** by the community, facilitating access and reducing HIV related stigma.

Moreover, the reviewed evidence suggests that antenatal, delivery and post-partum services are the only entry point for preventing perinatal and breast-feeding related HIV transmission. **Given the increased importance of MTCT of HIV** and the efficacy of antiretroviral therapy during pregnancy, **the integration of HIV with MCH services accordingly bears major potentials with regard to HIV prevention**. The integration was further shown to result in net savings (Askew & Berer, 2003). Although cost effectiveness and efficiency gains are among the main arguments for linked services, reliable cost-effectiveness data remain scarce (WHO, UNFPA, IPPF-HIV, UNAIDS, UCSF,

2009; Spalding et al., 2009). Firm conclusions on the cost effectiveness of linkage at policy, systems and services level can accordingly not be drawn.

A DFID funded review on progress, barriers and opportunities for scaling up linkages for SRH, HIV and AIDS, reporting on the experience of scaling up prevention of MTCT (PMTCT) through the integration with MCH suggests that **joint task forces and working groups facilitate scale-up of linkages and service integration** (Druce et al., 2006). In this regard, the authors refer to the experience in Kenya where a PMTCT task force was set up and developed joint guidelines, protocols, training and supervision schedules, which has been shown to increase the number of new clients, acceptance of HIV C&T and uptake of ART prophylaxis. In Uganda, stakeholders advanced joint policies and guidelines to support delivery of VCT, PMTCT and ART services and of integrated care (Druce et al., 2006; Dickinson et al., 2009). In this regard it can be suggested that effective SRH/HIV linkages depend on strong political leadership and joint SRH/HIV policy and coordination mechanisms (Dickinson et al., 2009), including collaborative resource planning processes that were shown to facilitate linkages (Vassall et al., 2011).

D Methodology

Pubmed, the Cochrane Library, Google Scholar, the Virtual Health Library and Scopus were searched for English language review articles[2] (if available) published between the years 1998 and 2013, using the following headings and text words:

("family planning" OR "contraception" OR "maternal health" OR "reproductive health") AND ("sexually transmitted diseases" OR "HIV" OR "HIV infections" OR "HIV prevention" OR "HIV testing" OR "AIDS") AND ("health services") AND ("integration") OR ("linking") OR ("linkages").

E Abbreviations

AIDS – Acquired Immunodeficiency Syndrome;
ANC – Antenatal care; ART – Anti-retroviral therapy;
C&T – Counseling and testing;
HIV - Human immunodeficiency virus;
MTCT – Mother to child transmission;
MCH – Mother and child health care; n.i. – not informed;
PMTCT – Prevention of mother to child transmission;
SRH – Sexual and Reproductive Health;
STI – Sexually transmitted infection;
US – United States; VCT – Voluntary HIV/AIDS counseling and testing

F Programs supported by the German Development Cooperation

The Health Programmes in Tanzania and Ruanda have started to support linking SRGR and HIV on the political and service provision level. Other programmes suitable to take up the challenge of linking SRGR and HIV are in the process of planning.

Key words
Sexual and reproductive health; HIV/AIDS; linkages; health service integration

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