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**interventions in practice**

**Background Paper**



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## Abbreviations and acronyms

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>ART</b>	Antiretroviral therapy
<b>CD4</b>	T-lymphocyte bearing CD4+ receptor
<b>C&amp;T</b>	Counselling and testing
<b>FHOK</b>	Family Health Options Kenya
<b>FP</b>	Family planning
<b>HIV</b>	Human immunodeficiency virus
<b>GBV</b>	Gender-based violence
<b>GHEKIO</b>	Groupe Haïtien d'Étude du Sarcome de Kaposi et des Infections Opportunistes
<b>GNP+</b>	Global Network of People living with HIV/AIDS
<b>ICW</b>	International Community of Women with HIV/AIDS
<b>IPPF</b>	International Planned Parenthood Federation
<b>ISH</b>	Institute for Students Health
<b>MCH</b>	Maternal and child health
<b>MDG</b>	Millennium Development Goal
<b>MSM</b>	Men who have sex with men
<b>PEPFAR 2</b>	President's Emergency Plan for AIDS Relief (reauthorization)
<b>PLHIV</b>	People living with HIV
<b>PMTCT</b>	Prevention of mother-to-child transmission
<b>PPAT</b>	Planned Parenthood Association of Thailand
<b>RH</b>	Reproductive health
<b>RPR/VDRL</b>	Rapid plasma reagin/veneral disease research laboratory (syphilis screening tests)
<b>SRH</b>	Sexual and reproductive health
<b>STI</b>	Sexually transmitted infection
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization

## A. Background and rationale: setting the scene

1. In this climate of harmonization, collaboration, increased accountability, and spurred by pressure to make more significant headway toward reaching the Millennium Development Goals (MDGs) in the next five years, the political and programmatic importance of linking sexual and reproductive health (SRH) and HIV responses has been increasingly gaining momentum. The rationale, laid out since 2004<sup>i</sup>, is indisputable – the majority of HIV infections are sexually transmitted or are associated with pregnancy, childbirth and breastfeeding; and the risk of HIV transmission and acquisition can be further increased due to the presence of certain sexually transmitted infections (STIs). Moreover, sexual and reproductive ill-health and HIV share root causes, including economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and social marginalisation of the most vulnerable populations.<sup>ii</sup>
2. The world is moving toward 2015 when progress toward attaining the MDGs will be ultimately judged. Increasingly these goals are recognized to be intertwined, though progress towards the goals is still insufficiently capitalizing on opportunities to strengthen a united response. The recent evidence<sup>iii</sup> that HIV was the leading cause of death in women of reproductive age in particular through the impact of HIV in Sub-Saharan Africa and contributing significantly to maternal mortality reverberated throughout the reproductive health and HIV communities. It was a wakeup call that the health MDGs 4 (child health), 5 (maternal health), and 6 (AIDS), are interconnected. Clearly, universal access to reproductive health services and to HIV prevention, treatment, care and support are joint goals. And together, they will contribute to and cannot be achieved without attaining MDG 3 – gender equality and empowerment of women.
3. Probably the most compelling argument for SRH and HIV linkages are that they make ‘people-sense’, acknowledging that health systems need to meet people where they are. This is a time-honoured concept espoused in the Declaration of Alma Ata on primary health care for “bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process”.<sup>iv</sup> Whether providing women with family planning services to empower them, delivering comprehensive sexuality education for young boys and girls, preventing child marriage, eliminating gender-based violence, managing sexually transmitted infections, ensuring access to female and male condoms for dual protection (against HIV/STI and unwanted pregnancy), or providing antiretroviral treatment alongside cervical cancer screening, it is critical that sound policies are in place to support these kinds of comprehensive approaches. Yet all too often the verticalisation of HIV and SRH programmes (both at the national level and in donor funding priorities) does not support this logical alignment. Territorialism, duplication of effort and increased stigma are often the result of this mismanagement.
4. Pioneered by both the 2004 Glion Call to Action on Family Planning and HIV/AIDS in Women and Children<sup>v</sup> and the New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health,<sup>vi</sup> the fundamental linkages were articulated and human rights were enshrined as the cornerstone of this joint response. Other international commitments followed.<sup>vii</sup> Upholding human rights is intrinsic to the linkages agenda, in particular the human rights of people living with HIV, key populations,<sup>viii</sup> and women and girls. SRH- and HIV-related stigma and discrimination against vulnerable people such as young persons – in particular young women and girls, and marginalised groups such as transgender people, sex workers, men who have sex with men, people who use drugs and people living with HIV – prevent them from attaining basic rights and health.

5. The 1994 Programme of Action agreed to at the International Conference on Population and Development (ICPD) was a landmark consensus document in furthering women's rights. Along with subsequent iterations, it has set a bold agenda for advancing the sexual and reproductive health and human rights of women and girls. This ICPD agenda is firmly reflected in the SRH and HIV linkages agenda, as addressing the challenges facing women and girls is one of the cornerstones of linkages - whether tackling gender-based violence, preventing mother-to-child transmission, or advancing educational attainment. There continues to be a groundswell of support for bringing women's groups on board to support the policy and programmatic approaches to linkages. Clearly, gender equality is at the forefront of linkages.
6. To address structural determinants affecting HIV and SRH such as gender equality, education, and economic stability, effective responses - both long and short term - must go beyond the realm of health service delivery points. Instead, linking SRH and HIV requires addressing such human rights and development concerns such as age of consent for SRH and HIV services, gender-based violence, child marriage, sexuality education, girls' education, and the meaningful participation of key populations in planning, implementation and monitoring. Effective responses to tackle these issues require a strong multi-sectoral response, including through policy and legal reforms. In delineating the full scope of a linked SRH and HIV response a distinction has been made between linkages and integration.<sup>ix</sup>

**Linkages:** The bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV. It refers to a broader human rights based approach, of which service integration is a subset.<sup>x</sup>

**Integration:** Different kinds of sexual and reproductive health and HIV services or operational programmes that can be joined together to ensure and perhaps maximize collective outcomes. This would include referrals from one service to another, for example. It is based on the need to offer comprehensive and integrated services.<sup>xi</sup>

7. Bi-directionality, whereby both the SRH and the HIV communities address relevant aspects of each others' agendas has been one of the hallmarks of linkages. Therefore it is imperative that any linked responses favourably impact on both SRH and HIV outcomes. Such responses include but are not limited to: rights-based family planning in the context of mother-to-child transmission of HIV programmes, ending gender-based violence and child marriage, providing HIV voluntary counselling and testing within antenatal care, promoting condoms within family planning programmes, and comprehensive sexuality education for young people. However, despite the promise of mutual gains, a linked response has not been the norm. HIV and SRH programming still remains largely vertical and has not, until recently, begun to be linked. Several factors have contributed to this situation, including:
  - At the outset of the HIV epidemic, the need to establish an emergency response to deal with the magnitude and severity of the impact in developing countries.
  - The historical roots of the HIV epidemic lead to the assumption that the "traditional" clients of SRH services differ from the "most at risk" clients attending HIV services.
  - The emergence of divergent donor funding streams that prioritize one area as opposed to another, instead of focusing on overall people-centered benefits and health systems strengthening.
  - The creation of HIV units that were not linked to sexual and reproductive units and largely neglected the sexual and reproductive needs of people living with HIV.

- The perception that HIV prevention and HIV treatment and care require two very separate responses, which has led to the SRH community largely neglecting ARV delivery.
  - The perceptions held by many sexual and reproductive health providers that HIV requires specialized training and specific skills that were outside the scope and remit of sexual and reproductive health.
8. Despite the current financial crisis and donor fatigue, there are a number of significant global health initiatives to support national processes - including the PEPFAR-2 Strategy, the US Government Global Health Initiative, the Global Fund to fight AIDS, TB and Malaria, the International Health Partnership, the UN Health 4 partnership, the UN Secretary General global strategy for women's and children's health, and the World Bank Health Systems Strengthening platform. These initiatives recognize the importance of supporting the linkages agenda and contributing to health systems strengthening.



**Figure 1:** A framework for priority linkages between sexual and reproductive health and HIV<sup>xii</sup>

9. Sexual and reproductive health programmes and policies relate to and include family planning (FP), maternal and newborn health (MNH), STIs, reproductive tract infections (RTIs), promotion of sexual health, prevention and management of gender-based violence, prevention of unsafe abortion and management of post-abortion care.<sup>xiii</sup> Although HIV could be viewed as an intrinsic component of a broader SRH health response, for the reasons cited above, HIV and SRH programmes and services often develop in parallel. Moreover, largely due to associated stigma and discrimination related to HIV itself and to the key populations with which it has historically been associated, all aspects of HIV cannot be adequately addressed within a SRH remit alone. Each national government has articulated their response to HIV and SRH, in a number of different ways, for example, for some countries HIV is a sub-component of STIs, which are grouped with infectious disease rather than with SRH. The framework that was developed for SRH and HIV (Figure 1) recognises these differing perspectives and consequent structures, and has built-in flexibility in order to support all kinds of national responses to linkages.
10. UNAIDS galvanized its latest strategic approach to impact on the AIDS epidemic by developing a Joint Action for Results UNAIDS Outcome Framework 2009-2011. This framework is designed to support universal access and contribute to attainment of the MDGs through investment and accountability in 10 priority areas: 1) reduce sexual transmission of HIV; 2) prevent mothers from dying and babies from becoming infected with

HIV; 3) ensure people living with HIV receive treatment; 4) prevent people living with HIV from dying of tuberculosis; 5) protect drug users from becoming infected with HIV; 6) empower men who have sex with men, sex workers, and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy; 7) remove punitive laws, policies, practices, stigma and discrimination from blocking effective responses to AIDS; 8) meet the HIV needs of women and girls and stop sexual and gender-based violence; 9) empower young people to protect themselves from HIV; and 10) enhance social protection for people affected by HIV. SRH and HIV linkages are essential for implementing these ten priorities. Addressing sexual transmission to prevent HIV is fundamental to the rationale for linking SRH and HIV, as sexuality, safer sex, and condoms are key aspects of both domains. Prevention of mother-to-child transmission of HIV is one of the pillars of linkages, the epitome of the intersection between MDGs 4, 5 and 6 through comprehensive maternal health services. Empowering and meeting the needs of young people, people living with HIV and key populations is at the crux of the linkages agenda and fundamental to the joint universal access goals of SRH and HIV. And the nexus between SRH, gender equality, and human rights forms the underpinning for meeting the HIV needs of women and girls, and ending sexual and gender-based violence against them.

11. This paper sets out to foster a common understanding of the conceptual basis and key principles for linking SRH and HIV; situate the linkages agenda in the current development environment; present the evidence to-date; articulate the full scope of linkages embedded in human rights, provide illustrative practical country experiences with integrated services; and stimulate frank discussion on how to strengthen linkages and sustain the momentum.

## B. Principles in action: making linkages work

12. In order to build a common understanding between the SRH and HIV communities of linked SRH and HIV responses, and to ensure they are underpinned by a human rights approach, broad principles for joint action have been articulated. One of the stumbling blocks in linking these fields has been different perceptions and familiarity with principles that are fundamental to each others' work. The following principles were articulated in 2009 by the SRH and the HIV communities and represent consensus on the key philosophical foundations and commitments upon which linked responses must be built:<sup>xiv</sup>

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:** Sexual and reproductive and human 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 (IDU), Men having Sex with Men (MSM), and Sex Workers (SW). Gender sensitive policies to establish gender equality and eliminate gender-based violence are additional requirements.
3. **Promote a coordinated and coherent response:** Promote attention to SRH 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 Principles).

4. **Meaningfully involve people living with HIV:** Women and men living with HIV need to 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 an adequate response to the described challenges and for meeting the needs of affected people and communities.
6. **Reduce stigma and discrimination:** More vigorous legal and policy measures are urgently required to protect people living with HIV and vulnerable populations from discrimination.
7. **Recognise the centrality of sexuality:** Sexuality is an essential element in human life and in individual, family and community well-being.

## C. Evidence of benefits: research and results

13. Bi-directional linkages between SRH and HIV-related policies and programmes can lead to a number of important public health, socio-economic, and individual benefits. The movement to link SRH and HIV had its impetus from both sides and is characterized by shared and separate motivations. Overall it was envisaged that linkages would yield the following mutually beneficial results:<sup>xv</sup>

- Improved access to and uptake of key HIV and SRH services
- Better access of people living with HIV to SRH services tailored to their needs
- Reduction in HIV-related stigma and discrimination
- Improved coverage of underserved/vulnerable/key populations
- Greater support for dual protection
- Improved quality of care
- Decreased duplication of efforts and competition for scarce resources
- Better understanding and protection of individuals' rights
- Mutually reinforcing complementarities in legal and policy frameworks
- Enhanced programme effectiveness and efficiency
- Better utilization of scarce human resources for health

### Linking HIV and SRH services presents greater benefits for people living with HIV because:

- It allows people living with HIV to access both HIV and SRH services under the same roof or in the same facility increasing the opportunities for a continuity of care without being externally referred.
- It expands the range of clinical services provided beyond HIV treatment and care to include management and treatment of sexually transmitted infections, congenital syphilis, family planning, cervical cancer screening and treatment, infertility treatment, prevention of mother-to-child transmission and other related services.
- It reduces the frequency and costs of health related appointments – as it reduces the need to take additional time out of work to attend appointments, transport costs, etc.
- It could help reduce HIV related stigma and discrimination as HIV will be 'normalised' as a core service within a facility.
- It provides increased coverage for marginalised and under-served populations.

- It could promote an increased culture of rights based responses to address the specific needs of people living with HIV.

14. While there was general acceptance that linkages between SRH- and HIV-related policies and programmes were steps in the right direction, many national governments and donors wanted robust evidence to support their increased investment in integrated service delivery. However, scant research had been undertaken to document the benefits of this approach despite the integration of SRH and HIV services in many settings for a considerable period of time, although not on a national scale.
15. Linking SRH and HIV is a broad-scoped area, embracing legal and policy areas such as age of consent to services, criminalisation, and national SRH and HIV strategies; addressing systems concerns ranging from partnerships, financing, capacity building, coordination mechanisms, and commodity security; and providing delivery of the full range of SRH services (maternal health, Family Planning, STI and Gender Based Violence (GBV) prevention and management and other reproductive health concerns) and of HIV services (prevention, treatment, care, and support). The clients of these services are also diverse, including women of reproductive age and their partners, young people, people living with HIV, and key populations. Hence, amassing an evidence base for this entire field is daunting. There have been discrete studies assessing certain aspects of linkages, which differ in their methodologies and robustness. Only one systematic review using the Cochrane style review has been undertaken to date, and even that study had methodological limitations and pointed to significant research gaps. Linkages as a discipline is relatively recent and dynamic field, and as the Cochrane review described below pointed out, studies were not designed expressly to assess linkages per se, e.g. no head to head comparisons of integrated versus non-integrated services, impact studies require long term investment, and policy aspects of linkages are less well studied though not of lesser importance.
16. Although only a select number of studies are highlighted in this paper, there are a number of areas pertaining to linkages that have been studied, e.g.:
- Linked interventions for young people<sup>xvi</sup>
  - Gender-based violence and HIV<sup>xvii</sup>
  - Antiretroviral drugs and maternal health<sup>xviii</sup>
  - Condoms for dual protection to prevent unintended pregnancies and STIs/HIV<sup>xix</sup>
  - Fertility intentions of women living with HIV<sup>xx</sup>
  - Selected aspects of SRH and HIV service delivery integration<sup>xxi</sup>
17. In order to gain an understanding of the effectiveness, optimal circumstances, best practices, and potential trends for strengthening SRH and HIV integrated services, a systematic review of the literature published between 1990 and 2007 was conducted in 2008. The following questions guided the systematic review:
- What linkages are currently being evaluated?
  - What are the outcomes of these linkages?
  - What types of linkages are most effective and in what context?
  - What are the current research gaps?
  - How should policies and programmes be strengthened?

### Systematic review of SRH and HIV linkages<sup>xxii</sup>

In order to capture the most recent innovative linkages initiatives, this systematic review was not limited to peer-reviewed studies, but also included “promising practices” (‘grey’ or non-peer-reviewed literature). A total of 58 studies (35 peer-reviewed studies and 23 promising practices) met the inclusion criteria for further analysis.

Peer-reviewed Studies / Promising Practices	HIV prevention, education & condoms <sup>(a)</sup>	HIV counselling & testing	Element 3 of PMTCT <sup>(b)</sup>	Clinical care for PLHIV	Psychosocial & other services for PLHIV
Family planning	54 / 27	6 / 18	2 / 8	1 / 6	6 / 7
Maternal & child health care	7 / 9	15 / 11	Excluded from review are studies not linked to others areas of SRH		1 / 4
GBV prevention & management	4 / 10	1 / 2	1 / 2	1 / 1	0 / 1
STI prevention & management	129 / 25	9 / 12	1 / 4	4 / 4	5 / 4
Other SRH services	0 / 5	1 / 2	0 / 1	2 / 0	1 / 0

**Figure 3:** Matrix of study results categorized by type of linkage

The numbers in each box of the matrix represent the number of studies that met inclusion criteria, categorized by linkage-type. The studies integrating HIV prevention, education and condoms with SRH services (column one) were not included in the final analysis as they have been reviewed elsewhere. Several studies incorporated multiple linkages, therefore the number of linkages in the matrix exceeds the total number of studies.

#### Outcomes of this review designed to answer key research questions pertaining to the potential benefits of linkages:

- 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<sup>xxiii</sup>
  - condom use
  - HIV and sexually transmitted infection knowledge
  - overall quality of service
- Linking SRH and HIV was considered beneficial and feasible, especially in:
  - family planning (FP) clinics
  - HIV counselling and testing centres (C&T)
  - HIV clinics

- Interventions which successfully implemented provider training resulted in improved provider knowledge and attitudes, leading to better SRH and HIV service provision.
- Preliminary analysis of both cost-effectiveness studies suggested net savings from HIV/STI prevention integrated into maternal and child health (MCH) services.<sup>xxiv,xxv</sup>

## Cost-effectiveness of integrated services

18. One of the potential benefits of integration is cost savings incurred through linked service modalities – e.g. multi-tasking, sharing equipment, and robust referrals. Increased coverage can lead to greater impact of outcomes and offset any initially higher start-up costs.

### Cost-effectiveness of integrating STI and HIV prevention, care, and treatment into family planning services: a review of the literature<sup>xxvi</sup>

It is often assumed that integration of STI/HIV services with Family Planning/Mother and Child Health services could offer cost savings by sharing staff, facilities, equipment, and other administrative and overhead costs<sup>xxvii</sup>. Indeed, one review found several reports suggesting that integration yielded savings<sup>xxviii</sup>. Reliable cost-effectiveness data remain sparse, however. Three cost-effectiveness studies were identified. The first, conducted in India, demonstrated significant savings because a relatively high proportion of clients (37 percent) accessed more than one service.<sup>xxix</sup> A South African study indicated that increased cost-effectiveness was achieved when clinic staff had sufficient time to provide HIV testing to all clients.<sup>xxx</sup> A Kenyan study suggested that adding HIV testing to Family Planning services increased costs only marginally; the combined costs amounted to less than half the estimated costs of a stand-alone voluntary counselling and testing site.<sup>xxxi</sup> Two studies pointed to the importance of staff having excess time before service integration begins if cost-effectiveness or improved productivity is to be achieved after new services are added.<sup>xxxii, xxxiii</sup> Concluding, more research is needed to obtain a better understanding of the monetary benefits of linking services.

19. Notably, recent modelling has demonstrated cost effectiveness and overall intensified impact of implementing pillar 2 of PMTCT - preventing unintended pregnancies among women living with HIV - by linking Family Planning with PMTCT programmes.<sup>xxxiv, xxxv</sup>

### Linked interventions for young people<sup>xxxvi</sup>

20. A systematic review of 80 studies was undertaken to assess the effectiveness of different HIV prevention interventions delivered in schools, health services, media and communities for young people. The following interventions were classified as 'go' and as 'ready' for widespread implementation and have implications for strengthening the links between SRH and HIV information and services for young people.
- **In schools:** Curriculum-based interventions including sexuality education, led by adults, that are based on defined quality criteria, can have an impact on knowledge, skills and behaviours
  - **In health services:** interventions can increase young people's use of services provided that they train service providers, make changes in the facilities to ensure that are "adolescent-friendly", and create demand and community support through actions in the community

- **In the mass media:** interventions can have an impact on knowledge and behaviours if they involve a range of media, example TV and radio supported by other media e.g. print, and are explicit about sensitive issues such as sexual behaviour, and communicate this in line with cultural sensitivities
- **In communities:** increased knowledge and skills can be achieved through interventions that are explicitly directed to young people and work through existing organizations and structures
- **For young people most at-risk:** interventions that provide SRH and HIV information and services through static and outreach facilities are most effective in reaching young people most at risk of HIV, for example young sex workers, young injecting drug users or young men who have sex with men.

## Gender-based violence and HIV<sup>xxxvii</sup>

21. Gender-based violence (GBV) violates human rights, and its prevention and management is an essential component of SRH, including access to legal and social justice and to health-related services such as emergency contraception, HIV post-exposure prophylaxis, and psychosocial counselling especially for survivors of sexual violence. Gender based violence and HIV overlap and intersect in complex ways. The vast majority of studies reveal that gender based violence or the fear of it may interfere with the ability to negotiate safer sex or refuse unwanted sex. Some evidence suggests an association, although not necessarily causal, that individuals who have been assaulted in childhood may later exhibit patterns of sexual risk taking that may increase their risk of acquiring HIV. Evidence also exists that living with HIV may constitute a risk factor for experiencing gender based violence, with studies finding an increase in violence following disclosure of HIV status or even following disclosure that HIV testing has been sought.

## Linkages Research Agenda

22. To date there are still some less well understood areas warranting further action and rigorous operational research. These include:
- Which integration models are optimal in particular settings
  - Impact of linkages (e.g. on unmet need for family planning, HIV incidence, etc.)
  - Cost-effectiveness of combining HIV and SRH interventions
  - How to involve men and boys with regard to HIV and SRH interventions
  - Impact of linked SRH and HIV services on stigma and discrimination
  - What are the incentives for service providers in linking services
  - Comprehensive SRH services for people living with HIV, including planning for safe, desired pregnancies and addressing unintended pregnancies, especially in settings where there is limited access to the full range of SRH services
  - Optimizing reach of services in challenging circumstances, including in humanitarian responses, settings with diverse cultural practices, and for survivors of sexual violence.

## D. Linkages in practice: applying the lessons

23. Implementing the linkages agenda requires a paradigm shift in the way in which all stakeholders from both the SRH community and those in the HIV field work in unison. Yet, the two fields have often been forced into territorialism and an unhealthy competition for scarce resources rather than actively encouraged to act on any of the natural synergies. Fully realizing the anticipated benefits inherent in linking the HIV and SRH responses requires a change in a stereotypical 'business as usual' approach, for example:
- National governments often appear to have strong National AIDS Councils and Country Co-ordinating Mechanisms for managing Global Fund to Fight AIDS, Tuberculosis and Malaria grants that do not adequately support many of the initiatives within other priority sectors, including SRH;
  - Donors who continue to support separate and unlinked responses, and impose conditionalities, are partly responsible for the creation of a dual track system in many countries in which the HIV portfolio is often not sufficiently linked to the SRH portfolio, especially to maternal and child health responses; and
  - The imperative of addressing the SRH needs of people living with HIV and key populations is particularly challenging in many concentrated and low level epidemics since current laws, policies and health systems are not sufficiently supportive.
24. Linking sexual and reproductive health and HIV policies and practises presents an unparalleled opportunity for all relevant stakeholders including the UN system; national policy makers; the donor community; national programme managers (SRH and HIV); politicians; researchers and civil society to address a range of challenges that will strengthen unified programme responses.
25. Leadership for and about linkages is not the sole mandate of the SRH movement. The HIV community needs to embrace and guide this agenda and increasingly networks of people living with HIV have begun to help lead this 'linkages' agenda and to proactively shape the content to respond to their rights and SRH needs.<sup>xxxviii</sup> Similarly, different sectors – education, the world of work, the private sector - need to meaningfully engage on relevant aspects of SRH and HIV linkages.
26. Despite a number of programmatic and policy challenges, progress on advancing the linkages agenda has significantly increased.

### **Factors that have proven to promote linkages include:**<sup>xxxix</sup>

- Positive attitudes and good practices among providers and staff
- An institutional commitment to ongoing joint capacity building
- The active involvement of the community and government during planning and implementation
- The addition of 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 linkages include:**<sup>xi</sup>

- 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.

27. The 'why' and the 'what' of linkages are clear and largely agreed. However, despite these established connections, for those on the front line of health care planning and delivery some of the key policy and service level challenges include:<sup>xii</sup>

- Making sure that integration does not overburden existing services in a way that compromises service quality, by ensuring that integration actually improves healthcare provision
- Managing any potential increased workload for staff who take on additional or 'task-shifting' responsibilities
- Allowing for increased costs initially when setting up integrated services and training staff
- Combating stigma and discrimination from and towards healthcare providers, which has the potential to undermine the effectiveness of integrated services no matter how efficient they are in other respects
- Adapting services to attract and involve men, who tend to see sexual and reproductive health, and especially family planning, as 'women's business' [e.g. SRH information and services integrated with male circumcision for combination HIV prevention services]
- Reaching those who are most vulnerable but least likely to access services, such as young people and those from key populations
- Providing the special training and ongoing support required by staff to meet the complex sexual and reproductive health needs of HIV-positive people effectively
- Motivating donors to move from supporting parallel to integrated services, and sustaining support for integrated policies and services.

28. Responding to the structural, policy and service delivery aspects of the linkages agenda has not met with unified action – and all too frequently, at the risk of not focusing on some of the more challenging tasks, certain aspects of integration are addressed more comprehensively than others. The lack of sufficiently sensitive indicators that will adequately capture the essence of the various linkage outcomes remains a challenge. Despite these obstacles, things are beginning to change and there are some sound country, regional and international examples that have pioneered action on the linkages agenda on all fronts – a) service delivery integration, b) strengthening systems, and c) policy.

#### **a) Service delivery integration**

Integrating SRH and HIV services recognizes the importance of empowering people to make informed choices about their sexual and reproductive health, and the vital role that sexuality plays in people's lives.

The moral and programmatic imperative of bringing the HIV and SRH responses into closer unison is clear. The 2005 Sexual and Reproductive Health and HIV/AIDS: A framework for priority linkages<sup>xiii</sup> highlights four strategic programmatic interventions:

- i. Learn HIV status and access services;
- ii. Promote safer and healthier sex;
- iii. Optimize the connection between HIV and STI services; and
- iv. Integrate HIV with maternal and infant health.

Innovative in-country work on integration has exceeded the scope of the framework as many traditional SRH facilities are increasingly providing ART delivery programmes as part of their services. Many traditional HIV service providers have begun to address the SRH needs of their HIV positive clients. Similarly, other sectors such as the world of work, and the private sector, are increasingly providing integrated services. There is also momentum to provide linked responses in humanitarian crises and conflict settings.

The table below gives some illustrative examples of various kinds of bi-directional integration that is currently being implemented in programmes around the world:

From SRH  to HIV	From HIV  to SRH
Family planning into HIV counselling and testing	HIV counselling and testing into family planning programmes
Family planning into prevention of mother-to-child transmission	HIV counselling and testing into antenatal care including congenital syphilis <sup>xliii</sup>
Family planning into HIV treatment, care and support	HIV treatment and care into community based reproductive health interventions
STI management including cervical and other cancer screening into HIV treatment, care and support	HIV treatment and care into post-partum care centres
Antenatal care into HIV treatment care and support	Antiretroviral therapy into SRH service delivery programmes
Preventing violence against women and girls into PMTCT programmes	Promotion of male involvement in HIV prevention into SRH services for men

#### **Models of integration:**

Determining the optimal model for integrating services depends on a variety of factors. To date, successful methods of service integration have captured the ground realities faced by a variety of service providers. From delivering all SRH and HIV services by one provider to providing selected high quality health and other services through innovative partnerships, the success of many integrated SRH and HIV services rests on the quality and effectiveness of referrals.<sup>xliiv</sup> Facilitated referrals need to be strengthened to ensure that many of the opportunistic illnesses related to HIV are addressed, including tuberculosis, malaria and hepatitis; and SRH concerns such as infertility and cervical cancer are made priorities in HIV services.

“This integrated clinic [Family Life Association of Swaziland] brings together family planning, antenatal care, maternal and child health services, prevention of mother-to-child transmission of HIV services and HIV counselling and testing, along with access to antiretroviral therapy. In the near future, I hope to see many more examples of integrated approaches to HIV.” (Michel Sidibé UNAIDS Letter to Partners: February 2010)

### **Meeting the sexual and reproductive health needs of a diverse group of people:**

The sexual and reproductive health desires of people living with HIV are as varied as the epidemic itself. The issues facing young people living with HIV as they embark on new relationships (repeated disclosure; potential sexual rejection because of HIV status, etc) are very different to the issues facing an HIV-positive couple who may wish to conceive (healthcare provider attitudes; accessibility of appropriate services). Addressing the SRH needs of people living with HIV would mean addressing issues as diverse as the fertility choices of women living with HIV to addressing the sexual health priorities of men who have sex with men.

### **Providing comprehensive services beyond the clinic door:**

The realities of peoples' lives involve many issues beyond the scope of health services. Yet, increasingly health services are the entry point to address food security, education, and microfinance. Therefore there should also be referrals that address these social and economic concerns, such as empowerment, gender transformation to improve relationships, micro-finance, skills development, legal services, nutrition, and access to psycho-social support.

The following three case studies have been drawn from the Gateways to Integration series which provide an in-depth uniform analysis of country experiences with various models of service integration initiated by non-governmental organizations in partnership with national governments and other stakeholders.

### **Case Study 1: Gateways to Integration: Voluntary HIV counselling and testing – an entry point for comprehensive sexual and reproductive health services All services under one roof<sup>xiv</sup>**

Haiti has one of the oldest AIDS epidemics and one of the highest rates of HIV infection in the world outside of sub-Saharan Africa. As a pioneer of integrated sexual and reproductive health and HIV services, GHESKIO has valuable lessons to share from its experience. GHESKIO's decision to offer sexual and reproductive health services integrated with its existing HIV programme, all under one roof, was motivated partly by the following factors:

- The great majority of HIV infections in Haiti are contracted sexually
- Without intervention, about a third of infants born to women living with HIV become HIV-positive themselves, and, in Haiti, AIDS is responsible for 20% of infant deaths<sup>xvi</sup>
- Although improving, stigma and lack of necessary professional skills result in many PLHIV being denied access to sexual and reproductive health care in other health facilities
- People do not have the time or money to go from one place to another to meet their different health needs.

GHESKIO has played a major role in influencing policy and practice in the Haitian national health system. This is particularly apparent in the way it has developed its model of integrated services targeting the endemic and most common diseases, such as tuberculosis, HIV, STIs, diarrhoeal diseases and malaria. Integrating sexual and reproductive health services into the voluntary counselling and testing network – to prevent unintended pregnancies and prevent mother-to-child transmission of HIV – has significantly increased access to services. This model of service provision was used in 22 public and private health centres and hospitals nationwide. As the country rebuilds following the devastating earthquake, such an integrated service delivery model can provide a platform for replication and scale-up.

## **Case study 2: Gateways to Integration: Providing ART in a sexual and reproductive health setting**

### **A model of integrated services<sup>xlvii</sup>**

The International Planned Parenthood Federation's affiliate in Kenya, the Family Health Options Kenya (FHOK) has a clinic in Nakuru which provides a good example of the Association's work in practice. As well as its original function offering family planning services, the clinic now offers general outpatient services. Clients can attend for any reason, but every opportunity is taken to raise the topic of sexual and reproductive health and to advocate for voluntary counselling and testing. More than 300 people a month seek HIV counselling and testing, and in 2004 nearly 1,000 clients sought treatment for HIV-related opportunistic infections, which is offered as part of general outpatient services. Currently:

- All FHOK clinics provide voluntary counselling and testing for HIV
- All clinics offer programmes which aim to prevent mother-to-child transmission of HIV as part of their maternal health services
- Five of the nine clinics provide antiretroviral therapy to people living with HIV.

## **Case study 3: Gateways to Integration: Investing in youth**

### **Reaching those most vulnerable to HIV<sup>xlviii</sup>**

The Institute for Students' Health (ISH), Serbia, caters for a population of 110,000 students plus university staff. It also offers non discriminatory SRH and HIV services for key populations such as men who have sex with men, sex workers and people who use drugs. The Institute has been prepared to push out the boundaries to create a model of care that meets the needs of its target populations in a more convenient and user-friendly manner while offering health professionals more effective and satisfying ways of working. As a pioneer of integrated SRH and HIV services in Serbia the Institute found that:

- Between 2006 and 2008, 3,000 young people a year accessed a number of HIV prevention services – including voluntary counselling and testing – at the ISH Centre in Belgrade.
- From 2006 to 2008 the number of people who use drugs accessing services at the Centre quadrupled.
- The ISH Centre became the preferred voluntary counselling and testing centre in Belgrade for men who have sex with men.

## **b) Strengthening systems**

Linking SRH and HIV requires that the supportive systems on which health and other services depend are addressed. The overall weakness of health systems is responsible for many of the gaps that impede the full enjoyment of the right to health, including to SRH and to HIV prevention, treatment, care and support. In line with the Paris Declaration on Aid Effectiveness<sup>xlix</sup> – which stipulates the need for country ownership, alignment with government priorities, and harmonization – systems need to be assessed to determine the extent to which they support effective SRH and HIV integration and linkages.

### **Imperative linkages mechanisms and systems:**

While there are a number of wider health systems considerations, in the context of SRH and HIV linkages, the following systems<sup>l</sup> should assessed and strengthened:

- **Partnerships** – for situation analysis, planning, budgeting, resource mobilization, advocacy, implementation, monitoring and evaluation by development partners including civil society (networks of people living with HIV, key populations, women's organizations, young people, etc)

- **Coordination mechanisms** – for SRH and HIV joint planning, management and administration of linked advocacy and policies, and integrated services
- **Human resources and capacity building** – joint SRH and HIV capacity building, including in-service training, of health providers and teachers; increase knowledge, skills and understanding of how to eliminate stigma and discrimination and gender inequality
- **Logistics and supplies systems** – for ensuring SRH and HIV commodities security, preferably combined systems, including but not limited to condoms for dual protection, lubricants, full range of contraceptives, STI drugs, post-exposure prophylaxis kits, delivery kits, ‘dignity’ kits for humanitarian settings, HIV test kits, post-rape kits, antiretroviral drugs, drugs for opportunistic infections, anti-malarials, iron/folate, safe injecting equipment, methadone, etc.
- **Laboratories** – for the combined needs of SRH and HIV including haemoglobin concentration, blood grouping and typing, STI diagnosis, (including RPR /VDRL for syphilis), HIV diagnosis (including rapid tests), CD4 count, HIV viral load, liver function tests, urinalysis, random blood sugar, pregnancy testing, diagnosis of cervical and other cancers etc.

#### **Addressing stigma and discrimination through capacity building of front line service providers:**

Reducing stigma and discrimination about HIV and SRH means facing and talking openly about issues that include sexuality, drug use, sex work, sexual violence, 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 services provide an opportunity for redress. Despite the growing global rhetoric, stigma and discrimination still hinder access to health services for people who are HIV-positive, young people, people who inject drugs, sex workers, and men who have sex with men. Health workers need resources, information, skills and sensitivity training related to the specific needs of the diverse range of clients, including the importance of confidentiality. Therefore linking SRH and HIV responses could act as a modality of HIV related stigma reduction.

#### **c) Policy**

Health service integration alone will not be sufficient to attain even the health MDGs, as the structural determinants of HIV and SRH must be addressed. Gender inequality, poverty, stigma and discrimination and low levels of education, will continue to impede the gains on the both the SRH and HIV fronts. Linkages support the fundamental principle of national ownership that enables governments, in partnership with civil society, to examine their human rights laws and policies. These include those related to criminalisation of HIV exposure and transmission; criminalization of practices/behaviours associated with key populations; access to SRH and HIV services including counselling and testing, rights-based family planning; gender-based violence; marriage, divorce and child custody, including, early and forced marriage; women's property and inheritance; female genital mutilation; and other punitive laws and policies that affect human rights.

Members of marginalised groups are often at particular risk of HIV infection and, once they become HIV positive, have an especially difficult time getting the support they need. Legal systems should provide special protection for key populations, people living with HIV, and marginalised groups, as well as access to quality legal services so that human rights violations can be appropriately addressed. These legal services and measures include programmes to reduce stigma and discrimination; human rights capacity building of key service providers; campaigns to raise awareness of human rights; and legal audits and reform programmes.

### **Highlighting issues facing women and girls:**

Women and girls bear a disproportionate burden from both HIV and AIDS and from SRH ill-health. Despite increased global attention, sustainable investment in the health, education, and rights of women, especially young women and girls, has not made sufficient impact on their lives. Many are still not empowered to protect themselves from HIV or mitigate its impact, including bearing much of the responsibility for HIV care. Since HIV is the leading cause of death in women of reproductive age in Sub-Saharan Africa, and contributes significantly to maternal mortality, merging 'classical' maternal and child health responses with selected HIV approaches is essential in this region. Recent increased attention to maternal mortality as a human rights concern, and awareness of the contribution of HIV to maternal mortality, underscores the value of linking MDG 5 and 6 responses.

The promotion of primary HIV prevention and addressing the SRH needs of HIV positive women should be the collective responsibility of maternal and child health and HIV advocates and practitioners. Of particular concern are the human rights violations of positive women including forced sterilisation and abortion. Gender-based violence is another human rights violation which has repercussions for poor SRH and increased risk of HIV and would benefit from a united front of advocacy and well-funded interventions, including addressing the heightened violence against sex workers and against people living with HIV. This investment in women-centred care can benefit from involving male partners and could alter service provision. Many national responses to these issues could be exponentially strengthened.

“There are some common strategies that can achieve results on universal access targets and Millennium Development Goals. These may include empowering leadership of women and girls, especially women and girls living with HIV, access to integrated HIV and sexual and reproductive health services, addressing violence against women and girls, and addressing the needs of marginalized women and girls.”<sup>ii</sup>

SRH and HIV integration occurs within the existing health sector and it is therefore imperative that the linkages agenda supports and directly contributes to health system reform. The rapid assessment tool described below is designed partially to uncover the various health systems challenges including donor-driven and vertical programming, lack of coordination, disjointed planning processes, infrastructure, logistics, and human resources constraints, and will ultimately help governments set priorities and contribute to health sector reform.

### **Rapid Assessment Tool for Linking SRH and HIV – Country Application**

A Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages was developed through collaboration with IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, Young Positives in 2008 and is being rolled out in 16 countries in 5 regions - Africa: Benin, Botswana, Burkina Faso, Cote D'Ivoire, Malawi, Swaziland, Tanzania and Uganda; Arab States: Lebanon, Morocco and Tunisia; Eastern Europe and Central Asia: Kyrgyzstan and Russian Federation; Latin America and the Caribbean: Belize; Asia and Pacific: Pakistan and Viet Nam. These national assessments, carried out with partners representing SRH, HIV, PLHIV and key populations, assess HIV and SRH bi-directional linkages at the policy, systems, and service-delivery levels, identify current critical gaps in policies and programmes, and contribute to the development of country-specific action plans to forge and strengthen these linkages. Such assessments are a first step in understanding the linkages scenario at the country level. A summary of the process and available findings of these 16 countries is being undertaken to report to the UNAIDS Programme Coordinating Board in June 2010 during the Thematic Session on SRH and HIV linkages.

**Donor understanding, support and funding for linkages:**

While the linkages momentum has begun to have a positive response from many of the major global funders, it is still not of the size and scope that is required. Some donors do not have a policy or specific funding streams to support work on linkages. The reasons they give for this include: the lack of a structural environment to promote and make linkages operational at country level; the existence of vertical plans, budget and monitoring and evaluation plans for SRH/HIV; and the need for country level ownership to lead processes.<sup>lii</sup>

In contrast, the Global Fund to Fight AIDS, Tuberculosis and Malaria, has begun to promote and fund HIV proposals that include SRH components, as have PEPFAR-2 and the US Government Global Health Initiative. The Global Fund has agreed to support the following, provided that linkages are made with HIV outcomes:<sup>liii</sup>

- i. Procurement of reproductive health commodities;<sup>liv</sup>
- ii. Family planning in the context of PMTCT;
- iii. The Rapid Assessment Tool for Linking SRH and HIV as part of operational research; and
- iv. Programmes to eliminate gender-based violence and address other aspects of gender equality.

USAID has taken steps in many countries, such as Kenya, Nigeria and Zimbabwe, to combine family planning and HIV funding into a single health programme. The HIV funds are used exclusively for HIV programming, while reproductive health integration efforts must be supported from the relatively small pot of family planning funds. Nevertheless, this combined funding approach acknowledges the value of linking the two programme areas.<sup>lv</sup> Other donors, such as the European Commission, Germany, the Netherlands, and the United Kingdom, explicitly encourage proposals that link HIV and reproductive health services.

### Case study: Financing<sup>lvi</sup>

Whilst few donors or funding mechanisms have adapted their remits or application processes to proactively attract and resource linkages, the Global Fund to Fight AIDS, Tuberculosis and Malaria has. The Global Fund provides unprecedented and innovative opportunities to 'make it happen' for reproductive health (RH) and HIV integration. This is due not only to what the Global Fund funds, but how the Global Fund works:

The Global Fund welcomes country proposals for RH/HIV integration:

- The Global Fund's definition of RH/HIV enables programmes to combine services (such as STI treatment and family planning information) with commodities (such as condoms and contraceptive pills). It also enables attention to linkages between socio-political issues (such as human rights and gender-based violence) that have often been neglected.<sup>lvii</sup>
- Since Round 8, the Global Fund has explicitly welcomed RH/HIV integration within country proposals, providing that its impact on HIV outcomes can be clearly demonstrated.<sup>lviii</sup>
- This has already resulted in the approval of a significant number of HIV proposals that include at least one component of reproductive health. (Grants totalling hundreds of millions of dollars have been approved.)
- The Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, Tuberculosis and Malaria ("Gender Equality Strategy") provides a comprehensive definition and clear road map towards increased and improved action to address the needs of women and girls, with a commitment to "champion activities that strengthen SRH-HIV service integration."<sup>lix</sup> The Strategy in Relation to Sexual Orientation and Gender Identities also commits to integration as an important strategy for sexual minorities and sex workers.<sup>lx</sup>

## E. Six key issues for consideration: acting on the agenda

29. Over the past few years the momentum in linking SRH and HIV responses at the structural, policy, and service delivery levels has gained increased strength. Key lessons and innovative insights have implications for addressing some of the identified challenges in meeting the MDG targets by 2015:
- a. **Encourage, promote and support the integration of SRH and HIV services through sustainable financing, harmonized policies and good practice:** An appropriate level and type of integration will depend on a variety of factors including the nature of the HIV epidemic; key indicators of SRH; and the size and scope of the existing SRH and HIV services (capacity; human and financial resources; location; etc). There is no one single model for integrating services and service integration is not a panacea for addressing all HIV and SRH outcomes. Political, institutional and organizational commitment by all relevant stakeholders to address the lack of harmonization and coordination must be intensified at the national levels. Linking SRH and HIV at the policy level will require the development of mechanisms to enable joint planning between national AIDS coordinating bodies and reproductive health departments at the ministerial level to ensure that the national AIDS and SRH strategies and costed plans are appropriately harmonized. Sustained good practice is grounded in a coherent capacity building strategy for health providers, managers, and policy-makers to ensure sound technical

knowledge of SRH and HIV as well as to foster attitudes and practices that uphold human rights.

- b. Increase the benefits of linking SRH and HIV by ensuring that relevant services and systems beyond the health sector are also routinely considered when responding to the synergies between SRH and HIV:** Linkages include other sectors that are imperative to address key SRH and HIV outcomes, notably education and the juridical sector. For example, gender based violence and child marriage impact on HIV and SRH outcomes and in order to respond, wider efforts are required including addressing the social and cultural practices and legal frameworks particularly punitive laws that hinder a comprehensive response. Similarly comprehensive sexuality education and life skills for young people are fundamental to SRH and HIV responses, and go beyond the provision of youth-friendly services and primary HIV prevention to include a focus on negotiation within relationships, self-esteem, and community participation. By collectively addressing the structural drivers of both HIV and SRH ill-health, underutilized opportunities toward wider health systems strengthening will be captured.
- c. Promote and foster collaborative action research to address the key research gaps in the linkages agenda:** Because the response to the linkages agenda is moving at a rapid pace, it is essential that the research gaps are addressed to ensure that the evidence base is strengthened. Key outcomes such as health, stigma reduction and cost-effectiveness of integrated programmes are of particular importance. Increasingly research should also be directed towards areas of integration that are currently understudied notably integrating SRH services with 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.
- d. Strengthen ties between key maternal and newborn health initiatives and relevant aspects of the HIV response:** Recent changes in the political environments around the world have created a more enabling milieu for linking maternal health and HIV. The prevention of mother-to-child transmission of HIV provides an opportunity to showcase the impact of linkages and simultaneously address some of the identified bottlenecks in promoting a comprehensive and sustained response. Few donors or funding mechanisms have adapted their remits or application processes to proactively attract and resource this aspect of integration.
- e. Maximize the understanding and promotion of linkages in concentrated HIV epidemics:** Addressing the sexual and reproductive health needs of key populations (e.g. men who have sex with men, sex workers and their clients, and people who use drugs), people living with HIV, and other marginalized populations in countries and regions with concentrated epidemics is an area that requires increased focus. Together with the imperative of creating supportive legal and policy frameworks and the need for accessible services, emphasis must be placed on their intimate partners.
- f. Remove punitive laws, policies, practices, stigma and discrimination that block access to integrated SRH and HIV services:** To enable outreach of sexual and reproductive health services to the general population, key populations as well as to PLHIV, legal and social barriers need to be addressed through inclusion of following programmatic elements: legal audit and law reform programs, access to legal services, programs to reduce stigma and discrimination, know your rights/ law campaigns and training of key service providers - not only health care workers but also judiciary and

police. Furthermore, integrated services need to be based on human rights principles as being non-discriminatory, inclusive, participatory, and accountable.

## **F. Essential resources: readings, writings and roadmaps**

### **a) International commitments on linkages**

- World Association for Sexual Health (2008) Sexual Health for the Millennium.
- GNP+ (December 2007) Global Consultation on Sexual and Reproductive Health and Rights of PLHIV.
- Global Partners' Forum (November 2007) Consensus Statement: Achieving Universal Access to Comprehensive Prevention of Mother-to-Child Transmission Services.
- Reproductive Health Matters (May 2007) Ensuring sexual and reproductive health for PLHIV
- UNGASS (June 2006) Political Declaration on HIV/AIDS.
- Prevention of Mother to Child Transmission (PMTCT) High Level Global Partners Forum (December 2005) Call to Action: Towards an HIV-Free and AIDS-Free Generation.
- UNGASS (September 2005) World Summit Outcome.
- UNAIDS (June 2005) Intensifying HIV prevention: UNAIDS policy position paper.
- UNFPA & UNAIDS (June 2004) New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health.
- UNFPA & WHO (May 2004) Glion Call to Action on Family Planning and HIV/AIDS in Women and Children.

### **b) SRH and HIV linkages**

- IPPF, UNAIDS, UNFPA, WHO, ICW, GNP+ & Young Positives (2009) Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide.
- WHO, UNFPA, UNAIDS & IPPF (2009) Gateways to Integration: A case study from Serbia.
- WHO, USAID & Family Health International (2009) Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services.
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- IPPF, UCSF, UNAIDS, UNFPA & WHO (2008) Linkages: Evidence Review and Recommendations.
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- WHO (2006) Reproductive Choices and Family Planning for People Living with HIV – Counselling Tool.
- WHO, UNFPA, UNAIDS & IPPF (2006) Linking Sexual and Reproductive Health and HIV/AIDS: An annotated inventory.
- WHO, UNFPA, UNAIDS & IPPF (2005) A Framework of Priority Linkages.
- UNFPA & IPPF (2004) Integrating HIV Voluntary Counselling and Testing Services into Reproductive Health Settings – stepwise guidelines for programme planners, managers and service providers.

**c) Financing**

- Friends Africa, Global AIDS Alliance, Interact Worldwide, International AIDS Alliance, IPPF & Population International (2010) Mobilizing for RH/HIV Integration: Make or break?
- WHO (2010) Making the case for interventions linking sexual and reproductive health and HIV in proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria.
- The Global Fund to Fight AIDS, Tuberculosis and Malaria (2009) The Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, Tuberculosis and Malaria.
- The Global Fund to Fight AIDS, Tuberculosis and Malaria (2009) The Global Fund Strategy in Relation to Sexual Orientation and Gender Identities (SOGI).
- UNFPA & Guttmacher Institute (2009) Adding it Up.
- Global AIDS Alliance (2008) Guidelines for Integrating Sexual and Reproductive Health into the HIV/AIDS Component of Country Coordinated Proposals to be submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria: Round 8 and Beyond.
- The Global Fund to Fight AIDS, Tuberculosis and Malaria (2008) Guidelines for Proposals: Round 8 (Single Country Applicants).
- USAID/DELIVER Project (2008) Policy brief: the Global Funds supports reproductive health commodity security.
- Wilcher R, Petruney T, Reynolds HW & Cates W (2008) From effectiveness to impact: contraception as an HIV prevention intervention. *Journal of Sexually Transmitted Infections*. 84(2), pp 54-60.

**d) PMTCT**

- The Inter-Agency Task Team On Prevention of HIV Infection in Pregnant Women, Mothers and their Children PMTCT (forthcoming 2010) Programming Guidance: Primary Prevention of HIV and Prevention of Unintended Pregnancies in Women Living with HIV (working title).
- PAHO (2009) Clinical guidelines for the elimination of mother-to-child transmission of HIV and of congenital syphilis.
- WHO (2009) Rapid Advice: Use of Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants.
- WHO & CDC (2008) Investment Case for the Elimination of Congenital Syphilis.
- The Inter-Agency Task Team On Prevention of HIV Infection in Pregnant Women, Mothers and their Children (2007) Guidance for Global Scale Up of Prevention of Mother-to-Child Transmission of HIV: Towards universal access for women, infants and young children and eliminating HIV and AIDS among children.
- WHO & UNFPA (2006) Glion Consultation on Strengthening the Linkages between Reproductive Health and HIV/AIDS: Family Planning and HIV/AIDS in Women and Children.
- UNFPA & WHO (May 2004) Glion Call to Action on Family Planning and HIV/AIDS in Women and Children.

**e) Sexual and reproductive health and human rights of people living with HIV**

- GNP+ & UNAIDS (2009) Positive Health, Dignity and Prevention: Technical consultation report.
- GNP+, ICW, Young Positives, EngenderHealth, IPPF & UNAIDS (2009) Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A guidance package.
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- GNP+ (December 2007) Amsterdam Statement on Sexual and Reproductive Health and Rights for People Living with HIV.

- WHO (2006) Sexual and Reproductive Health of Women Living with HIV/AIDS: Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings.

#### **f) Selected linkages research**

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## End notes

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<sup>iii</sup> The Inter-Agency Task Team On Prevention of HIV Infection in Pregnant Women, Mothers and their Children (2007) *Guidance for Global Scale Up of Prevention of Mother-to-Child Transmission of HIV: Towards universal access for women, infants and young children and eliminating HIV and AIDS among children*.

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<sup>v</sup> UNFPA & WHO (May 2004) *Glion Call to Action on Family Planning and HIV/AIDS in Women and Children*.

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<sup>vii</sup> *International commitments for linking sexual and reproductive health and HIV:*

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<sup>viii</sup> *Key Populations: Populations for which HIV risk and vulnerability converge. HIV epidemics can be limited by concentrating prevention efforts among key populations. The concept of key populations also recognizes that they can play a key role in responding to HIV. Key populations vary in different places 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. From: IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW & Young Positives (2009) *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide*, p. 6.*

<sup>ix</sup> *Definitions supported by the Interagency Working Group on SRH and HIV Linkages*.

<sup>x</sup> IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW & Young Positives (2009) *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide*.

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<sup>xii</sup> WHO, UNFPA, UNAIDS & IPPF (2005) *A framework for priority linkages*.

<sup>xiii</sup> Definition from IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW & Young Positives (2009) *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide*, p. 7.

<sup>xiv</sup> IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW & Young Positives (2009) *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide*.

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- <sup>lvii</sup> *World Health Organization research of 214 approved proposals to Rounds 1-7 identified that all but two included at least one element of SRH service. But the vast majority focused on 'traditional' areas (e.g., 25% on PMTCT, 25% on STI prevention, diagnosis, and treatment, and 25% on sexual health promotion). Few focused on 'less traditional' areas, such as gender-based violence.*
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