

A Practical Guide

to Integrating Reproductive Health and HIV/AIDS into Grant Proposals to the Global Fund

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Acronyms

ART	Antiretroviral Therapy	MTCT	Maternal to Child Transmission
ANC	Antenatal Care	OGAC	Office of the Global AIDS Coordinator, USA
BCC	Behavior Change Communication	PEP	Post-exposure Prophylaxis
CBHC	Community Based Home Care	PEPFAR	President's Emergency Program for AIDS Relief (USA)
CCM	Country Coordinating Committee	PLHIV	People living with HIV
CDC	Centers for Disease Control, USA	PMTCT	Prevention of Maternal to Child Transmission
CSO	Civil Society Organization	RH	Reproductive Health
DHS	Demographic Health Surveys	SRHS	Sexual and reproductive health services
FP	Family Planning	STI	Sexually Transmitted Infections
GF	Global Fund	STD	Sexually Transmitted Diseases
GFATM	Global Fund for AIDS, Tuberculosis and Malaria	SW	Sex Worker
HAART	Highly Active Antiretroviral Therapy	TB	Tuberculosis
HSS	Health Systems Strengthening	UNGASS	United Nations General Assembly Special Session
ICPD	International Conference on Population and Development	UNFPA	United Nations Fund for Population Activities
ICW	International Community of Women Living with HIV/AIDS	USAID	United States Agency for International Development
IDU	Intravenous Drug User or Intravenous Drug Use	VCT	Voluntary Counseling and Testing
IEC	Information, Education, Communication	WHO	World Health Organization
IPPF	International Planned Parenthood Federation		
IUD	Intrauterine Device		
MDG	Millennium Development Goals		
M & E	Monitoring and Evaluation		
MSM	Men who have sex with men		

chapter 1

Introduction

All outcomes must be designed to “mitigate the impact caused by HIV/AIDS, TB and malaria in countries in need” (Global Fund Framework, ND)

The 2006 Maputo Plan of Action, adopted by the African Union, calls for countries to “strengthen commitment to achieving universal access to reproductive health services, including family planning, and recognize and support the contribution of these services to HIV/AIDS prevention efforts.”

Starting in recent proposal rounds, The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) has stated more explicitly that countries can include reproductive health as part of their proposals on AIDS, tuberculosis and malaria, as long as a justification is provided on the impact of reproductive health (RH) on reducing one of the three diseases.¹ This document is for countries and organizations, including CCMs, government and nongovernmental organizations and civil society organizations, to help in integrating reproductive health, including family planning (RH) and HIV/AIDS in proposals submitted to the Global Fund. The document takes a country approach to integration since the Global Fund seeks to support proposals that build on and strengthen national programs.

Over the past several years, a number of international agencies have called for stronger links between reproductive health and family planning and HIV/AIDS programs and services, including the World Health Organization, UNFPA, UNAIDS, UNGASS, and the African Union.² Many organizations have issued guidance on linkages and integration, including WHO, UNFPA, IPPF, UNAIDS, and USAID.³ Numerous conferences and meetings have been dedicated to the topic of linkages and integration.⁴

Linking and integrating RH and HIV/AIDS increases people’s access to a range of information and services that affect HIV outcomes. This is particularly important for women and young people since women now account for nearly 60% of HIV infections in sub-Saharan Africa and young people aged 15 to 24 account for an estimated 45% of new HIV infections around the world.⁵ Furthermore, despite advances in treatment, nearly three individuals become infected with HIV for every

one person who begins antiretroviral treatment.⁶ To expand prevention efforts, reaching people at risk of HIV through all appropriate program entry points is critical, including RH programs.

Grounded in the research, programmatic and policy literature on linkages and integration, as well as successful country proposals that include integration, this document seeks to answer four main questions:

1. What is integration?ⁱ
2. Given a country’s context, what policies and programs could be linked and integrated?
3. What are the implementation challenges to integration to be aware of when writing a proposal?
4. How can integration be monitored and evaluated?

The document also provides the evidence that integration with RH can make a difference to HIV/AIDS outcomes. This evidence is critical given the Global Fund’s requirement that funding for integrated programs is contingent on their impact on HIV prevention, care and treatment outcomes.

This document provides references and links to many other resources available on various aspects of linkages and integration. It also provides examples from country programs and the integration components of successful Round 8 proposals.

i A note on terminology: While, this document addresses aspects of both linkages and integration of RH/HIV, we use the term integration more prominently in the discussion because the Global Fund uses that term broadly to include linkages.

chapter 2

What is Integration?

LINKAGES AND INTEGRATION

Linkages and integration of RH and HIV can take place at several levels and to various degrees within a health system. In addition, in order to address linkages and integration of RH and HIV, other sectors besides the health sector may need to be an area of focus. For example, in order to provide sexuality education for adolescents, the Ministry of Education and civil society groups working with out-of-school youth may be of critical importance, along with youth-friendly health services. Linkages involve addressing structural issues that leave people vulnerable whereas integration involves the reorganization and reorientation of policies, programs and services to ensure the delivery of a set of essential interventions as part of the continuum of care for HIV prevention, care and treatment that also meets the RH needs of clients (Box 2.1).

COMPONENTS TO LINK

Linking RH and HIV/AIDS policies, programmes and services can contribute to addressing wider structural issues that affect people's ability to prevent HIV transmission. For example, deep-seated structural issues such as gender inequality and poverty can lead to stigma and discrimination, gender-based violence, early marriage, and inability to negotiate condom use, among other intermediate outcomes, which affect the ability of women and men of all ages to protect themselves against HIV. As the Global Fund noted in 2008, "Harmful gender norms, including those that reinforce the submissive role of women, cross-generational sex, concurrent partnerships, and gender based violence are key drivers of the HIV/AIDS epidemic. Economic, educational, legal and political discrimination faced by women and girls contribute to their vulnerability."⁷ Existing laws which criminalize HIV transmission may prevent women living with HIV from safe delivery of their infants and men from testing for fear of criminal liability risks. Gender based violence or

Box 2.1

Linkages and Integration

Linkages: The policy, programmatic, services and advocacy synergies between sexual and reproductive health/family planning and HIV/AIDS

Integration: Various types of sexual and reproductive health/family planning and HIV/AIDS services or operational programmes that can be joined together to enhance outcomes.

Source: WHO, UNFPA

fear of violence, may prevent disclosure of HIV status.⁸ Addressing these structural and legal issues, which are included in the Global Fund's new Gender Strategy, are crucial for mitigating the impacts of HIV.

COMPONENTS OF RH TO INTEGRATE

The consensus reached at the International Conference on Population and Development in Cairo is the basis for calls for forging linkages and promoting integration of RH and HIV/AIDS. Reiterated through the Glion Call to Action, ICPD acknowledges "the rights of women to decide freely on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence, and the need to improve access to services so that couples and individuals can decide freely the number, spacing and timing of their children. In order to ensure that these rights are respected, policies, programmes and interventions must promote gender equality, and give priority to the poor and underserved populations."⁹

For purposes of integration, the UN Population Fund (UNFPA) lists three main areas of RH: contraceptive services, maternal health services and services related to sexually transmitted infections (STIs), including HIV/AIDS, and other gynecologic and urologic problems.¹⁰

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A LIFECYCLE APPROACH TO INTEGRATION

In addition to strengthening the enabling environment to address structural linkages, within the areas of intersection of RH and HIV/AIDS, taking a lifecycle approach, from youth to adulthood, the following information and services could contribute greatly to mitigating the impact of HIV/AIDS:

- **Educating young people** about sexuality and reproductive and disease outcomes and addressing gender norms that affect power and sexual relations.
- **Reducing all unintended pregnancies.**
- **Providing accurate information** regarding HIV and a range of health issues, including reproductive health outcomes.
- **Providing access to services at various entry points** that integrate HIV into RH and RH into HIV.
- **National policy linkage:** one policy governing both RH and HIV/AIDS or a special policy guiding integration that reinforces the linkages between RH and HIV/AIDS.
- **Sectoral and interministerial linkages:** clear guidelines linking the integration work of various sectors (e.g. education, agriculture, justice) and the work of various departments within ministries (e.g. departments of reproductive health, STD, HIV, etc.)
- **Subnational integration:** the extent to which administrative integration of programs occurs at the provincial, district and local levels (or relevant country equivalent).
- **Service integration:** the extent to which service delivery functions at the service delivery point would require modification of worker roles, allocation of time, referral requirements, etc. Programme integration at community level, including mobilization for RH and HIV and activities to bring about behavioral and social change.

FORMS OF INTEGRATION: ADMINISTRATIVE AND SERVICE

Integration can take many forms and is complementary with efforts to forge broader linkages among RH and HIV/AIDS to address structural issues. It is useful to think of integration as administrative and service integration. Administrative integration joins policy and program components together and service integration joins services at the point of contact with clients.¹¹

Clearly determining what type and level of integration to propose, and related policy and program challenges, is important for the success of integration in proposals and, equally importantly, in implementation. Levels of integration can include:

More details about administrative and service integration are provided in later sections.

chapter 3

What is the Evidence
that Integration
Affects Outcomes?

Integrating RH and HIV/AIDS increases people's access to a range of information and services that affect HIV outcomes. This is important particularly for women and young people since women now account for nearly 60% of HIV infections in sub-Saharan Africa and young people aged 15 to 24 account for an estimated 45% of new HIV infections around the world.¹²

Furthermore, despite advances in treatment, nearly three individuals become infected with HIV for every one person who begins antiretroviral treatment.¹³ To expand prevention efforts, reaching people at risk of HIV through all appropriate program entry points is critical, including RH. Appendix 1 presents compelling evidence that integration can make a difference to outcomes.

INTEGRATION CONTRIBUTES TO REDUCING MORTALITY FROM HIV AND AIDS

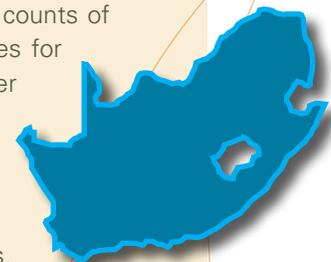
Timely access to Highly Active Antiretroviral Therapy (HAART) can increase life expectancy and quality of life for those living with HIV. For pregnant women living with HIV, "the single most significant intervention that could reduce mater-

nal mortality, infant HIV transmission rates and mortality, namely the timely initiation of antiretroviral therapy for life, remains largely underutilized. Neither costs nor the availability of drugs are the major limitations, but rather dysfunctional health service delivery."¹⁴

- By integrating HIV care into routine antenatal care, rather than as a separate program, women's lives can be saved. Through adequate training of providers in maternal health, antenatal care can fast-track women living with HIV who are diagnosed during antenatal care "into programmes providing holistic care, including treatment with HAART..."¹⁵
- Women with advanced HIV disease, as defined by high viral load, low CD4 count and AIDS, are at greatest risk of transmitting the virus during pregnancy and delivery and it is in this subset of pregnant women with advanced HIV disease in which HAART can have the greatest impact on reducing perinatal transmission. With combination antiretroviral therapy, perinatal HIV transmission can be decreased to less than 1%.¹⁶

Country Example: **Getting Women into HAART in South Africa**

In South Africa's Western Cape Province, pregnant women with CD4 positive counts of 200 or fewer cells are immediately referred to separate HIV treatment facilities for HAART initiation, contributing to a low rate of vertical transmission of HIV. Other options include receiving HAART through PMTCT or patient navigators. Late entry into care for adults is associated with poor outcomes (Abrams et al., 2007). Approximately 9% to 15% of pregnant women living with HIV have CD4 counts under 200 cells/ml and should receive HAART. "In spite of this striking relationship and opportunity to improve maternal and child health outcomes, neither HIV staging nor HIV morbidity data are commonly recorded in antenatal records" (Rollins and Mphatswe, 2008: 182).



***Family planning “tends to be the best-kept secret in HIV prevention”
(Ward Cates, President, Family Health International)¹⁷***

Example: Access to Contraception Contributes to PMTCT

One model demonstrated that, for the same level of expenditure, increasing contraceptive use among women who are not currently using it and who do not want to get pregnant through voluntary family planning services and outreach will avert almost 30 percent more HIV-positive births than HIV counseling and testing coupled with nevirapine prophylaxis.

Source: Wilcher et al., 2008

Country Example: FP in ART in Uganda

A recent study in Uganda found that following introduction of family planning, the number of ART clients accessing family planning showed a threefold increase. Many clients noted that ART services had improved with the introduction of family planning.

Source: Searing et al., 2008



INTEGRATION CONTRIBUTES TO REDUCING UNINTENDED PREGNANCY AND PERINATAL TRANSMISSION

Much attention is given to preventing HIV in infants once pregnant women know they are HIV+, through promotion of testing and counseling and treatment of infants during birth. These efforts have resulted in significant reduction of “mother to child” transmission of HIV. Yet, there is another intervention that could have an enormous impact on reducing perinatal transmission. Unintended pregnancies account for 14 to 58 percent of all births in countries where the burden of HIV is the greatest,¹⁸ and some studies suggest that rates of unintended pregnancy are higher among women living with HIV.¹⁹

- Ensuring that women have the means to avoid unintended pregnancy, through access to contraception is an effective – and underutilized – intervention in reducing perinatal HIV transmission.^{20,21} In fact, reducing unintended pregnancies is one of the four pillars of the World Health Organization’s Prevention of Mother to Child Transmission

(PMTCT) strategy, yet it has not received the attention given to the other pillars.²²

- Given that rates of testing in many countries are low, expanding access to contraception is critical. Women of childbearing age account for nearly half of those infected with HIV, and most do not know their HIV status.²³ Therefore, contraception to prevent all unintended pregnancies will also reduce unintended pregnancies in HIV-infected women (who do not know that they are HIV-positive) can have a major impact on reducing HIV-positive births and by extension, the number of AIDS orphans.²⁴
- The cost of reducing perinatal transmission would go down with the inclusion of family planning in HIV programs.^{25,26}
- Clients of HIV treatment programs welcome access to contraception.²⁷ Most women living with HIV are sexually active²⁸ and need access to contraception and comprehensive RH care. Providing these services will have a significant impact on HIV outcomes and mitigating the effects of HIV/AIDS.

INTEGRATED SERVICES CAN CONTRIBUTE TO MORE PEOPLE GETTING TESTED FOR HIV

Access to testing needs to be greatly expanded to increase the number of people who know their status. For many women globally, VCT is accessed through antenatal care or at delivery. Access to VCT through other venues than through maternal health services will increase the numbers of female adolescents and women who can access VCT.²⁹ Also, due to the need for confidentiality when women are tested alone, VCT for men and couples can be promoted through integration by providing VCT in a number of settings—such as STI clinics, workplaces, etc.—that can reach men as well as women.

A case study of integration at the NGO Family Health Options Kenya, found that providing services for HIV/AIDS at sexual and reproductive health clinics attracts new clients including VCT for a target group not traditionally reached by VCT services. A recent systematic review found that the majority of studies reviewed on RH and HIV

integration reported an increase or improvement in behaviors linked with HIV, namely increased condom use, and increased uptake of HIV testing.³⁰ For example, improving access to nonbarrier contraceptives among couples already using condoms for HIV prevention increased dual method use in a study of couples at a VCT clinic in Lusaka, Zambia.³¹ Integrating family planning into VCT services and VCT into FP is acceptable to both providers and clients and does not appear to affect the quality of service.³²

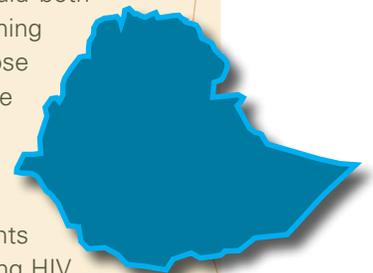
INTEGRATED SERVICES CAN EXPAND THE REACH OF PROGRAMS AND SERVICES TO MORE TARGET GROUPS

Young people are best reached through integrated programs. Young people tend to be more motivated to use condoms to prevent unintended pregnancy than HIV, so programs that focus on both can increase condom use.^{33 34} Condom use—whether motivated by pregnancy prevention or HIV prevention—will both reduce unintended pregnancy and reduce HIV transmission and acquisition.

Country Example: FGAE in Ethiopia

A study of VCT records at the Family Guidance Association of Ethiopia (FGAE) of clients attending reproductive health clinics found that those clients whose counselors could both provide VCT and family planning counseling or where both VCT and family planning were provided in the same room were more likely to initiate HIV testing than those attending facilities where HIV and family planning services were simply in the same facility. The odds of self-initiated testing was four times greater for men and more than seven times higher for women in sites with services provided in the same room or by the same provider, compared to co-located services. Facilities with larger new family planning loads raise the likelihood of female clients self-initiating VCT services. Older married women in the study had an astounding HIV prevalence rate of 34 percent. This is a group that is not typically targeted for VCT and yet has extensive unmet need for HIV care and services. While the Government of Ethiopia's HIV policy is supportive of HIV and reproductive health services integration, these services remain predominantly vertical in terms of program administration, funding and service delivery.

Source: Bradley et al., 2008





Country Example: **Increasing Contraceptive Use Among HIV-positive Women Through VCT**

A recent study of women in Malawi presenting for VCT found that following receipt of their HIV-positive test results, contraceptive use increased from 38% before VCT to 52% one week later. Women who were HIV-positive and not pregnant were provided HIV care and access to family planning services. During a year-long follow up, at each visit women were asked, "Would you like to have another child, or would you not like to have any more children?" With knowledge of their HIV-positive status, women were less likely to desire future pregnancies and the incidence of pregnancy was lower among women not desiring future children. These HIV-positive women were practicing family planning to avoid unintended pregnancies.

Source: Hoffman et al., 2008.

Young women who first attend health services, either for family planning, maternal health, sexual violence or VCT need integrated services so that their multiple needs can be met. A study of FP and HIV/AIDS integration found that women obtaining VCT in Ethiopia, Kenya, Rwanda, South Africa and Uganda were young with limited knowledge about family planning. If this is their first point of entry into a health system, these young women need accurate information on contraceptive options. Evidence has been available for over a decade that in countries with strong youth-friendly sexual and reproductive health services, the incidences of youth pregnancy, abortion and STIs are consistently much lower than in countries where these services are not available.³⁵

Adolescent orphans and vulnerable children are in special need of access to RH services. A study in South Africa found that female and male adolescent orphans ages 14 to 18 were significantly more likely than non-orphans to have been sexually active, and at younger ages.³⁶ A study in Zimbabwe also found that female orphans aged 15 to 18 had a higher incidence of HIV infections than their non-orphan peers.³⁷

Community Based Home Care (CBHC) programs can also incorporate integrated services to reach clients, family members and providers. A study

in Kenya found that a significant percentage of clients, as well as caregivers in HIV/AIDS home based care programs had an unmet need for family planning; some desired more children. Almost half of both groups had sex during the previous six months.³⁸

Reaching women in need of abortion and post-abortion care can also expand the reach of programs and services to more target groups. A study of 706 women in Tanzania who accessed post-abortion care were offered counseling both about contraception and HIV and STIs, with over half agreeing to VCT.³⁹

Since globally much of the HIV testing for women takes place during pregnancy, maternal health services need to be linked with HIV services so that women who test HIV-positive can be followed up post-partum for HIV treatment and care.⁴⁰

Studies found that in some countries women living with HIV were not given any information about the interaction between contraceptives and their antiretroviral medications.⁴¹ In some countries, women who are already aware of their HIV positive serostatus who present for maternal health services are heavily stigmatized.⁴² Women living with HIV need to have RH services that meet their needs. A recent study found that 40 of 230

Adolescent orphans and vulnerable children are in special need of access to RH services.

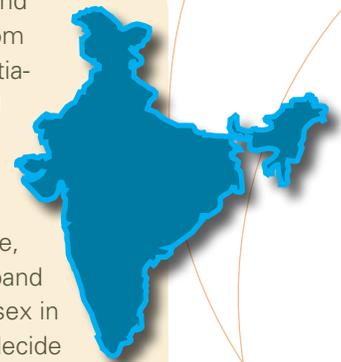
HIV positive women in Namibia had been sterilized against their will and without their consent in government health services, despite guidelines issued by the Ministry of Health to guarantee the protection of human rights of people living with HIV. HIV positive women in Namibia noted that fear of forced or coerced sterilization prevents them from seeking health services.⁴³ " In addi-

Mapping of 1,545 sex workers, youth and people living with HIV found that operational guidelines on the sexual and reproductive health need to be developed and that both providers and people living with HIV had insufficient knowledge of the sexual and reproductive health issues of people living with HIV. People living with HIV wanted to access family planning and STI services at ART

Country Example: **Key Role of CSOs in HIV and SRH Outcomes**

A project by HIV/AIDS Alliance, India, consisting of increased awareness of RH and HIV, including contraception, pregnancy and antiretroviral therapy; teaching of condom negotiation skills; awareness of laws and rights; strengthening leadership and negotiation skills of women; a resources directory of all services for HIV, VCT, pregnancy and other RH services; and outreach via peer educators and outreach workers led to notable results. While a survey of 2,284 women in five sites in India had a baseline of 86% of women knowing that there are methods to avoid HIV. After one year of the intervention, 96% of women knew that there are methods to avoid HIV. At baseline, 54% of women stated that women are justified to refuse to have sex with their husband if he has an STI. After one year of the project, 74% agreed that women can refuse sex in this circumstance. After one year of the program, 71% of women said they jointly decide their contraceptive needs with their husband.

Source: International HIV/AIDS Alliance in India, 2007.



tion, "the continued widespread use of single-does nevirapine despite WHO's recommendation to employ more effective combination therapies that do not potentially jeopardize women's future treatment outcomes."⁴⁴

In addition, key populations who are most at risk for HIV acquisition, such as sex workers, often do not access government reproductive health services despite great need. A 2008 study of 522 female sex workers in four states of India found that sex workers wanted to access VCT, maternal health, STI, abortion, family planning and sexual and reproductive health services from mainstream facilities, but were deterred by stigmatizing behavior from providers.⁴⁵ Sex workers often pay extra for services which should be available free of charge through government facilities.⁴⁶

centers.⁴⁷ Community outreach by civil society groups with reproductive health information and services expands the reach of programs and services to those who need it most. A recent study found that while HIV prevalence is highest in key populations, such as sex workers, the Global Fund's 2006 360 Stakeholder Evaluation found that addressing the needs of vulnerable and marginalized populations remains one of the Global Fund's biggest challenges.⁴⁸ Lack of knowledge among health care providers about the specific sexual health needs of sex workers means that the care they do receive is often inappropriate and fragmented.⁴⁹

INTEGRATED SERVICES CAN REDUCE STIGMA AND DISCRIMINATION AND INCREASE ACCESS TO AND USE OF SERVICES

Integrating HIV services into RH/FP services can provide a less stigmatizing way for women to access HIV services than going to a dedicated VCT center or a dedicated HIV care and support center. Numerous interviews with people living with HIV found that when HIV services are in a separate facility, those people seen entering and leaving are then known to be HIV positive and then report stigma and discrimination.⁵⁰ A 2008 study of 522 female sex workers in four states of India found that sex workers wanted to access VCT, maternal health, STI, abortion, family planning and sexual and reproductive health services from mainstream facilities, but were deterred by stigmatizing behavior from providers.⁵¹ Likewise, providing women and men with access to RH in HIV/AIDS settings can reduce the stigma and discrimination they might face revealing their status to RH staff. At the same time, training is needed for RH providers, both for additional relevant knowledge and to reduce stigma and discrimination in providing RH services for people living with HIV.

ADDRESSING GENDER-BASED VIOLENCE REDUCES RISK FOR HIV

Addressing factors that increase vulnerability, considered a linkage issue, is part of a global strategy to improve reproductive health and HIV outcomes. Violence is a risk factor for HIV.⁵² Forced sex by a person living with HIV increases the risk of HIV acquisition. Women whose partners are violent are less likely to be able to negotiate condom use. The Global Fund specifically supports proposals which prevent or mitigate sexual violence, including advocacy for legal change and enforcement.

Studies around the world have shown high rates of violence and rape,⁵³ and violence during pregnancy is not uncommon.⁵⁴ Post exposure prophylaxis (PEP), if started within 72 hours after rape, can reduce the likelihood that women will acquire HIV. Women who are raped need to know about post exposure prophylaxis, emergency contraception and, where legal, abortion. A study in South Africa showed that integration of pregnancy testing, emergency contraception, STI treatment, VCT and PEP in a rural district hospital led to patients being more likely to have completed

Country Example: Dominican Republic



Clínica Evangelina Rodríguez of the NGO Profamilia in Santo Domingo, Dominican Republic, provides a range of services, including family planning, VCT, echocardiograms, PEP, and HIV treatment and care. Anyone in the waiting room could be there for a number of different health problems, rather than just for HIV services. In a country where HIV is still highly stigmatized, HIV patients appreciate the opportunity to get high quality family planning and HIV services without being open about their sero-status to anyone they might know in the waiting room. In addition, universal precautions are practiced, with staff having all the necessary equipment. Training to combat stigma and discrimination against people living with HIV is mandatory and ongoing, with documented firing for breaches where staff have discriminated against patients living with HIV. Treatment and care for patients with HIV was integrated into reproductive health services, resulting in increased CD4 counts at six months for 32 of 35 patients and HAART for 72 pregnant women living with HIV.

Source: Mir et al., 2006; Mir et al., 2008.

the full 28 day regimen and improved services for all the aspects of reproductive health. There was a reduction from 28 hours to 18 hours between the assault and receiving the first dose of PEP, with service utilization increasing.⁵⁵ Availability of PEP and trained providers are often deciding factors for women when seeking services following rape.⁵⁶

Sexuality education that addresses the unacceptability of gender based violence, such as the African Youth Alliance (AYA) curriculum adopted by Ghana in its successful Round 8 AIDS proposal, can address gender norms which sanction violence. An evaluation of the broader AYA program found a significant positive impact of AYA on a number of variables, including condom use, contraceptive use, and partner reduction.⁵⁷

The role of gender norms in promoting gender-based violence and fueling the AIDS pandemic is increasingly clear.⁵⁸ “There is growing evidence that HIV/STI and violence risk for both young men and young women is linked to early socialization that promotes certain gender roles as the norm. These norms include support for men to have multiple partners, or to maintain control over the behavior of their female partners.”⁵⁹ Participants in a study in Botswana who held three or more gender discriminatory beliefs had 2.7 times the odds of having unprotected sex in the past year with a non-primary partner as those who held fewer gender discriminatory beliefs.⁶⁰ Addressing gender norms that affect sexual relations is showing strong results around the world, particularly peer-based programs that work with young men.⁶¹

A NOTE ON STI AND HIV

While increased prevalence of STIs has a clear correlation with increased risk for HIV⁶² and treating STIs are important for reproductive health, how treatment of STIs impacts HIV outcomes is still unknown.⁶³ Additional research is underway.



chapter 4

Given a Country's Context,
What Policies And Programs
Could be Linked and
Integrated?

“A one size fits all approach to FP/HIV linkages and service integration does not exist” (FP/HIV Integration Technical Working Group, 2008)

Decision-making processes concerning integration and what kind of integration to propose will depend on the epidemiology of HIV and other reproductive health indicators in the country. Different levels of integration may be appropriate for different health care facilities, depending on available resources, capacity and facility set-up.

At the same time the Global Fund is extending support for RH and HIV/AIDS integration, it has also produced a gender strategy that relates to linkages by encouraging countries to strengthen attention to addressing gender inequalities in their programs.⁶⁴ Through the gender strategy, the Global Fund supports “programs that ensure equal and equitable access to prevention, treatment, care and support for the most vulnerable populations, including women and girls...”⁶⁵ Integration of RH and HIV/AIDS programs and addressing structural linkages are closely related to the gender strategy. For example, the gender strategy calls for targeting the structural issues that increase the vulnerability of women, girls... including socio-cultural, legal, political and economic inequalities and discrimination.”⁶⁶

**TYPES OF LINKAGES AND INTEGRATION:
RH→HIV AND HIV→RH**

Integration can be bi-directional with RH integrated with HIV/AIDS and HIV/AIDS integrated with RH. In the past few years, a number of relevant frameworks and guides have been produced that are useful references when developing integrated programs and promoting linkages. These frameworks and guides are shown in Box 4.2. While a minimum level of integration or linkages between family planning and HIV/AIDS have been delineated (see Figure 4.1), this has not been done yet for other areas of RH, such as sexuality education and providing information and services, although suggestions on what could be integrated exist,

**Box 4.1
Guidelines Related to Integration**

In terms of integrating reproductive health and HIV, Global Fund guidelines for Round 9 note support for:

- “Activities to reduce girls’ and women’s vulnerability to the three diseases, such as... prevention and mitigation of sexual violence and advocacy for legal change and enforcement;” and
- “Interventions related to interactions between the three diseases, including providing access to prevention services through integrated health services, especially for women and adolescents through reproductive health care.”

Source: WHO, UNFPA,

e.g. in the *Guidelines for Integrating Sexual and Reproductive Health into the HIV/AIDS Component Country Coordinated Proposals to be Submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria*.

While integration may be vital in some settings, not all country proposals may be appropriate for integration. Integration is not advisable if decentralization leads to competition with other priorities. Integration of RH with other services that are fundamentally weak may weaken all services.⁶⁷ In addition, the integration of HIV services into a RH program may not be appropriate at a national level if an epidemic is concentrated or low-level. In this scenario, the majority of RH clients may not be at risk of HIV or in need of HIV-related services and therefore, targeted HIV programming would have more impact.⁶⁸ However, it is critical for key populations, such as sex workers, to have access to comprehensive reproductive health services.

Box 4.2**Major Linkages and Integration Frameworks and Guides**

Sexual and Reproductive Health & HIV/AIDS: A Framework for Priority Linkages, developed by WHO, UNFPA, UNAIDS, and IPPF in 2005 “proposes a set of key policy and programme actions to strengthen linkages between SRH and HIV/AIDS programmes.” The framework highlights four priority areas at the intersection of SRH and HIV/AIDS, namely: learn HIV status; promote safer sex; optimize connection between HIV/AIDS and STI services; and integrate HIV/AIDS with maternal and infant health. This framework is accompanied by a systematic review of evidence, an assessment tool and country case studies.

In 2007, a consortium compiled Guidelines for Integrating Sexual and Reproductive Health into the HIV/AIDS Component Country Coordinated Proposals to be Submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria. These guidelines list possibilities for integration of SRH and HIV/AIDS through VCT, PMTCT, ART, adolescent programs, programs for vulnerable populations (injecting drug users, sex workers, men who have sex with men, and people living with HIV), programs to address gender-based violence, and strategies for health and community system strengthening. For each of

these components, the guidelines highlight the need to scale up what works related to training, services, supplies, advocacy, capacity building, monitoring and evaluation. The guidelines were updated for Rounds 8 and 9 in early 2008.

In 2007, the USAID-funded Acquire Project published a framework for integrating family planning and HIV/AIDS treatment services, titled Family-Planning Integrated HIV Services: A Framework for Integrating Family Planning and Antiretroviral Therapy Services. The framework provides a list of possible family planning services that can be integrated into five levels of HIV services.

A multiagency FP/HIV Integration Working Group, supported primarily by USAID, is developing Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs and Services (FP/HIV Interagency Technical Working Group, 2008). This document describes the benefits and challenges of different types of integration, provides examples of integration of FP into HIV and HIV into FP services. Evidence from programs worldwide suggests that integration of FP and HIV should include at least a minimum level of services.

Sex workers and other key populations are less likely to access government health services as they experience stigma and discrimination.⁶⁹ The Global Fund will “champion and fund...activities that...focus on women who face challenges in being able to access health services...such as sex workers.”⁷⁰

KNOWING YOUR HIV/AIDS EPIDEMIC AND THE COUNTRY'S REPRODUCTIVE HEALTH CONTEXT

HIV proposals to the Global Fund need to be based on a clear understanding of the epidemiology of HIV in the country, what UNAIDS has termed, *Know Your Epidemic*.⁷¹ For proposals that include integration with RH, it will also be important to know the country's reproductive health context – including policies, programs, and output and outcome data.

Figure 4.1 Minimum Level SRH/FP and HIV/AIDS Integration

FP → HIV

Screen for unintended pregnancy

Counsel on:

- ▶ Dual protection/condom use

Offer referrals for:

- ▶ Clients at risk for unintended pregnancy, refer to FP services
- ▶ Clients desiring pregnancy, refer to FP services for information on healthy timing and spacing of pregnancy
- ▶ HIV+ clients desiring pregnancy, refer to PMTCT services for counseling on safe pregnancy and to reduce MTCT

HIV → FP

Counsel on:

- ▶ HIV/STI transmission and prevention and testing
- ▶ Reproductive choices and contraceptive options for HIV+ clients
- ▶ Dual protection and promotion of condom use
- ▶ Information on healthy timing and spacing of pregnancy

Screen for risk of HIV/STI

Offer referrals for:

- ▶ VCT for clients at risk of HIV
- ▶ Care and treatment for HIV+ clients
- ▶ Importance of PMTCT for all clients who want to get pregnant
- ▶ Syndromic management for clients suspected of having another STI

Source: Adapted from Wilcher and Askew, 2008.

The Global Fund requires countries to provide some of these epidemiological data. To plan for RH and HIV/AIDS integration, it will be important to have a wider range of data to understand the reproductive health context:

- What is the total fertility rate – that is, how many children do women have?
- What is contraceptive prevalence?
- What is the rate of unmet need for family planning?
- What percentage of pregnancies are unintended?
- What percentage of pregnancies to HIV-positive women are unintended?
- What percentage of women have experienced violence from their intimate partners?
- What percentage of pregnant women receive antenatal care?
- What percentage of births are delivered in medical facilities?
- Which key populations are at risk for HIV? What are the HIV prevalence and incidence rates among various key populations? What are the main drivers of the HIV epidemic for specific populations?
- Median age of first sex, marriage and first pregnancy.
- STIsⁱⁱ

ii Research is still ongoing to assess which STIs and treatment for STIs might impact HIV transmission and acquisition; however it is important to address STIs as part of comprehensive RH.

Integration of RH and HIV/AIDS programs and addressing structural linkages are closely related to the gender strategy.

Additionally, in considering linking integrating programs, it will be important to assess the availability of RH health services:

- Do adolescents have access to comprehensive skills-based sexuality education, knowledge and methods to reduce their HIV risk and unintended pregnancies and if HIV-positive, services that meet their needs?
- Do women living with HIV have access to contraception? Do women living with HIV have access to accurate information on their contraceptive options, emergency contraception and access to safe abortion care or post-abortion care?⁷² Do women of unknown serostatus have access to contraception? Are women provided information and services promoting dual method use (both condoms and contraception?)
- Do women have access to antenatal care? Skilled birth at delivery? Post-partum family planning? Do these services provide voluntary counseling and testing? PMTCT services? Access to HAART for women?
- Do key populations, such as sex workers and marginalized women have access to VCT, contraception, information on prevention of perinatal transmission and access to HAART?
- Do men who have sex with men have access to screening and treatment for sexually transmitted infections, as well as VCT, condoms and HAART?
- What proportion of maternal mortality is due to unsafe abortion? Do women leave abortion services or post-abortion care having had family planning counseling and referrals or provision of VCT with links to HIV treatment and care?
- How are men reached by RH/HIV prevention and services? How are couples reached?

Good sources of RH and gender-related data:

- The National Statistical Office of the country
- Measure Demographic and Health Surveys by country –
 - Main country survey: <http://www.measuredhs.com/countries/>
 - Service Availability Module: Service Provision Assessments: <http://www.measuredhs.com/aboutsurveys/spa.cfm>
 - Domestic Violence Module: http://www.measuredhs.com/topics/gender/archives/dv_publications.cfm
- Relevant country studies (e.g. operations and programmatic research and program evaluations)
- Country studies on policies, law and rights.
- *Identifying What Works: Evidence on HIV and AIDS Interventions for Women and Girls*. New York: Open Society Institute. [Forthcoming on www.osi.org].
- WHO Multi-country Study on Women's Health and Domestic Violence against Women Country Fact Sheets http://www.who.int/gender/violence/who_multicountry_study/fact_sheets/en/index.html
- Women Stats Project <http://www.womanstats.org> for information on domestic violence, sexual assault and rape
- Information generated by the participation of communities and key populations in assessment.

Following are illustrative examples of countries with varying HIV prevalence and fertility rates. These case studies are based on mixes of actual country experience. For these country case studies, the country names are not given since no illustrative country case study represents a single country. References that were used in developing the country case studies are included in the reference section.

Illustrative Country Example: **High HIV Prevalence, Medium Fertility**

This country has an HIV prevalence rate of 15 to 30 percent. Concurrent partnerships, particularly by men, but also by women, both within and outside of marriage are common and widely accepted, including in government-sponsored AIDS campaigns. Treatment has been rolled out, but there is little condom distribution, stigma against women living with HIV who become pregnant, and no private confidential VCT for youth under the age of 21. Access to contraception is inadequate and fewer than half (55%) of women use any method of contraception. Women in this country have an average of three children in their lifetime. For a country with these characteristics, integration might include the following:

- Provide comprehensive sexuality and life skills education with on-site school clinics or nearby youth friendly clinics that provide groups sessions on comprehensive sexuality education, including abstinence and partner reduction; peer education; contraceptive options; VCT; and male and female condom distribution.
- Provide voluntary contraceptive options as well as dual method promotion with either male or female condoms in VCT centers; reaching women before they get pregnant to reduce unintended pregnancy; through prenatal care and PMTCT programs; through HIV treatment and care programs.
- Expand access to family planning and in family planning clinics and youth friendly centers, provide VCT as well as contraceptive options, with links to HIV treatment and care for those who test HIV positive.
- Increase availability of condoms and oral contraceptives through community based promotion and distribution.
- Provide women living with HIV who do not want to become pregnant with counseling concerning the interaction between various contraceptive options and antiretrovirals and nonjudgmental counseling regarding sexual activity.
- Provide women living with HIV who want to become pregnant information on the safest ways to reduce perinatal transmission.
- Ensure that providers receive ongoing training in HIV and RH/FP, including contraceptive options for HIV-positive women and to counsel nonjudgementally concerning sexual activity.
- Behavior change communications strategies to increase knowledge on the risks of multiple concurrent partnerships and how to reduce these risks through condom use, VCT and fewer partners.
- Address policies on age of confidential VCT without parental consent.

* "Prevention programmes should aim to reduce the occurrence of multiple sexual partnerships, whether or not they are concurrent, and to communicate the likely additional risk of concurrent relationships – including those that are long term and socially accepted. In the countries in sub-Saharan Africa where HIV prevalence is extremely high, the probability that one's sexual partner is infected with HIV is around one in four to six, making it extremely risky to have unprotected sex with anyone whose HIV status is unknown" (UNAIDS, 2008: 45; Cassels et al, 2008 cited in UNAIDS, 2008:119).

Illustrative Country Example: **Low HIV Prevalence, High Fertility**

This country has an HIV prevalence of under two percent, with transmission occurring largely through heterosexual sex. However, prevalence is uneven with some areas registering prevalence of 20 percent. Women have an average of five children, which is two more than they say they would like to have. Fewer than one in five women are using contraception and there is an unmet need for family planning of 35 percent. The data do not assess the ideal number of children that men would like to have. Abortion, recently legalized, remains unsafe and delinked with postabortion care that includes access to contraception. An estimated one-third of maternal mortality is due to unsafe abortion, and abortion accounts for more than half of gynecological admissions.

Only one in three women receiving abortion services leave with a contraceptive method. Furthermore, despite higher HIV prevalence in ANC sites (one study found rates over 10% in urban ANC sites and 3% in rural ANC sites), little family planning is done in PMTCT programs to reduce the number of unintended pregnancies and thus perinatal transmission. The low status of women exacerbates the impact of HIV/AIDS. Nearly three-quarters of the women have experienced some form of sexual violence, and nearly one in five said their first experience of sexual intercourse was forced. In this context, integration might include:

- Expand access to contraception to reduce unintended pregnancy. Provide voluntary contraceptive options as well as dual method promotion with either male or female condoms in VCT centers; through PMTCT; through prenatal and antenatal care; through HIV treatment and care programs.
- Expand access to family planning and in clinics and youth friendly centers, provide VCT as well as contraceptive options, with links to HIV treatment and care for those who test HIV positive.
- For all abortion services, provide contraceptive counseling, provision of dual methods, PEP in cases of rape, and referral to VCT. Create safe abortion services, through pre-service and in-service training; optimal equipment; and counseling.
- Provide PEP and emergency contraception in case of rape.
- Address the status of women through legal reform and BCC to make violence against women unacceptable.
- Community mobilization and interactive learning activities for boys and girls as well as men and women to foster gender equity.

Illustrative Country Example: **Meeting the Needs of MSM and Sex Workers**

This country has two populations with behavior that places them at high risk for HIV: MSM, who do not have female partners and do not engage in sex work, but who often do not use condoms consistently and mostly female sex workers (SWs). Abortion is illegal but post-abortion care is readily available. Female sex workers want to access VCT, maternal health, STI, post-abortion care, family planning and sexual and reproductive health services from mainstream facilities, but are deterred by stigmatizing behavior from providers. In this context, integration might include:

- Civil society and community organizations can conduct outreach to sex workers and MSM through peer education concerning reproductive health and HIV, with information on non-stigmatizing services.
- On-site mobile clinics at hotels frequented by sex workers, voluntary comprehensive sexual and reproductive health services for sex workers that include voluntary family planning; voluntary STI screening; legal referral for rape and violence; services for rape and violence including post-exposure prophylaxis; information and linkages to PMTCT services, including for sex workers who are living with HIV. By creating on site services which meet the needs of SWs, SWs will be able to access services which welcome them and where they do not feel stigmatized.
- In post-abortion care services, where women are having unintended pregnancies, offer joint VCT for women and their partners; VCT for women alone; contraceptive options; and linkages to HIV treatment and care for those who test HIV positive.
- For MSM, offer access to STI services, condom counseling and community sensitization programs to reduce stigma and discrimination.

KNOWING YOUR NATIONAL POLICIES AND PROGRAM STRUCTURE FOR HIV AND REPRODUCTIVE HEALTH

The Global Fund supports proposals which: “Build on, complement, and coordinate with existing regional and national programs in support of national policies, priorities and partnerships.”⁷³

Policies and programs are generally separate for HIV/AIDS, family planning and maternal health. A 2004 analysis of family planning content in the HIV, VCT and PMTCT policies of 16 developing countries found that only half included at least some mention of family planning in their national HIV/AIDS policies.⁷⁴

Country examples show how existing vertical program structures can inhibit integration and what countries can do to promote needed integration:

Some countries are taking steps to promote integration of relevant program structures. While the Government of Ethiopia’s HIV policy is supportive of HIV and reproductive health services integration, these services remain predominantly vertical in terms of program administration, funding and service delivery.⁷⁵ In the proposal that was successful in Round 7, the Government of Ethiopia proposed: “Accelerating the integration of PMTCT services with maternal and child health care and family planning services,” and training over 2,000 staff working in MCH in PMTCT, targeting all

Illustrative Country Example: **Addressing Gender-based Violence**

In this country, a population-based survey found that 50 percent of women in the capital city have experienced violence, with marital rape, while not considered a crime, reported frequently. Women in sero-discordant couples who need to access post-exposure prophylaxis (PEP) or abortion due to marital rape do not qualify for PEP or legal abortion services since marital rape does not “exist” in the legal framework. CSOs in the country provide comprehensive care for survivors of rape, included STI/HIV and post-exposure prophylaxis; emergency contraception; counseling; and forensic medical services. Services outside of the capital city are largely unavailable. Most women consider violence a normal part of life. Women often do not disclose their HIV-positive serostatus to their partners for fear of violence. Abortion is illegal except in case of rape, but no safe legal abortion services are available. Women do not access STI services. In addition, a 2006 study found high rates of violence against women in PMTCT programs, particularly among those women who tested HIV-positive.*

This country could consider a program that includes:

- Conduct a public campaign to make violence unacceptable in all circumstances, as well as increasing awareness that there is no consensual sex for anyone under the age of consent;
- Implement a policy forum to change the law to allow victims of marital rape to access PEP;
- Provide services for rape, including PEP nationally;
- VCT, links to HIV services, STI screening and treatment through antenatal care, PMTCT and family planning to make services less stigmatizing for women;
- Outreach programs to women and men to reduce the acceptability of violence with information on the health risks of both violence and HIV for men, as well as women;
- Link PMTCT programs with services for survivors of rape;
- Economic options to allow women living with violence to leave their partners; and
- Train the judicial sector and the police, as well as for health providers, along with public campaigns to increase the knowledge for women of their legal rights in case of rape and to increase the likelihood that women will seek assistance in case of rape;
- Community mobilization to improve communication and relationship skills between couples to reduce violence;
- Couples counseling with the permission of the woman first to reduce stigma of testing HIV positive.

Country Example: Integration of HIV and RH in Kenya

From Policy to Practice

The government and civil society of Kenya came together in the late 1990s with the epidemiological data showing that many women of reproductive age were living with HIV, were suffering from gender based violence, had significant numbers of unwanted pregnancies, and had fairly high rates of antenatal care. Women living with HIV often wanted information on the best timing and safest way to carry a pregnancy to term and have a healthy baby who was HIV negative. National policies had separate policies for family planning, maternal health and HIV. Yet significant numbers of pregnant women were living with HIV and significant numbers of women living with HIV wanted information and contraceptive services to meet their needs. Changing national policy was critical to rolling out integrated programs to impact HIV outcomes.

Kenya created a Committee consisting of Ministry of Health officials charged with family planning, HIV, maternal health, and gender based violence to come together in regular meetings to develop an integrated policy. Civil society organizations, particularly women's groups with expertise on these topics were also an integral part of the Committee's work. A small budget was allocated for the Committee's work, to cover travel stipends for the participation of civil society groups. Within two years, a new policy was put in place, "Strategy for the Integration of Family Planning and HIV Voluntary Counseling and Services." The revised policy provided one framework for HIV, maternal health, gender based violence, family planning and other reproductive health needs. The Kenyan government issued revised norms and guidelines (Ayisi et al., 2008). Table 1 shows what RH/FP and HIV/AIDS services have been integrated.

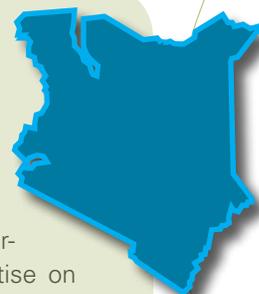


Table 1. Kenya Model for HIV and RH Integration: What is being Integrated?

HIV/AIDS SERVICES			SRH SERVICES		
VCT	+	FP, ART, BCC, STI, condoms	FP	+	VCT, ART, BCC, STI, condoms
PMTCT	+	FP, ART, BCC, STI, condoms	ANC	+	PMTCT, ART, BCC, FP, STI, TB screening, condoms
ART	+	BCC, STI, FP, condoms	Delivery	+	STI, PMTCT...
BCC	+	FP, STI, VCT, condoms	Post-partum	+	VCT, ART, BCC, FP, STI, condoms
Note: VCT – voluntary counseling and testing FP – family planning PMTCT – preventing mother to child transmission ANC – antenatal care ART – antiretroviral therapy PAC – postabortion care BCC – behaviour change communication STI – sexually transmitted infection			PAC/Abortion	+	VCT, ART, BCC, FP, STI, condoms
			Post-rape	+	VCT, CT/PEP, ART, BCC, EC, condoms
			STI	+	Condoms
			Cervical cancer screening	+	VCT, BCC, FP, condoms

Source: Ayisi et al., 2008.

(continued) Country Example: **Integration of HIV and RH in Kenya**

A study of integration in Kenya in 2007 found that progress has been made and offered a number of action steps related to existing operational barriers to integration. These recommendations offer a useful guide to other countries planning for integration:

- Develop a clear national policy; strategy; and operational, service and supervision guidelines to support integration efforts
- Strengthen the ITWG (Interagency Technical Working Group), giving it more authority and a budget to oversee the integration process
- Strengthen the Kenyan Medical Supplies Agency (KEMSA) to provide efficient logistical support and commodities security
- Increase the number of service providers and sensitize and build the capacity of new and existing staff and senior managers and stakeholders
- Renovate and organize existing health service structures
- Conduct public education campaigns to inform community members of the availability of integrated services.

women of child-bearing age, all pregnant women, and their male partners and families. Nursing outreach workers are supposed to reach pregnant women in rural areas, however, provision of family planning was not included in the proposal.

In January 2008, Nigeria developed a policy guiding the integration of RH and HIV/AIDS services. In developing the policy, the Federal Ministry of Health noted that unmet need for contraception was 17 percent and HIV sero-prevalence was 4.4 percent. Contraceptive prevalence of modern effective methods was eight percent. Only 33 percent of pregnant women deliver with skilled care. The rationale for integration noted by the Ministry is that: "Women seeking HIV-related services... are often both sexually active and fertile while a significant proportion of individuals seeking RH services are exposed to the risk for HIV infection or are already infected."⁷⁶ The government recognizes that "currently, prevention, counseling, family planning and other SRHS services are not routinely offered as part of VCT services or HIV treatment services" and that "HIV-positive people's rights to informed fertility choices are

routinely ignored." The goal of the 2008 policy is to "increase access to quality RH/HIV services in order that missed opportunities are reduced."⁷⁷ Proposed indicators include increasing contraceptive prevalence rate by 2 percent per year; a 25 percent reduction in adult HIV prevalence rate every five years; reducing the maternal mortality ratio to 125 per 100,000 live births by 2010 and increasing the number of facilities offering integrated RH/HIV services.⁷⁸ In addition, the Nigerian Ministry of Health proposes to conduct in-service training and pre-service training on RH/HIV integration.

KNOWING WHAT CSOS ARE DOING/CAN DO IN INTEGRATION

Civil society organizations (CSOs) were generally the first in countries to integrate RH and HIV/AIDS services and have flexibility in programming compared to government programs. CSOs usually have more limited reach than government health services. Countries should consider strengthening CSO and government collaboration to provide integrated services. CSOs can provide services,

Country Example: **GHESKIO in Haiti**

From 1985-2000, the Group Haïtien d'Étude du Sarcome de Kaposi et des Infections Opportunistes (GHESKIO), a CSO with a VCT center in Haiti, increased the integration of additional health services. The number of new people seeking VCT increased from 142 in 1985 to 8,175 in 1999, a 62 fold increase. Of new adults seeking VCT in 1999, GHESKIO provided AIDS care to 17 percent, TB treatment to 6 percent, STI management to 18 percent and 19 percent became new users of a contraceptive method. Of the 6,709 adults coming for VCT in 1999, 36 percent benefited from at least one service visit. Of the 2,013 adults who tested HIV positive, 56 percent benefited from at least one service visit and 21 percent referred a sexual partner for VCT. One hundred and ten HIV-negative sexual partners of HIV-positive individuals were identified, and of these, 85 returned for repeat HIV testing after a median of 18 months, and none of these 85 seroconverted. The prevalence of HIV of patients served by GHESKIO was 30 percent, or six times the prevalence rate in the general adult Haitian population.

In 1989, TB screening, diagnosis and treatment was added; in 1991, STI management; in 1993, family planning services and nutritional support to families affected by HIV. In 1999, GHESKIO added services for HIV-positive pregnant women and their infants, including zidovudine and infant formula. Since 1999, GHESKIO has provided emergency contraception and three drug postexposure antiretroviral prophylaxis to female rape survivors and to health care workers after accidental HIV exposure. On their first visit to GHESKIO, individuals are assisted to develop a personalized HIV risk reduction strat-

egy. Patients reporting a history of cough for more than three weeks are provided on-site, same day TB screening including clinical exam and sputum smears. Patients with STI symptoms are provided treatment based on algorithms. All patients are screened for syphilis. Same day pregnancy tests are conducted. Condoms are provided. All patients are encouraged to obtain family planning. Post test HIV-negative patients are counseled in groups of five. All HIV-positive patients are counseled individually, encouraged to refer sexual partners and offered comprehensive HIV care, including HAART for all adult patients, PMTCT, long-term access to HAART when women give birth, treatment of opportunistic infections, home care, education to family care givers and nutritional support. Availability of other reproductive health services may encourage people to access VCT despite the strong stigmatization people who are diagnosed with HIV still face in Haiti. A case study conducted in 2007 of linkages and integration at GHESKIO concluded that stigma and discrimination are impediments to integration and require constant attention; providing services under one roof enhances the uptake of counseling and testing; counseling sessions for clients seeking testing are excellent opportunities for wider RH counseling; linking services expands reach to men, young people and PLHIV with RH care and having staff trained in both HIV/AIDS and RH gives flexibility in organizing services.

Sources: Peck et al., 2003; WHO et al., 2008a.



address causes of vulnerability to HIV/AIDS (for example, conduct community mobilization and education on the unacceptability of violence), facilitate community responses to the epidemic, educate communities about their right to quality health care services, and improve outcomes through ongoing support of users. Here are two case examples of how CSOs integrated RH and HIV/AIDS services.

Civil society organizations can play a vital role in providing integrated services outside of health based facilities. CSOs are usually best positioned to reach marginalized key populations. For example, the most successful program to reduce HIV prevalence among sex workers has been conducted by sex workers organizations, mobilizing peer educators, combating stigma, increasing educational opportunities and other non-clinic based interventions.⁷⁹ Stigma reduction programs, while important to conduct with health care providers, are also effective in community based interventions, which are usually spearheaded by CSOs.

INTEGRATION AS PART OF HEALTH SYSTEMS STRENGTHENING

Under Health Systems Strengthening (HSS), the Global Fund supports programs that addresses the three diseases in ways that will contribute to strengthening health systems.⁸⁰ The goal of HSS, according to WHO, is to address “health systems bottlenecks in such a way that specific health outcomes are met while system-wide effects are achieved and other programmes also benefit.”⁸¹ According to its 2008 factsheet, “The Global Fund recognizes the importance of supporting the strengthening of public, private and community health systems where weaknesses and gaps in those systems constrain the achievement of improved outcomes in reducing the burden of HIV, tuberculosis and malaria.”

Health services strengthening involves: effective, safe, good quality health interventions to those that need them; when and where needed; with a minimum waste of resources; a well performing health workforce with the best health outcomes

Country Example: FHOK in Kenya

Kenya’s main NGO providing family planning, the Family Health Options Kenya (FHOK), has worked to integrate services since 1999. As part of the Models of Care Project, initiated by GTZ and implemented by the International Planned Parenthood Federation, FHOK is a pioneer in offering ARV in an RH/FP setting. FHOK has also sought to expand its client base with a focus on youth and men, and developing partnerships with other non-governmental organizations and community support organizations. A 2007 case study found that HIV and RH services can be linked and integrated, and that providing ARV within an RH setting is possible. The case study offered a number of recommendations that are also useful to other countries and CSOs considering integration, including the need for flexible funding from donors; the need to reach men and provide for their needs; that the best way to promote sexual and reproductive health among young people and to raise awareness of HIV is to make information and services available as part of a wider programme that addresses their social needs; and that by providing space for community groups to meet, or a base for their activities, clinics can strengthen the links with their client population to their mutual benefit.

Source: WHO, 2008b.

Health services strengthening involves: effective, safe, good quality health interventions to those that need them

possible with sufficient staff and well distributed; equitable access to medical products and technologies that are scientifically sound and cost-effective; health financing to ensure that people can use needed services; leadership and governance; and a well functioning health information system (WHO, 2007). HSS is important to integration since it requires attention to the organization of the health system and to addressing policy and program barriers to offering RH and HIV/AIDS services together or at least through referral. Policy issues related to integration and linkages that are discussed in this guide, including integrating supplies initiatives and logistics systems, are applicable to HSS efforts.

Strengthening community responses within Health Systems Strengthening contributes to the national capacity to respond to HIV/AIDS, increase the human resources to address HIV/AIDS and integrates community responses into the overall health system.

THE IMPORTANCE OF COMMODITIES

Both HIV/AIDS and RH programs rely on commodities for prevention, including condoms and contraceptives. As part of their integrated proposals, countries can request Global Fund money to procure reproductive health supplies, including contraceptives, such as oral contraceptives,

Illustrative Country Example: An HSS Approach to Integration

This country has high rates of maternal mortality and large numbers of women between the ages of 15 to 35 are living with HIV. Women do come for antenatal care but often give birth at home, as the quality of care in maternal health hospitals is poor. Despite the cultural norm that women have other women with them at birth, the woman must be unaccompanied in the hospital. The maternal wards are dirty; there is not enough food, water or sheets. While women who test HIV positive learn of their status in antenatal care and want to do everything possible to give birth to an HIV-negative infant, women will not come to the hospitals to give birth.

The country assesses this situation as a weakness and proposes to improve maternal health wards in hospitals for the purposes of having an impact on uptake of PMTCT. However, separate wards for PMTCT would increase stigma and discrimination against pregnant women living with HIV. Therefore, maternal health wards in the major hospitals are improved which leads not only to an increase in uptake of PMTCT interventions but also strengthens the maternal health system of this country for all pregnant women. In fact, a recent study from Ivory Coast showed that implementing a PMTCT program in five urban health facilities improved the quality of antenatal and delivery care in general (Delvaux et al., 2008).

Country Example: HSS and Integration in Cambodia

Cambodia in Round 5 argued that achievements in HIV have been at the cost of increased system fragmentation, noting that Cambodia is seriously off track to meet MDG 5 for maternal health. Cambodia proposed that GF programs be integrated with health sector planning and procurement plus distribution systems, with activities including strengthening drug forecasting, procurement storage and distribution systems (WHO, 2007b: 30).

Source: WHO, 2007b: 30.



Community based groups can be invaluable in CCMs in their experience in designing integrated RH/HIV programs with a wide reach to program beneficiaries.

injectables, IUDs, etc., as well as condoms, yet not enough countries are doing so. An analysis conducted in 2007 showed that while 47 countries have procured male condoms using money from the Global Fund, the bulk of the procurement has been made by only a small number of countries. In fact, Tanzania (28 percent), Namibia (25 percent) and DR Congo (9 percent) are together responsible for 62 percent of the total. Two countries—Namibia (64 percent) and Djibouti (27 percent)—are responsible for over 90 percent of female condoms purchased with Global Fund money.⁸²

In 2008, Rwanda became the first country to fund contraceptive procurement through its Global Fund grant. “In a significant step for both contraceptive security and HIV prevention in Rwanda, local Global Fund stakeholders have decided to fund contraceptives by providing a three-year commitment worth more than US\$2.4 million from Round 7 Funds. Global Fund financing has been used in the past to finance condoms in a number of countries, but Rwanda is believed to be the first country to fund contraceptives as part of its efforts to fight HIV/AIDS.”⁸³ Countries can highlight the need for purchase of reproductive health supplies both in their HIV proposals and in Health Systems Strengthening (HSS) proposals.

The GF has awarded HSS grants to countries that have included RH organizations in CCMs and as recipients. For example, the Global proposal awarded to Azerbaijan included the National Office on Reproductive Health and Family Planning as a member of the CCM, in addition to the civil society group, Open Society Institute, Azerbaijan, which provides comprehensive sexual and reproductive health services, HIV services and Harm Reduction for women IDUs. While it is useful to include civil society organizations with expertise in reproductive health on CCMs, this is a necessary but not sufficient mechanism to produce an integrated proposal and to get RH CSOs as prime or sub-recipients on Global Fund grants. The critical issue is what integration is proposed.

For more information on Health Systems Strengthening, see the Global Fund’s Factsheet: The Global Fund’s Approach to Health Systems Strengthening. Additional resources include:

- WHO. 2007. *Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes: WHO’s Framework for Action*. Geneva, Switzerland.
- WHO. 2007. *The Global Fund Strategic Approach to Health Systems Strengthening; Report from WHO to the Global Fund Secretariat*. Geneva, Switzerland.
- Physicians for Human Rights. 2009. *Toolkit for Using Round 9 of the Global Fund for Health Systems Strengthening*.

INTEGRATION AS PART OF COMMUNITY SYSTEMS STRENGTHENING

Countries can also address integration through community system strengthening (CSS) mechanisms supported by the Global Fund.⁸⁴ CSS are initiatives intended to extend support to community-based organizations (CBO) in order to expand access to programs. In this context, community-based organizations that provide integrated RH/HIV services could be beneficiaries of this support. Beyond service delivery, the Global Fund recognizes the important role CBOs play in advocacy and mobilization – thus supporting RH/HIV linkages and integration.

The Global Fund stipulates that part of HSS funds should go to community strengthening and all Round 8 proposals should address community strengthening. Community based groups can be invaluable in CCMs in their experience in designing integrated RH/HIV programs with a wide reach to program beneficiaries. CSOs can often be the most effective mechanism to reach the most vulnerable key populations in a country’s AIDS epidemic, but may need capacity building to expand successfully. Strengthening communities

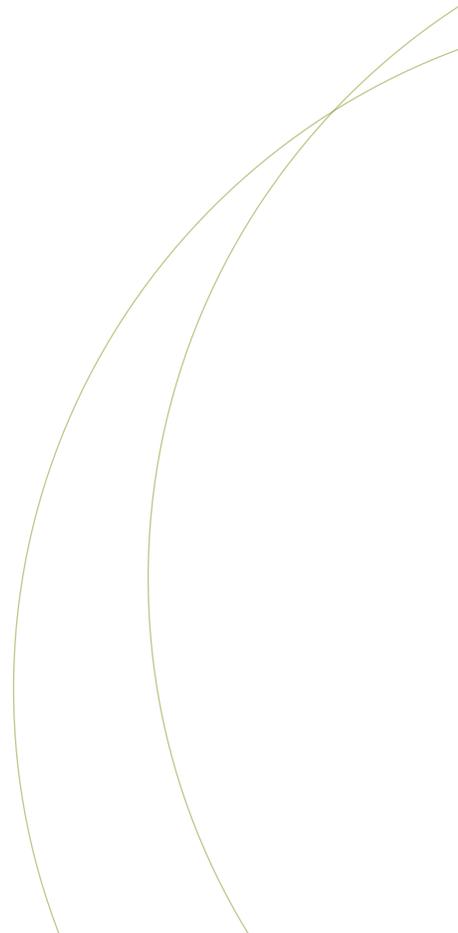
to advocate for financial resources, policies and laws to address RH/HIV integration can also be effective.

For more information on Community Systems Strengthening, see the Global Fund's Factsheet: The Global Fund's Approach to Community Systems Strengthening and a series of case studies, title, Civil Society Success on the Ground. Community Systems Strengthening and Dual-Track Financing: Nine Illustrative Case Studies.

TOOLS TO ASSESS THE CONTEXT AND FEASIBILITY FOR RH/FP AND HIV/AIDS INTEGRATION

Two tools have been developed to help countries and organizations assess policies and programs related to RH and HIV/AIDS and the feasibility of linkages and integration.

- IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives. 2008. *Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages: A Generic Guide*. NY: UNFPA.
- Population Council. N.D. *Assessing Integration Methodology*. Washington, DC: Frontiers, Population Council.



chapter 5

What is Needed for
Successful Integration?

The main challenge of integration is knowing the policy and program environment and designing integration strategies that are feasible within the policy and program structure or including strategies to change policies, program structures, and operational guidelines, as needed, to accommodate integrated programs and services. Experience around the world suggests that the challenges to integration fall under a range of operational areas, including policy, training, commodities and logistics, supervision and staff sensitization, provider load and task shifting, BCC/IEC materials, space, referrals, community-based programs, record-keeping/health information systems, and monitoring and evaluation.⁸⁵

While each country and organization are unique, some common challenges to implementing and sustaining integration beyond pilot projects include the need for:

- **Policy guidelines** that cover integration and that enhance coordination, involve target audiences and stakeholders in policy and program design (which ministry, agency or organization has the authority and responsibility for designing guidelines; which stakeholders need to be at the table)
- **Resource allocation** for integration (which ministry, agency or organization allocates resources and how do the resources flow through the health system or organization)
- **Service delivery design.** Determining how and where integrated services will be provided (e.g. clinic based, community-based, etc.) and which ministry, agency or organization has the authority and responsibility to approve the design.
- **Information program design.** Determining how and where integrated information and education will be provided and which ministry, agency or organization has the authority and responsibility to approve the plan (e.g. the Ministry of Education for sex education in schools) and which to develop materials.
- **Commodities and logistics** systems strengthening to include the range of reproductive health commodities, including condoms and other contraceptives, such as oral contraceptives, injectables, IUDs, etc., so that programs can emphasize both dual protection through condom use and dual method use that includes access to condoms and other contraception.
- **Human resources.**
 - Addressing **which providers can provide which integrated services, where** and considering **task shifting** to hire peer educators, people living with HIV and others;
 - Designing and implementing **training** for integration (what does existing training for providers include regarding RH and HIV/AIDS and which ministry, agency or organization is responsible for curriculum reform for pre-service and in-service and for create a minimum for what training is needed for HIV and RH providers)
 - Creating **supportive supervision** systems so that providers receive reinforcement for integration and support for implementation
- Increasing the capacity for referral systems (what **referral** mechanisms exist and how could referrals be strengthened? Which ministry, agency or organization is responsible for approving and implementing modified referral systems?)
- **Monitoring and evaluation.**
 - Modify epidemiological data collected to reflect integration needs (what ministry, agency or organization has the authority and responsibility for epidemiological data)

Discrimination by health workers to key groups, such as sex workers, MSM and people living with HIV creates obstacles for access to health services.

Successful Round 8 Country Proposal to the Global Fund: **Madagascar**

Why integrate?



The Madagascar Action Plan, 2007-2012 calls for immediate attention, collaboration across ministries and dedicated resources to make contraceptives and family planning advice available and ensure that HIV/AIDS prevalence remains at one percent. The Madagascar Action Plan also declares commitment to achieve UN Millennium Development Goals, including promoting gender equality and empowerment of women; improving maternal health; and combating HIV/AIDS. Contraceptive prevalence in Madagascar is 27 percent.

Context, Challenges and the CCM

In order to better understand the determinants of the HIV epidemic, Madagascar undertook an analysis of vulnerable communities. Epidemiological data showed that sex workers, MSM, prisoners, clients of sex workers, IDUs, young people and people living with HIV/AIDS should be the target populations in the GF proposal. Over half of those living with HIV/AIDS are women. Data were collected which showed which geographic areas had the lowest access to information, condoms and health services and which groups should be prioritized in programming: Mining operations where sex workers congregate; cattle markets with mobile and wealthy men contracting sex workers; tourist activities; and traditional festivities favoring risky sexual intercourse. In addition, young adolescent girls ages 10 to 15 are subject to sexual abuse and underage marriage, with pregnancy in girls as young as 13. Some MSM also have sex with women and are also sex workers, with low condom use and multiple partnerships. A 2007 behavioral surveillance survey found that most sex work is not considered sex work by those who practice it. In addition, the surveil-

lance data found that the median age of first sexual intercourse is under 17 years of age for both boys and girls, yet only 16 percent of girls and boys used condoms at last sexual encounter. The data also showed a high proportion of paid sex.

Only 30 percent of the country has geographic access to VCT. Discrimination by health workers to key groups, such as sex workers, MSM and people living with HIV creates obstacles for access to health services. Risk reduction is not discussed when giving an HIV positive result. VCT is only for those older than age 18, yet younger adolescents are at risk. Risk reduction policies are needed for IDUs. Private sector services do not provide data. Community based distribution of contraceptives and condoms are weak. Non-integration of services in the community presents a constraint.

Madagascar included a number of CCM partners with expertise in reproductive health, such as the Ministry of Health and Family Planning and civil society organizations, such as FISA, a pioneer in family planning which has experience integrating family planning with HIV/AIDS with a focus on youth and a gender perspective; and SAF, which promotes reproductive and maternal health, with experience in training on both reproductive health and HIV.

Proposed Integration Components

Madagascar proposed prevention services for sex workers and their clients; prison inmates; MSM; IDUs and marginalized young people, as well as regular sexual partners of key populations exposed to risk; and the general population living in concentration zones of key groups and gateways. Programming was also designed to meet the needs of people living with HIV/AIDS.

(Continued) Successful Round 8 Country Proposal to the Global Fund: **Madagascar**

The proposal included the following:

- Peer education and reproductive health services integrated through routine services in public and private centers.
- Friendly clinical services for people living with HIV/AIDS, in addition to protecting the rights of PLWHA.
- A training curriculum for reproductive health of adolescent men.
- Peer education for key populations on reproductive and sexual health as well as prevention of STIs and HIV.
- Piloting a website responding to questions on sexual and reproductive health.
- Encouraging participative dialogue between parents and youth about HIV and reproductive health.

- Advocacy with parents to prevent sex work by young girls.
- Offering prevention services including VCT and family planning, as well as condoms.

Proposed M&E

- Request GF funds to improve epidemiological surveillance
- Reduce the rate of new infections among the populations most exposed to risks of infection
- Maintain the low prevalence in the general population
- Report the number of people in high risk groups having received peer education
- Report the number of functional health centers for young people

- Modify client records, registers and monitoring and evaluation systems (what ministry, agency or organization has the authority and responsibility for M&E systems)

Resources on practical implementation issues related to integration are included in Appendix 3. Two examples of such guidance, both which focus on operational issues, include:

- FP/HIV Integration Working Group. 2008. "Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services. A Tool for Planning and Implementation." DRAFT.

While this document focuses on family planning, the guidance is relevant to all other aspects of reproductive health.

- Mitchell, M., S. Mayhew and I. Haivas. 2004. *Integration Revisited*, Background paper to the report, *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*. NY: UN Millennium Project.

This document, which was written for the Millennium Project, highlights the challenges of integration that need to be taken into consideration in the design and implementation of policies and programs that successfully introduce and sustain RH and HIV/AIDS integration.

Successful Round 8 Country Proposal to the Global Fund: **Ghana**

Why integrate?

Ghana's 2003 DHS data showed that the female to male ratio of HIV seroprevalence was 1.8:1. Furthermore, 69 percent of women made at least four ANC visits and another 17 percent made two to three ANC visits with a trained health professional, yet only 10 percent of pregnant women test for HIV. Gender norms in Ghana which sanction extra-marital relationships for men yet lack of sexual decision making by women increase HIV risk. In its 2008 progress report to UNGASS, Ghana reported that HIV prevalence in the 15-24 age group rose from 1.9 percent in 2005 to 2.5 percent in 2006.

Context, Challenges and the CCM

Ghana stated that one of the gaps in the national response to HIV was: "a rather slow integration of HIV and AIDS and Sexual and Reproductive Health (RH) in spite of the unique opportunities offered by Prevention of Mother to Child Transmission (PMTCT) (and) STIs...." (p. 22, Round 8).

CCM membership included the Ministry of Women and Children's Affairs, the Society for Women and AIDS in Africa (SWAA), the National Population Council and Planned Parenthood Association of Ghana (PPAG). PPAG provides reproductive health care and is the largest RH NGO in Ghana. PPAG has pioneered life education for youth, male clinics and the integration of family planning in development projects. In 1999 PPAG transformed the organization from family planning to integrated RH focusing on youth through peer education, along with comprehensive facility based RH services. PPAG partners with the Ghana Network of NGOs in HIV, to form a national advocacy coalition to address national RH/HIV issues. In addition, District AIDS Committees (DAC) have been established in all 170 districts, which include youth and women's as-

sociations. Partners for rape services include the Federation of Female Lawyers, as well as the Ghana Police Service.

Proposed Integration Components

Ghana proposed as a major goal in Round 8 RH and HIV integration in their HIV proposal. Activities proposed included:

- Train all midwives in HIV counseling and testing and STI services by integrating these with family planning. Develop guidelines and standards to facilitate integration in collaboration with the Ghana Registered Midwives Association. Increase couples HIV counseling, addressing male partners and discordant partnerships. Train staff in private maternity homes on combination antiretroviral therapy in line with current national guidelines. Implement standard infection prevention practices in labor, delivery and postpartum by procuring and distributing equipment, commodities and consumables.
- Provision of HIV prevention and counseling and testing at family planning service delivery points.
- Provide sexual and reproductive health education and services for women living with HIV and their partners, with peer educators providing information.
- Integrate RH and HIV services at health service delivery points.
- Behavior change communication aimed at changing harmful gender norms.
- Provide services for rape survivors.
- Peer outreach to female sex workers to emphasize correct and consistent condom use with non-clients such as husbands, lovers and boyfriends.



(Continued) Successful Round 8 Country Proposal to the Global Fund: **Ghana**

- Training prison staff, prisoners and police as peer educators in the integration of RH and HIV.
- Train 1,200,000 youth in integrated RH/HIV through PATH's Life Skills Curriculum for Ghana from the African Youth Alliance which provides comprehensive sexuality education, including topics of reproductive health, HIV/AIDS, promoting gender equity and gender based violence. Training will be done by Planned Parenthood Association of Ghana (PPAG).
- Establish 28 youth centers to offer integrated RH and HIV education, with trained community outreach service providers. Train football clubs to disseminate RH and HIV information.

Proposed M&E

- By 2013, 4,200 providers will be trained and 1,150,000 pregnant women will be offered counseling and testing.
- Report the number of clients from family planning clinics who are counseled and tested.
- Collect qualitative data to inform decisions to improve performance.
- Report the number of young people reached with life skills for integrated RH and HIV education.

Successful Round 8 Country Proposal to the Global Fund: **Burundi**

Why integrate?

Burundi's national reproductive health policy is integrated into the country's "Strategic Framework to fight Poverty and the National Health Development Program," and includes safe pregnancy; family planning; sterility and sexual dysfunction and case management; abortion prevention and case management; STI/HIV/AIDS prevention and case management; promoting reproductive health among young people and teenage men; sexual abuse prevention and case management; and breast, cervical and other gynecological cancer prevention and case management.

Context, Challenges and the CCM

Burundi has a generalized epidemic, with high prevalence in vulnerable groups. Delaying testing for HIV is more common in men than in women. Weak integration of PMTCT in reproductive health services was noted in Burundi's Round 8 proposal as a key problem. Weak promotion of PMTCT both at the community level and within health services have led to weak demand for PMTCT services. Lack of partner involvement has also led to challenges in the PMTCT program. PMTCT programs lack geographic coverage. Few health services have ambulances for pregnant women to get to the hospital. Initiation of no cost care for pregnancy and delivery in 2006 has increased skilled attendance at birth from 22.9% in 2005 to 41% in 2007 (Republic of Burundi progress report to the World Bank, 2008). A Human Rights Watch report found that in 2006, women who had delivered by Caesarean section accounted for an estimated 35% of indigent hospital patients who were detained (HRW, 2006). However, 60% of births still take place at home without skilled attendance, with only 66% of health centers having a maternity ward and only 12% of staff receiving practical training in basic

obstetric care (Republic of Burundi progress report to the World Bank, 2008). In 2005, maternal mortality was 615 per 100,000 (Republic of Burundi progress report to the World Bank, 2008). Burundi's contraceptive prevalence rate is 4.7% (Republic of Burundi progress report to the World Bank, 2008). A UNFPA study found that 19% of adolescents and women report sexual violence (UNFPA, 2004). Referral systems are not efficient. Insufficient resources are dedicated to the health sector: less than 3% as compared to the recommended 15%.

The CCM included representatives from UNFPA, the Burundi network of gender related associations and NGOs (CAROB), as well as government representatives from Human Rights, Gender, Youth, Public Health and Women's Matters.

Proposed Integration Components

Burundi plans to strengthening the STI/HIV program by integrating reproductive health and improving direct prevention, care and support interventions among the general population and key at-risk populations.

- Outreach will be conducted through community agents to reach vulnerable populations to encourage VCT, including young mothers, drug users, prisoners, sex workers, war veterans, uniformed personnel and their spouses, truck drivers, and those who have been displaced and repatriated.
- Communication strategies will be developed together with these groups. BCC activities will be conducted by peer educators and monitored by supervisors.
- VCT will be integrated into reproductive health services.

(Continued) Successful Round 8 Country Proposal to the Global Fund: **Burundi**

- Ongoing decentralization of PMTCT with additional training should increase uptake of PMTCT programs. “Access to PLWHA to ARVs increases life expectancy and gives couples the legitimate right to experience father and motherhood under safe conditions...Strengthening and improving the quality of reproductive health interventions is necessary to take into account the specific needs of PLWHA and in particular in the case of HIV-positive couples or couples with differing status to prevent unwanted pregnancy if applicable. To strengthen the skills of health providers..., 600 providers from PLWHA case management centers will receive 12 days of training on family planning” (p. 40 of Burundi’s Round 8 Proposal).
- Awareness of family planning options and service locations will be provided for women of reproductive age and PLWHA by 425 community members from 85 CSOs.
- A study is proposed on involving men in PMTCT.
- Organizations specializing in the care of victims of sexual abuse, in particular for young girls, are proposed, with training in sexual and reproductive health of young people and case management of people who are victims of sexual abuse for 60 providers.
- Budget allocations delineate expenditures for both reproductive health and PEP.
- Burundi proposed making female condoms available and accessible to vulnerable groups. Note that the female condom can be a means of improving sexual communications, equalizing imbalances in sexual decision-making and empowering women to protect themselves from HIV (Gaddi et al., 2008; Barbosa et al., 2007).
- Female and male condoms will be promoted to prevent both HIV and unwanted pregnancies.

Proposed M&E

- The number of female condoms distributed.

Successful Round 8 Country Proposal to the Global Fund: **Zambia**

Why integrate?

An overall goal for Zambia is to strengthen the health system to better meet MDG targets and national health priorities.

Context, Challenges and the CCM

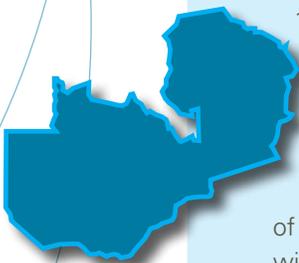
Zambia identified the following challenges to integration:

- Lack of evidence based HIV prevention strategy to inform programming.
- Shortage of and inability to retain trained human resources.
- Because of stigma, few women share their HIV status and men avoid counseling and testing.
- Inadequate integration of PMTCT in reproductive health services.
- Guidelines for PEP and PEP are not used appropriately.
- Weak linkages between PMTCT and ART.
- Few livelihood options to cope with the impact of AIDS.
- Gender policies are not institutionalized in most organizations.
- Lack of disaggregated data by sex; lack of gender impact analysis and indicators.
- Multiple partnerships are common. In the age group 15 to 49 years of age, over 14% of men have multiple partnerships compared to fewer than 2% for women. In DHS 2007 for Zambia, 20% of men and 2% of women had sex with two or more partners in the 12 months before the survey and 38% of men and 17% of women reported sex with someone who was not their spouse in the prior 12 months.
- Women than men are 1.4 times more likely to be living with HIV: 16% to 12%. Women not in union have an HIV prevalence of 18%, whereas men have the same HIV prevalence rate of 15% whether in union, not in union, or in polygamous union.
- Only 34% of young people can correctly identify ways of preventing sexual transmission of HIV.
- Family planning and safe motherhood, including antenatal and postnatal care are overstretched by the impact of the AIDS epidemic. Integration is weak.
- Women accept violence as a norm, with a 2005 survey showing that over 15% of females have had forced sex.
- Between 60 to 70% of women ages 15 to 49 are literate compared to 70 to 80 % for men; with only 48% of rural women literate compared to 75 % of men.
- Women are the major caregivers, with 16% of all households headed by widows, who lack access to food and basic services.
- The practice of dry sex.
- Women lack negotiation powers during sex.

The Technical Working Group of the Ministry of Health to develop the proposal included the Society for Women and AIDS in Zambia and Women & Law in Southern Africa.

Proposed Integration Components

- Reach 200,000 in-school and out of school youths every year with life skills and enhance assertiveness among the girls aged 15 to 24 in life skills HIV education.



(Continued) Successful Round 8 Country Proposal to the Global Fund: **Zambia**

Support integration of PMTCT in reproductive health and family planning services in 800 PMTCT outlets per year, including procurement and supply of family planning commodities and PMTCT “that extends to the father.” (p. 24)

- Research to establish best practices and strategies for integration.
- Training on integration for health workers.
- Provide PEP guidelines for clinical staff; procurement and distribution of PEP kits; providing PEP to 1,800 people per year; dedicated budget in proposal for PEP.
- Train 220 police officers per year to appropriately assist survivors of sexual violence and abuse.
- Protective shelters for women, girls and boys who have experienced violence and provide OVCs protection against abuse.
- Increase male involvement in home based care activities.
- Provide training to women and girls in business skills.
- Allow women to use services without spousal approval.
- Train 1,200 community health workers with updated curriculum to provide health education on how to prevent HIV transmission, domestic violence and family planning to reduce HIV prevalence and reduce maternal mortality.

- Increase spending on health and hiring health workers, despite IMF budgetary agreements. Provide living support to community health workers and OVCs account for over 33% of the budget.
- Request 30% of the budget for family planning commodities, in addition to commodities needed for safe delivery.

Specific HSS and RH/HIV integration:

- Zambia proposed to integrate RH services and PMTCT.
- Create linkages between PMTCT and ART.
- Mainstream gender analysis.
- Improve health workforce to address both maternal mortality and PMTCT.
- Train Community Health Workers to provide basic health education on family planning, domestic violence, HIV, substance abuse and childhood immunization.
- Improve demographic surveillance systems which will improve monitoring and evaluation for RH and HIV, as well as other indicators, increasing reliable statistics on births, deaths and details on the cause of death, with the goal of providing empirical, longitudinal, population based health information on HIV, TB and malaria.

Proposed M&E

- % of health facilities with PEP available

chapter 6

How can integration be
Monitored and Evaluated?

A strong monitoring and evaluation plan is an important component of proposals to the Global Fund. In order to monitor and evaluate the success of integration activities, proposals should include relevant indicators with appropriate targets. Countries should ensure that the indicators are measurable and that the data can be collected and reported through the country's M&E and data management system. As part of its new gender strategy, the Global Fund has requested countries to disaggregate data collected to measure relevant indicators by sex.

The Global Fund has a number of resources related to monitoring and evaluation, including the 2006 edition of the M&E Toolkit, *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria*, which is currently being updated. UNAIDS, through its Monitoring and Evaluation Reference Group (MERG), is spearheading the development of an indicator registry, which should be available in 2009.

Below are examples of indicators to monitor integration in selected AIDS proposals that were successful with the Global Fund. Those in italics are additional possible indicators to measure integration. These are illustrative indicators – proposals should include indicators that measure the outcomes proposed.

COVERAGE INDICATORS:

- **People reached with services and goods**
 - Number of students with family life education
 - Number of young people reached with life skills-based HIV/AIDS education in schools.
 - Number of young people reached with life skills for integrated RH and HIV education.
- Number of pregnant women reached with counseling and testing
- Number of clients from family planning clinics who are counseled and tested
- Number of clients reached with family planning services
- Number of women accessing PMTCT and women of unknown serostatus tested and treated for syphilis
- Number and percent of people with access to free treatment for syphilis
- Number and percent of FP clients that are counseled and tested for HIV
- % of sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission
- *Number of identified most at risk populations (MARPs) reached with relevant comprehensive reproductive health services (e.g. contraception, maternal health, STI as well as HIV)*
- *Number of women reporting sexual violence who have been counseled and tested for HIV and received post-exposure prophylaxis (PEP) and emergency contraception according to national guidelines.*
- *Number of MSM reporting sexual violence who have been counseled and tested for HIV and received post-exposure prophylaxis (PEP)*
- *Number of HIV positive pregnant women receiving post-partum contraceptive counseling and choice of contraceptive method*
- *Number of young people reached with comprehensive RH and HIV skills based education*

■ Service points supported

- Number of facilities providing PMTCT services for pregnant women with HIV/RH integrated service.
- Number of sites providing HIV/RH counseling and testing services.
- % of health facilities with PEP available
- Number of health facilities offering integrated FP and HIV services
- Number of functional health centers for young people

■ People trained to deliver services [according to national guidelines]

- Number of providers trained to offer counseling and testing to pregnant women
- *Number of HIV/AIDS providers trained to offer counseling and referral for RH services*
- *Number of RH providers trained to offer counseling and referral for HIV/AIDS services*

■ Commodities Distributed

- Number of female condoms distributed

IMPACT INDICATORS

- *Percent reduction in the proportion of unintended pregnancies among all women*
- Percent reduction in the proportion of unintended pregnancies among women living with HIV
- Percent reduction in sero-prevalence rate of syphilis

OPERATIONAL RESEARCH

The Global Fund will fund operational research to study strategies for implementation. Because implementation of RH and HIV/AIDS integration is new, countries should consider adding operations research to their proposals. One country with a successful proposal indicated that they would collect qualitative data to inform decisions to improve performance related to integration. Another noted a plan to conduct research to establish best practices and strategies for integration. Examples of strong operations research studies are available through the Population Council (www.popcouncil.org) and Family Health International (www.fhi.org). The Tides Foundation has recently funded projects that integrate family planning and HIV health care in six countries in sub-Saharan Africa, with documentation of model programs forthcoming.

MONITORING DATA QUALITY

The Global Fund has implemented data quality auditing of its grants. Tools are available for grantees to assess and strengthen their M&E systems and include the following:

- Measure Evaluation (on behalf of the Global Fund to Fight AIDS, TB and Malaria and multiple organizations). 2008. *Routine Data Quality Audit Tool*. Chapel Hill, NC: MEASURE Evaluation.
- Global Fund to Fight AIDS, TB and Malaria, PEPFAR, MEASURE Evaluation, USAID, Health Metrics Network, WHO, UNAIDS, World Bank and Roll Back Malaria. 2006. *Monitoring and Evaluation Systems Strengthening Tool*. Chapel Hill, NC: UNC, MEASURE Evaluation.
- Global Fund to Fight AIDS, TB and Malaria. 2008. "Carrying Out an M&E Self Assessment." *Monitoring and Evaluation Manual 4*.

chapter 7

Conclusion

Once integration is in place, monitoring and evaluation, together with operational research, are critical to ensure successful results.

Integrating RH and HIV can greatly contribute to mitigating the AIDS pandemic by reducing unintended pregnancy; preventing perinatal transmission; expanding to more target groups; reducing gender based violence; meeting the needs of people living with HIV and providing our youth with the knowledge and services they need. Whether to integrate, how to integrate and exactly what to integrate will depend on a country's epidemiological profile, policies and program structures.

Experience with implementation of integration initiatives in countries around the world shows that scale up and sustainability requires attention to policy and program operations issues. Once integration is in place, monitoring and evaluation, together with operational research, are critical to ensure successful results.

Civil society organizations have often been at the forefront of efforts to integrate RH and HIV/AIDS and are ideally positioned to work with governments and other CCM members to propose integration policies, programs and projects to be included in country proposals to the Global Fund. Indeed, a number of CCMs with civil society organizations as a vital part have been awarded funds by the Global Fund for integrated HIV/AIDS proposals, particularly in Round 8.

This document, with links to a range of resources, will help CCMs, civil society organizations and others developing proposals for the Global Fund that contribute to preventing HIV and mitigating the effects of the AIDS pandemic through programs that link and integrate RH and HIV/AIDS.

chapter 8

Appendix: Selected Manuals and Materials for Integrated Services

- African Youth Alliance. 2003. *Life Planning Skills: A Curriculum for Young People in Africa*. Washington, DC: PATH. [http://www.ayaonline.org/CDWebDocs/AYAResources/Toolbox/ProgramAreas/LPS/LPS\(GH\)Facilitator.pdf](http://www.ayaonline.org/CDWebDocs/AYAResources/Toolbox/ProgramAreas/LPS/LPS(GH)Facilitator.pdf)
- Bott, S., A. Guedes, A. Gueznes and C. Claramunt. 2004. *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals*. NY, NY: International Planned Parenthood Federation: Western Hemisphere Region. http://www.ippfwhr.org/atf/cf/%7B4FA48DB8-CE54-4CD3-B335-553F8BE1C230%7D/gbv_guide_en.pdf
- Bruce, L., W. Liamila, M. Menziwa, and D. Khoza. 2008. *Balanced Counseling Strategy Plus Trainer's Guide*. Washington, DC: Population Council. http://www.popcouncil.org/pdfs/frontiers/Manuals/BCS-Plus/BCSPlus_TrainersGuide.pdf
- Duvvury, N., N. Prasad and N. Kishore. 2006. *HIV & AIDS – Stigma and Violence Intervention Manual*. Washington, DC: International Center for Research on Women. http://www.icrw.org/docs/2006_SVRI-Manual.pdf
- Colombini, C., S. Mayhew, and C. Watts. 2008. "Health-sector Responses to Intimate Partner Violence in Low- and Middle-income Settings: A Review of Current Models, Challenges and Opportunities." *Bulletin of the World Health Organization* 86 (8): 635-642. <http://www.who.int/bulletin/volumes/86/8/07-045906.pdf>
- Cooley, L. and R. Kohl. 2006. *Scaling Up – From Vision to Large-Scale Change: A Management Framework for Practitioners*. Washington, DC: Management Systems International. <http://www.msiworldwide.com/files/scalingup-framework.pdf>
- Engenderhealth and ICW. 2006. *Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls*. NY, NY. Website: http://www.engenderhealth.org/files/pubs/hiv-aids-stis/SRH_for_HIV_Positive_Women_English.pdf
- Farrell, B. 2007. "Family Planning-Integrated HIV Services: A Framework for Integrating Family Planning and Antiretroviral Therapy Services." NY: Engenderhealth, The Acquire Project. http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/FP-HIV-Integration_framework_final.pdf
- Foreit, K, K Hardee and K Agarwal. 2002. "When Does it Make Sense to Consider Integrating Family Planning and STD/HIV Services?" *International Family Planning Perspectives*. 28(2): 105-107. www.guttmacher.org/pubs/journals/2810502.html
- IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives. 2008. *Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages: A Generic Guide*. NY: UNFPA. Printed in Mexico. http://www.unfpa.org/upload/lib_pub_file/815_filename_inkages_rapid_tool.pdf
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chapter 9

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ENDNOTES

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