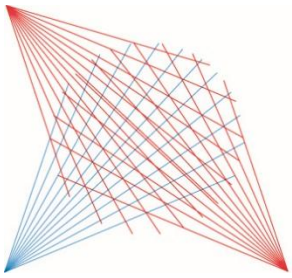

Share-Net International

Integrating the SRHR and HIV response

STATE OF THE ART REPORT

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ABSTRACT

This report was commissioned by Share-Net International to provide background and analysis of the current state of integration and linkage for an expert meeting on sexual and reproductive health and rights and HIV integration to be held in conjunction with the 2015 AIDS Impact Conference. As such, the report traces the history of sexual and reproductive health and rights (SRHR) and HIV linkages and integration at the global level, including an overview of the current policy and funding landscape. It also provides examples of initiatives that focus on SRHR and HIV linkages and integration across the spectrum of policy, health systems, and service delivery. These examples are a selection of recent initiatives conducted in Share-Net and Dutch government priority countries that have contributed to the evidence base around SRHR and HIV linkages and integration. They range from a global working group on SRHR and HIV Linkages, to research initiatives and implementation programs on the ground. The report concludes with some analysis of the current landscape of SRHR and HIV linkages and integration, noting that there is still progress to be made in terms of translating and monitoring work through health systems, and funding women's organizations to contribute to the evidence base. Finally, some questions are posed to prompt further discussion.

I. INTRODUCTION

Inequality is bad for our health. When people who are already situated in contexts where they have insufficient access to quality healthcare, education, and social support also experience poverty, gender inequality, and discrimination, it is difficult for them to care for themselves.[i] This is especially true regarding sexual and reproductive health (SRH), because SRH decision-making and practices are heavily influenced by intimate partner and family relationships, as well as by social norms and taboos that can make it difficult for people to access information and care related to SRH.[ii] [iii] And even when these services are available it is often difficult to bring populations who are already marginalized in healthcare settings, such as young people, into care.[iv] This is particularly true in relation to HIV treatment and care, [v] which is often separated from other SRH services that are understood to include family planning (FP), maternal and child health (MCH), sexually transmitted infections (STIs), reproductive tract infections (RTIs), safe abortion, and sometimes gender-based violence (GBV) prevention.[vi] However, HIV is most commonly transmitted through sexual contact,[vii] and it is now gaining traction as a sexual and reproductive health and rights (SRHR) issue. One of the ways in which HIV has come to the forefront as an SRHR issue has been within the context of the SRHR and HIV linkages and integration agenda. And some research on linkages and integration suggests that stronger coordination across these related sectors could result in improved access to and uptake of services, better health outcomes, and greater efficiencies across health systems from policy to program level. [viii] [ix]

Context of the Report

This report was commissioned by Share-Net International to provide some background and analysis of the current state of linkages and integration for an expert meeting on SRHR and HIV integration to be held in conjunction with the 2015 AIDS Impact Conference. As such, the report traces the history of linkages and integration at the global level, including an overview of the current policy and funding landscape, and provides examples of initiatives that focus on linkages and integration across the

spectrum of health systems and service delivery. These examples are not meant to comprehensively cover the current field, but instead offer detailed descriptions and findings to help Share-Net meeting attendees think about current and ongoing themes, opportunities, and challenges for linkages and integration.

In order to provide context and framing most useful to Share-Net members, the consultant conducted a review of the literature on linkages and integration, and also reached out to experts in the field with a focus on identifying initiatives that have contributed to the evidence base around linkages and integration, or are in the process of doing so. In addition, the report examines initiatives that are currently running or that have concluded in the past 3-5 years, with special attention to programs in Share-Net and Dutch government priority countries. The report closes with some analysis of the current landscape of linkages and integration and questions for further discussion.

Definitions of Terms

In order to more fully engage with the spectrum of policies and programming related to linkages and integration, this report follows the distinction that IPPF, UNFPA, WHO, UNAIDS, GNP+, and Young Positives make between **linkages** as "bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV" that refer to a human rights-based approach, and **integration**, which is a subset of linkage: "Different kinds of SRH and HIV services or operational programmes that can be joined together to ensure and perhaps maximize collective outcomes." [x] The report therefore considers initiatives that have sought to bring HIV and SRHR together in various ways from the level of health systems to direct service delivery. Here, we refer to the WHO definition of **health systems**, which includes, "(i) all the activities whose primary purpose is to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve…."[xi] It is worth noting here that several initiatives outlined below, specifically those using the Interagency Working Group on SRH & HIV Linkages' Rapid Assessment Tool (details below), differentiate between "policy" and "systems". Findings from these initiatives are therefore presented as reported by the authors themselves. However, in following the WHO definition we ultimately consider the term "health system" to encompass both of these aspects.

Further, coming from the perspective that true sexual and reproductive health are best realized when inequalities that create barriers to health and wellbeing are removed, we take a comprehensive view of **SRHR** as outlined in the International Conference on Population and Development Programme of Action. This document states, "reproductive health … implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."[xii] Since this definition is situated within a document that advocates for a broad approach to reproductive health within a framework of rights and development, UNFPA and the Center for Reproductive Rights suggest that it can be interpreted to suggest that sex and reproduction should take place in a context of gender equality, poverty eradication, and sustainable development. In addition, it implies that people should be able to have a safe and satisfying sex life; the ability to reproduce; and the right to decide if, when, and how frequently to reproduce.[xiii]

A Brief History of SRHR and HIV Linkages & Integration

The beginnings of SRHR and HIV integration are usually traced back to the International Council on Population and Development (ICPD) in 1994,[xiv] although we could perhaps find the seeds of an integrated approach in the 1978 Declaration of Alma-Ata that called for more robust, well-funded healthcare at the primary care level.[xv] However, the World Bank and International Monetary Fund imposed "structural adjustment" policies on developing countries shortly after Alma-Ata. These policies promoted competition in the global market and privatization while directing resources away from government programs, such as public health services.[xvi] AIDS was first discovered around this time and rapidly spread such that, by the time of ICPD, it had become a global public health emergency in a context of shrinking public health resources and infrastructure. This emergency prompted the creation of the Joint United Nations Program on HIV/AIDS (UNAIDS) in 1996; and a major shift in global funding priorities to focus specifically on HIV and AIDS beginning with the World Bank's Multi-Country AIDS Program (MAP) in 2000, and followed by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in 2003. Indeed, global development assistance for HIV and AIDS far outweighed funding for SRHR from 2009 – 2011, and funding for reproductive health care and family planning fell by 50% from 2000 - 2010.[xvii]

Beginning in 2004, the call for SRHR and HIV linkages and integration was picked up again in declarations such as the New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health[xviii] and the Glion Call to Action on Family Planning & HIV/AIDS in Women and Children,[xix] while regional declarations like the Maputo Plan of Action in 2006[xx] have included provisions on integration as well. And, as the Millennium Development Goals are adapted into the post-2015 Sustainable Development Goals, several formerly distinct targets (MDG 4 to reduce child mortality; MDG 5 to improve maternal health; and MDG 6 to combat HIV/AIDS and malaria) are being combined into one comprehensive goal for health. Alongside these declarations, some of the largest bilateral and multilateral development agencies that have historically funded HIV and AIDS and SRHR work have also taken up the integration cause at the level of policy and strategy. These include: the Global Fund to Fight AIDS, Tuberculosis and Malaria,[xxi] [xxii] the U.S. President's Emergency Plan for AIDS Relief (PEPFAR),[xxiii] [xxiv] [xxv] UNAIDS,[xxvi] [xxvii] the World Health Organization (WHO),[xxviii] [xxix] the United Nations Children's Fund (UNICEF),[xxx] and the UK's Department for International Development (DfID).[xxxi] So, the call for linkages and integration is making its way back into global agendas.

Opportunities, Challenges & Research Priorities

Recent research points to some of the opportunities SRHR and HIV linkages present, as well as major challenges countries face when trying to implement integrated programming and linkage at different levels. A 2011 review of the literature on general service integration at the primary care level (e.g. adding an additional service such as family planning to pre-existing primary care services) in low- and middle-income countries suggests that integration may improve service uptake and some health outcomes, although fully integrating services, such as STI treatment and prevention or family planning into routine primary care, may decrease service use and patient satisfaction without significantly improving health outcomes.[xxxii] Other research specifically on SRH and HIV has also shown that integrating these services is feasible and that linked policies and programming generally produce positive health outcomes.[xxxiii] Effective integration and linkage are best realized in a context where:

health systems are strong; rights, particularly those of women and girls, are upheld and respected; communities are meaningfully engaged; and financing is sufficient and thoughtful.[xxxiv]

However, scaling up integrated programs has been challenging due to separate policy making processes, a lack of clarity around what integration really means, and lack of clear technical guidance.[xxxv] In particular, some research has shown that unequal vertical funding streams for SRHR and HIV, which fund separate but parallel activities,[xxxvi] have proven a major barrier to both SRH and HIV linkages and integration.[xxxvii] [xxxviii] However, some would contend that separate funding streams ultimately result in more funding overall for both HIV and SRHR.[xxxix]

While much of the research on linkages and integration has focused on service delivery, barriers tend to occur at higher levels within health systems (e.g. funding), which suggests a need to prioritize future research on program economics, outcomes, and impacts to inform policy makers and managers.[xl] Further, at the service level there is a dearth of research on integrating services for people living with HIV, reducing gender-based violence (GBV) in this context, and integrated services for men and boys,[xli] as well as issues that are often neglected, such as abortion.[xlii] In particular, the lack of attention to GBV (sometimes used interchangeably with the term "Violence Against Women")[1] is notable given that major development agencies like USAID[xliii] and PEPFAR[xliv] are making this issue a priority. Since these major development agencies are currently focusing on GBV, this may be an opportune moment to include work around this issue in the linkages and integration agenda.

II. RECENT WORK ON SRHR AND HIV LINKAGES AND INTEGRATION

Alongside higher-level shifts in development, a number of initiatives around linkages and integration have recently developed across the globe; a selection of these initiatives is presented in detail below. This selection focuses on projects and programs that, although they are not necessarily affiliated with Share-Net or the Dutch government, are located in Share-Net and Dutch priority countries. Further, these initiatives were selected because they are contributing to the evidence base on linkages and integration, and are either currently running or have recently concluded. The initiatives generally fall into two types: those operating across countries that focus on influencing linkage across the spectrum of policy, systems, and services, and those that focus on building the evidence base at the country level. One of the programs, the SRHR & HIV Linkages Project, works in both areas. The descriptions below include the initiatives' locations, partners involved, core components, and any findings thus far.

Interagency Working Group on SRH and HIV/AIDS Linkages (Global): 2008 – Present

The Interagency Working Group on SRH and HIV/AIDS Linkages (IAWG) was first convened in 2008 under the auspices of the WHO's Department of Reproductive Health and Research, the Department of HIV/AIDS, and UNFPA. It is currently co-chaired by WHO, UNFPA and IPPF, and includes 24 member agencies that work to advocate for political commitment to a linked SRH and HIV agenda; support

1 "Violence Against Women" (VAW), is defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." WHO. "Fact Sheet: Violence Against Women," November 2014.

countries to strengthen linkages at the levels of policy, systems (e.g. program monitoring and supply chain management), and service delivery; and create a shared understanding of SRH and HIV linkages by building the evidence base and sharing research, good practice, and lessons learned. [xlv] According to its 2015 work plan, the IAWG currently focuses on: mapping SRH and HIV linkages toolkits that have already been developed, or are in the planning stages, and developing a dissemination strategy to support promotion and use of these toolkits and research findings at the country level; keeping an eye on "hot topics", working out the implications for the SRH and HIV linkages agenda, and supporting advocacy related to these topics; and collecting and sharing planned and ongoing research, key findings, and data collection tools and instruments on SRH and HIV linkages.[xlvi]

The Rapid Assessment Tool for SRH and HIV Linkages

Since its inception, the IAWG has developed several tools and best practice case studies to support countries to realize SRH and HIV linkages at the levels of policy and practice. One of these tools is a Rapid Assessment Tool that is divided into three levels at which countries should assess bi-directional linkages between SRHR and HIV: policy, systems, and service delivery. The Tool is intended to identify opportunities and gaps in policies and programs that can be addressed through high-level planning.

The Rapid Assessment Tool guide includes lists of who should be involved in the work and instructions for carrying out the assessment, including guidelines for conducting comprehensive interviews with policy- and program-level personnel in both the SRH and HIV fields. In order to conduct an assessment, a country first needs to establish a team that is composed of leaders from HIV and SRH organizations, networks of people living with HIV, and organizations that focus on key populations. The assessment process then begins with a desk review of laws, policies, and strategic plans across sectors. This review should include special attention to human rights issues, key populations, stigma, and gender equality issues, among others.

The desk review process is followed by interviews and/or focus group discussions with representatives in each of five categories: policy decision-makers and program planners; civil society and community leaders; donors and development partners; service providers in settings where HIV and/or SRH services are available; and clients of related services, such as family planning, PMTCT, and drug treatment. At the policy level, the guide aims to answer the question, "What is the level and effectiveness of linkages between sexual and reproductive health and HIV-related policies, national laws, operational plans and guidelines?", [xlvii] and includes questions related to national policies around HIV and SRH, including making services explicitly available to key populations, as well as policies around gender equality, criminalization, preventing gender-based violence, and anti-discrimination laws. This section also includes questions on budgetary allocations for HIV and SRH. At the systems level, the guide asks, "To what extent do systems support effective linkages of SRH and HIV?"[xlviii] This section includes questions for program managers at the national, local, and district levels on: partnerships among different agencies and different sectors; planning, management, and administration; staffing, human resources, and capacity development; logistics and supplies; laboratory support; and monitoring and evaluation. The final section of the guide asks, "To what extent are HIV services integrated into SRH services and SRH services integrated into HIV services?"[xlix] It includes questions for providers on the types of services they offer and how, including GBV prevention and management, as well as questions about policies and/or systems that constrain linkage. This section also includes a client exit interview to use at health facilities, which asks what

kinds of services a patient accessed, what they were offered, and how they felt about the experience. Following the completion of the assessment, the team should meet with the stakeholders involved to share findings and discuss next steps.[l]

Since 2008 the Rapid Assessment Tool has been implemented in 49 countries across Latin America and the Caribbean, West and Central Africa, Southern Africa, East Africa, Asia and the Pacific, Eastern Europe and Central Asia, and the Middle East and North Africa. In 2011, the IAWG commissioned an implementation review of the Rapid Assessment Tool in 20 countries across the represented regions. According to the review, 75% of the countries surveyed felt they could not have achieved current levels of linkage without undergoing the Rapid Assessment, and they found the process particularly useful for identifying work already taking place around linkage, as well as for laying the groundwork for plans to move forward. Overall, the review found that the process was useful for countries to identify gaps in coordination between HIV and SRH programs, and since conducting the Rapid Assessment a number of countries have taken action to improve linkages and integration. At the policy level, countries like Swaziland and Cote d'Ivoire have used documentation from the Rapid Assessment to support the development of national strategic plans for HIV and SRH, while in Bangladesh the process served as an impetus for policy makers to commission further research and planning around linkage. At the systems level, most countries reported changes in coordination and stronger partnerships between the SRH and HIV sectors following the Rapid Assessment, as well as increased capacity building and some level of change in monitoring and evaluation related to linkage. However, most countries have not made significant changes in logistics systems to strengthen linkage. And finally, at the provider level most countries surveyed have made some progress in implementing the service changes recommended in the Rapid Assessment. Based on these results, the implementation review also identified three major over-arching barriers across countries that should be addressed in order to create effective linkages at the country level: vertical funding mechanisms; insufficient acknowledgment of the needs of key populations; and insufficient monitoring of linkages.[li]

SRH and HIV Linkages Indicators

Through its work at the country level, the IAWG also identified difficulties in monitoring SRH and HIV linkages as a challenge to program planning and implementation. As a result, the group developed a compendium of indicators and related assessment tools for SRH and HIV linkages.[lii] In addition to drawing from other sources that had already established indicators related to integration and linkage, this compendium includes two new indicators designed specifically to measure integration at the service delivery level. One indicator uses "marker" services to measure integration: whether HIV counseling and testing are offered at sites that provide SRH services, or whether modern contraceptive services are offered at sites providing HIV services. The other indicator uses "baskets" of services: whether a site offers both one type of HIV service (e.g. HIV counseling and testing, PMTCT) from a pre-defined "basket" of services, as well as one type of SRH service (e.g. FP counseling, antenatal care), and the model used to offer these services. In addition, the compendium includes an "uptake" indicator, the percentage of female patients who visit a clinic for FP services and are tested for HIV at the same visit, to measure patient use of integrated services.

The new indicators were pilot tested in seven of the UNFPA/UNAIDS SRHR and HIV Linkages Project (more below) countries in Eastern and Southern Africa, and have been approved by the UNAIDS Monitoring and Evaluation Reference Group. In a findings report from the pilot test, UNFPA and UNAIDS found that integration was happening at many of the project sites, which were general health

centers offering a range of services, but it was not "structured and systematic".[liii] Further, the report states that collecting data for the indicators is possible, but the indicators should be adopted and operationalized within a broader context that involves strengthening monitoring and evaluation systems as a whole and also providing training and capacity building for service providers.[liv]

Integra Initiative (sub-Saharan Africa): 2008 – 2015

The Integra Initiative is managed by IPPF in partnership with the London School of Hygiene and Tropical Medicine (LSHTM) and the Population Council. It is an implementation research project that examines the benefits and costs of four different models for delivering integrated HIV and SRH services in Kenya, Swaziland, and Malawi (both high and medium HIV prevalence settings) with the goal of reducing HIV infection and unintended pregnancies. The first model, tested in Kenya, involved offering HIV prevention services (e.g. condom promotion, STI screening) within family planning consultations. Under the second model, tested in Kenya and Swaziland, HIV services (e.g. repeat testing for mothers, HIV testing for infants, referral to HIV services if necessary) were integrated into post-natal care and family planning. Model three involved offering both HIV and SRH services together (e.g. family planning, maternal and child health services, HIV testing and care, STI services, and youth counseling) in select IPPF clinics in all three study countries. Model four focused on the sexual and reproductive health needs of people living with HIV in Swaziland and compared two integrated models to two stand-alone HIV service models. Integrated services were divided into "fully" integrated, where both SRH and HIV services were offered by one provider in one room, and "partially" integrated, where different providers offered SRH and HIV services in separate rooms at the same facility. These services were compared to stand-alone HIV service clinics; one of which was a separate clinic on a hospital campus, and the other was a free-standing HIV clinic. Using these models, the Integra study aimed to determine the benefits of different service delivery models in terms of quality of services and uptake, the impact of integrated services on risk behaviors associated with HIV, and the efficiency of different integrated service delivery models.[lv]

While the results of the Integra study are still being released, the research team has published a number of papers on their findings thus far. When comparing patient satisfaction between integrated sites and stand-alone HIV clinics in Swaziland, the investigators found that patients tended to prefer either fully stand-alone or fully integrated (versus partially integrated) clinics, but recommend a variety of treatment models due to the complexity of patient satisfaction and variations in healthcare needs.[lvi] The Swaziland team also found that patients reported feeling less stigmatized at clinics that are either fully stand-alone or fully integrated, as opposed to clinics with partially integrated services. This was because patients felt it was more likely their HIV status would be exposed at a partially integrated site through procedures such as name calling in the waiting room, room labeling, and ART patient cards. Further, some patients felt more comfortable at stand-alone sites, where they could identify and connect with others who were also living with HIV.[lvii]

Integra has also produced findings on integration from the healthcare provider perspective. First, the Integra researchers looked at the effectiveness of peer mentoring, in which a provider who has experience in both HIV and FP, or HIV and post-natal care (PNC), mentors another provider. These findings suggest that peer mentoring is an effective and sustainable way to increase provider capacity in an integrated setting, and that mentoring is associated with an increase in the range of services offered, as well as an increase in the number of patients seeking services.[lviii] Integration can also motivate staff and help them to better share workload, although healthcare service providers' overall

performance depends heavily on organizational factors that are often lacking, such as clinical supply chains and resources, salary, and the availability of technical support.[lix]

Finally, some analysis of the integration process at the clinic level in Swaziland suggests that sites receiving an Integra intervention package (which included a training package to facilitate mentoring among front-line health providers; job aids to promote integration, e.g. a Balanced Counseling Strategy Plus (BCS+) toolkit; counseling cards; and ongoing support) did not necessarily integrate more than non-intervention study sites. This may have been due to limitations in the research design, as well as an increase in integrated services offered in non-intervention sites. Further, even when integrated HIV services were offered in FP and MCH settings, women did not necessarily receive them. The study authors suggest this could have been due to scale-up of ART services in one clinic area that may have displaced other HIV and MCH services, or that integration declined in areas where patients did not need regular HIV services. However, the study did show that clinics across a range of settings (from large urban facilities to smaller facilities in rural areas) do have the capacity to integrate HIV and STI services with MCH, including family planning, antenatal care, and child care.[lx]

Data analysis for the Integra Initiative is ongoing. The latest results are available at: www.integrainitiative.org/frequently-asked-questions/.

Building Momentum for SRH/HIV Integration (South & Central Asia): 2011 – 2015

The Building Momentum for SRH/HIV Integration project was an IPPF project funded by the European Union in eight countries across South and Central Asia: Afghanistan, Bangladesh, India, Iran, Maldives, Nepal, Pakistan, and Sri Lanka. Building Momentum was modeled on a project conducted in sub-Saharan Africa that generated funding for integration from the Global Fund,[lxi] and accordingly it was intended to advocate for SRH and HIV linkages and integration within the Global Fund's Country Coordinating Mechanisms (CCMs), as well as at the level of government health systems. However, due to the postponement of Global Fund round 11 funding, this component of the project was scaled back in implementation and the participating countries have focused instead on advocacy at the country level.[lxii]

Each of the participating countries began their involvement in the process by using the IAWG's Rapid Assessment Tool. In Bangladesh, a Share-Net priority country, this assessment resulted in recommendations to develop a common understanding of the importance of SRH and HIV linkages among policy makers and to incorporate linkage policies into the national HIV strategy. At the systems level, the assessment report recommends creating a communications strategy to reach the public with messages around linkages, training program managers and service providers, coordinating funding sources, and developing a monitoring strategy. Additionally, recommendations at the service provider level include identifying and replicating good practices around integration, decentralizing some government program activities to civil society organizations, and promoting condoms as dual protection. The report concludes with priority next steps, such as forming an SRH and HIV linkages subgroup within the National Coordination Committee on HIV/AIDS and to form a national task force on linkage. Finally, the report notes that findings from the assessment have been shared and some language around SRH/HIV linkage were consequently incorporated into the National Strategic Plan (NSP) for HIV/AIDS 2011 – 2015.[lxiii] Indeed, Bangladesh's NSP includes language around, for example, providing a "comprehensive service package" for Most At Risk Populations (MARPs) that includes STI

diagnosis and treatment, as well as HIV counseling and testing,[lxiv] and incorporating provider-initiated HIV counseling and testing into antenatal clinics.[lxv] The NSP also includes provisions for convening forums across sectors, such as the National Partnerships Forum on HIV and Sex Work Issues and "Build[ing] linkages between HIV specific agencies and services across the health system…" [lxvi] So, it seems that the assessment process resulted in some success early on.

Two years into the Building Momentum project, the IPPF South Asia Regional Office conducted a midterm evaluation to assess and document progress so far. This report states that as of 2012 each country had developed a multi-sectoral country team, but that the teams were still in the early phases of sharing information without creating a common agenda. Additionally, 11 small grants had been given out to civil society organizations to support advocacy around building support for integration at the community level. The midterm evaluation report found that among these organizations staff knowledge had increased around what integration is and its importance, but this understanding was not yet translating into strong advocacy messaging or funding proposals. Although advocates had succeeded in holding meetings with some government representatives, they often were not pushing a clear agenda in these meetings, which may have to do in part with difficulties identifying clear advocacy priorities around integration. [lxvii] Challenges at the level of policy and systems also included separate funding streams and management systems, and how to integrate a gender component into SRH/HIV programs in order to address rights issues, such as GBV.[lxviii]

Overall, the evaluation report notes that the extent of integration at service delivery sites has been mixed. This may be due to the fact that Building Momentum was implemented as a discrete project at the service level, integrating HIV services into SRH services. Some sites have consequently made integrated service delivery part of their daily activities, while others have treated the effort as just "another project".[lxix] So, the report points out that some activities related to linkages or integration at sites that are less integrated may not be captured in monitoring activities simply because they are seen as outside the scope of the project.[lxx] Consequently, recommendations from the evaluation report include strengthening project monitoring and integrating it into daily activities, as well as capacity building around advocacy and identifying concrete next steps to further the linkage agenda.[lxxi] Since no additional findings or follow up evaluation reports have been released from Building Momentum as of yet, it is not clear at this point whether any actions have been taken to address the challenges outlined above. However, it is expected that these materials will be released later in 2015 and made available on the www.integrainitiative.org website.

SRHR & HIV Linkages Project (Southern Africa): 2011 – 2015

The SRHR & HIV Linkages Project is a joint project of UNFPA and UNAIDS in Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia, and Zimbabwe. The project has run from 2011 and it aims to expand to an additional three countries. Informed by the work of the Integra Initiative (outlined below), the SRHR & HIV Linkages Project is meant to facilitate integration at the level of country health and development systems and policies across all of the countries involved, as well as to strengthen integrated monitoring and evaluation. Further, it involves integrating services at the facility level in Botswana, Malawi, and Swaziland.

Each of the participating countries has used the Rapid Assessment Tool developed by the IAWG to assess existing linkages at the policy level and to identify priorities. Integrated services have since

been piloted in each country, along with an ongoing monitoring and evaluation component.[lxxii] In Zambia (one of the Dutch priority countries in sub-Saharan Africa), the Rapid Assessment resulted in recommendations such as: harmonizing SRH and HIV policies and frameworks at the level of national policy, as well as at the systems level; highlighting gender-based violence prevention and management in all policies related to health; allocating budgets for integration; recruiting more health workers; integrating SRH and HIV at the service level; and strengthening monitoring and evaluation around linkages and integration across all levels of policy, systems, and service. After these findings were disseminated, the Adolescent Technical Health Working Group (TWG) reviewed the report and made additional recommendations, which include revising the national sexual education curriculum to include HIV and supporting full operation of the TWG.[lxxiii]

As one component of the response to the Rapid Assessment and follow-up recommendations, the SRH & HIV Linkages project in Zambia has developed an HIV counseling and testing campaign aimed at young people in Lusaka Province. Following consultations with student leaders from high schools across the province, the Linkages project launched the "Love Life? Ziba HIV!" campaign. This campaign involved two weeks of outreach in schools that included group sexual health education, HIV counseling and testing, and referrals to ART centers for students who tested HIV-positive. The campaign also included a "street bash" for out of school youth that featured peer education, reproductive health service provision (including distributing condoms and educational materials), and referrals to a nearby health clinic. [lxxiv]

Although the information available on the "Love Life? Ziba HIV!" campaign is limited at this moment, it is noteworthy that the issue of improving sexual health education for young people was identified with the Rapid Assessment Tool and was consequently addressed through this work. Further, the Linkages project reports that, after participating in the campaign, 400 young people subscribed to a new SMS-based system that provides information about HIV and health center locations. Further, 35% of the students involved underwent HIV testing, and three percent of these students were found to be HIV-positive and were referred to services. Those involved in the campaign have since developed a set of recommendations around youth services to carry forward, including the development of a national SRHR/HIV youth health brand, increasing the number of health centers that are youth-friendly, building capacity for service providers around working with youth, training peer educators, and better equipping health centers.[lxxv]

Link Up (sub-Saharan Africa, South & Southeast Asia): 2013 – 2016

Link Up is a three-year (2013-2016) project led by the HIV/AIDS Alliance and funded by the Netherlands Ministry of Foreign Affairs. The project works with local organizations in Bangladesh, Burundi, Ethiopia, Myanmar, and Uganda to improve the sexual and reproductive health and rights of young people. Link Up aims to reach young people (under age 24) who are living with or affected by HIV, and particularly focuses on young people living with HIV, sex workers and children who are exploited for sex, and LGBT people. Link Up programming involves integrating SRHR services into pre-existing HIV programs, and focuses on mobilizing young people to reach out to their peers and link them to services.

Link Up activities in Share-Net focus countries include a program run with the Health and Social Action Bureau (HASAB) in Bangladesh that mobilizes young people in marginalized populations to reach out

to their peers with information on SRHR and HIV, and to make referrals to Marie Stopes' Bangladesh mobile clinical services. Since young people who live on the streets are at high risk for HIV in Bangladesh, peer education sessions are held at Dhaka's largest train station. In these sessions, peers discuss issues such as SRHR, HIV and STI prevention, drug use, and gender. Young people who require additional information and/or health services are then referred to Marie Stopes clinics. In Burundi, the Alliance Burundaise contre le Sida (ABS) has worked with a local network of young people living with HIV to open a youth center that offers educational talks, support groups, and social activities. The center, which focuses on young people at high risk, offers HIV counseling and testing, as well as some contraceptive options. They refer out to health clinics for ART, and STI diagnosis and management.[lxxvi]

While Link Up is still under evaluation, the project has produced some initial findings. A series of country assessments found that integration is on national health agendas and these agendas also prioritize reaching out to young people. However, the needs of young people living with HIV ultimately are not well addressed. In fact, these assessments suggest that a lack of data on young people most affected by HIV makes it difficult to develop appropriate services. Further, because all five countries criminalize HIV transmission, along with behaviors highly associated with transmission, such as sex work and drug use, young people often do not feel safe accessing services.[lxxvii]

Link Up also recently released a report detailing five priority issues that young people in the project countries agreed need to be addressed in order to create effective HIV and SRHR services for youth. These priorities are: provide quality SRH services from well trained service providers; protect, respect, and promote young people's SRHR; ensure full access to HIV and SRHR information and education; promote gender equality and address gender-based violence; and meaningfully engage young people in decision making that affects their lives.[lxxviii] Finally, Link Up is also doing some work to add to the evidence base on integration through a formal evaluation. This evaluation is led by the Population Council and is designed to involve young people in research and analysis. In addition to evaluating Link Up program activities, this process is intended to identify effective strategies to reach young people in key populations and to fill research gaps around marginalized populations (e.g. the reproductive health needs of female sex workers, and stigma and discrimination among men who have sex with men).[lxxix]

FACES (Kenya): 2004 – Present

The Study of HIV and Antenatal Care Integration in Pregnancy (SHAIP)

In partnership with the Kenya Medical Research Institute (KEMRI), the University of California, San Francisco (UCSF) created Family AIDS Care and Education Services (FACES) in Nairobi in 2004. FACES supports the Kenyan Ministries of Health to deliver quality HIV services at their clinics. Through FACES, UCSF and KEMRI ran the Study of HIV and Antenatal Care Integration in Pregnancy (SHAIP) in 12 clinics from 2009 – 2012. The clinics involved in this randomized controlled trial were randomized to provide services that were either fully integrated (in which antenatal care (ANC), PMTCT, and HIV treatment services were all delivered in the ANC clinic) or non-integrated (in which ANC clinics provided ANC and basic PMTCT services, but referred clients to a separate HIV clinic for HIV treatment). In this context,

the study aimed to evaluate rates of maternal enrollment in HIV care and treatment, infant HIV testing uptake, and HIV-free infant survival.[lxxx]

In qualitative interviews with SHAIP providers, researchers found that integrated services led to some increases in efficiency, a decrease in the amount of time HIV-positive patients needed to spend in the clinic, and closer relationships between providers and patients. However, integration also resulted in increased provider workload due to additional trainings, longer sessions with patients, and record keeping. [lxxxi] In terms of patient health, providers speculated that women receiving integrated services were more likely to remain engaged in care and to adhere to their HIV treatment regimen. These preferential outcomes may be due to the closer relationships providers can build with patients who they see for longer visits that include multiple services under an integrated model. They may also be due to a perceived reduction in stigma patients feel when they receive ANC services alongside women who are HIV-negative in a setting where their HIV status is not made explicit.[lxxxii] However, like the Integra researchers, those working on the SHAIP study also point out that when women attend an integrated ANC clinic where other patients' HIV status is not clear, they may miss opportunities for social support among peers.[lxxxiii]

HIV-positive patients themselves reported higher satisfaction with services at integrated clinics, as opposed to non-integrated clinics, which may be due to the ease of receiving services in one place. [lxxxiv] In addition, the researchers speculate that women living with HIV may prefer service at a fully integrated clinic because they feel less stigmatized receiving ANC services in a setting where their HIV status is not made explicit.[lxxxv] Notably, the HIV-negative women accessing integrated services also preferred them over non-integrated services, which may have to do with empathy toward friends and family members who are HIV-positive, as well as perceived risk of contracting HIV in a high-prevalence setting.[lxxxvi] However, patient attrition was high at both integrated and non-integrated sites. The researchers point out that this high attrition suggests barriers to service beyond lack of integration, although they do not speculate on what these barriers might be. And ultimately, integrated services were not associated with reduced risk of HIV transmission to infants, nor did it appear to affect short-term maternal health outcomes. This may be due in part to delays in initiating HAART for women who tested positive, as well as low ARV adherence.[lxxxvii]

Cluster-Randomized Controlled Trial Evaluating Integrating Family Planning into HIV Care

FACES has also conducted a study in which family planning services were integrated into HIV clinics. This was a randomized controlled trial in which 12 HIV clinics in Nyanza, Kenya, were randomized to integrate family planning services, while six clinics served as controls and referred patients requesting contraception to a family planning clinic located within the same facility. Peer educators at all participating sites conducted group health education sessions at HIV clinics before the study officially began, reviewing reasons why people living with HIV might want to use contraception and different contraceptive options. Staff at the study sites also underwent training on how to talk with patients about their contraceptive use and interest. According to guidelines for integration established by the Kenyan Government, clinic staff would discuss family planning needs and options with patients, and intervention site clinics had a range of reversible contraceptives available. During meetings with patients, providers were also instructed to encourage male involvement in family planning and joint

partner decision-making. According to patient report and clinical chart review, researchers found that patients accessing integrated services were using more effective contraceptive methods than those at the control sites, although condom use went down slightly (though not statistically significant) at the integrated sites despite clinic staff encouraging a dual method approach to family planning. Still, there was no significant reduction in pregnancy incidence at the intervention sites, which the researchers suggest may be due to the short follow up time (one year).[lxxxviii]

Although integrated services ultimately did not have an effect on patients' familiarity with family planning methods, the study researchers suggest this may be due to high rates of familiarity at baseline. And researchers did find a relationship between integration and decreased negative attitudes toward family planning among men.[lxxxix] Providers interviewed for the study further suggested that involving men more directly in family planning could have positive effects on contraceptive uptake and use, particularly because men access reproductive health services less often than women do. However, this work does not draw any conclusions on whether or not integrated services improve contraceptive use through increased male partner involvement.[xc]

The Jamii Bora Study

Following the SHAIP and family planning integration studies, FACES is currently developing and testing an intervention that is home-based and focuses on couples. Community health workers will be trained to deliver Couples HIV Counseling and Testing (an evidence-based protocol) in the home, and couples participating in the study will be randomized to receive care at a standard ANC clinic, or an intervention site to determine the efficacy of this model. Since men rarely attend antenatal visits with their female partners, the study aims to reach both women and men more effectively with health information. Ultimately, the researchers hope that the home-based model will reach more couples with HIV counseling and testing, encourage repeat HIV testing during pregnancy for women who test HIV-negative, and increase utilization of PMTCT services among women who test positive. However, because the study is still in its implementation phase, results have not yet been released.[xci]

III. CONCLUSIONS

The initiatives outlined above range in scope from a working group that develops SRH and HIV linkages tools at the global level to service delivery studies coordinated by research institutes on the ground. Considered together, these efforts show attention to some of the priority research questions and challenges identified in the Introduction while also pointing to areas where work is still needed. While initiatives like the IAWG's Rapid Assessment Tool, Building Momentum, and SRHR & HIV Linkages are working to improve motivation and capacity for linkages and integration across health systems down to the level of service delivery, results so far have been mixed. For example, even after completing Rapid Assessments, some Building Momentum countries have faced challenges around identifying priorities for advocacy at the policy level, as well as misunderstandings around how exactly to conduct advocacy around linkages and integration. However, in Bangladesh some language related to linkages and integration was ultimately included in the country's National Strategic Plan. Similarly, SRHR & HIV Linkages work in Zambia resulted in policy recommendations, but it is not yet clear to what extent these recommendations have been considered or included in high-level decision making. Both of these programs seem to show that the IAWG's Rapid Assessment Tool can be useful for generating

discussion and recommendations around linkages and integration, and potentially have some impact at the policy level.

However, it is unclear how effective the Rapid Assessment Tool is for creating changes at the level of program funding, logistics, and monitoring. Several projects at the level of service integration (e.g. the Integra and SHAIP studies) similarly point to lack of capacity and resources as an ongoing challenge. Strengthening monitoring and evaluation for SRHR and HIV linkages and integration could help to track this work and also to make the case for more linkages at the level of policy and systems. However, the FACES and Building Momentum work show that basic record keeping in an integrated program can be challenging when providers are asked to do extra work in a setting that is already resource constrained, or in which they have multiple competing projects. And although the IAWG has developed indicators specifically for integration, they also point to a general need to improve monitoring and evaluation systems in order to effectively use the indicators.

Although strengthening monitoring systems to build an evidence base for linkages and integration may be a challenge, service-level integration projects like Integra and FACES have generated promising findings related to some of the research priorities outlined in the Introduction. Integra is notable for developing evidence around program efficiency that could in turn influence higher-level decision making. Other findings at the service level suggest that fully integrating service delivery settings may help to reduce stigma, which is often a barrier to care for people in marginalized populations. Further, integrated services may also increase male involvement in reproductive health and family planning, which could have positive implications for women's health. And although Link Up has not yet produced any definitive findings, evidence on effective strategies to reach young people with integrated programming should complement the Integra and FACES findings.

One research priority area in which the evidence is still thin, though, is the area of gender-based violence (GBV) prevention, and the relationship between linkages and integration and women's rights more broadly. Projects like the Rapid Assessment Tool and SRHR & HIV Linkages are notable for framing SRH and HIV within a broader context of rights, including attention to gender relations, GBV, and the rights of marginalized populations. However, this attention largely seems to come at the level of policy and is not yet being picked up at the service level. In particular, both the Integra and FACES initiatives have focused on integrating HIV services with family planning and/or maternal and child health. While one arm of the Integra study focused on the SRH needs of people living with HIV, a focus on FP and MCH rather than the spectrum of sexual and reproductive health and rights tends to be limited to women of reproductive age, and particularly married women. This focus can exclude marginalized populations, especially the young women who increasingly make up a large percentage of those living with and affected by HIV and AIDS.[xcii] In addition, as programs like Link Up point out, young people and people who are otherwise marginalized often require specialized services beyond those traditionally offered in reproductive health or family planning clinics.

When it comes to gender-based violence and its relationship to SRH and/or HIV, this is a huge topic that has been treated extensively in the literature,[xciii] [xciv] and it is outside the scope of this report to address the issue in great detail. However, the Rapid Assessment Tool makes it clear that GBV is a priority area in the linkages and integration agenda and projects such as Building Momentum suggest that actually incorporating GBV prevention and management into this agenda is an ongoing challenge. However, the issue is barely raised in the implementation studies on service integration. In the future,

this is an area that would be worth exploring. However, this work should be done with careful attention to the "gender" component of GBV in order to preserve a truly rights-based approach. It is no coincidence that gender-based violence is often conflated with "Violence Against Women" (VAW), since sexual and intimate partner violence disproportionately affect women.[xcv] As a result it is most important that women, especially HIV-positive women, lead and be directly involved in related research. However, a recent publication from the International Community of Women Living with HIV & AIDS Eastern Africa (ICWEA) points out that even within the HIV arena organizations led by and for women, and particularly women living with HIV, have received fewer resources than others.[xcvi] Thus, even when women-led organizations are able to pilot service-level integration initiatives, they can face difficulty accessing further funds to scale up promising practices.[xcvii] This trend aligns with larger trends in funding for women's issues globally, which receive a small portion of development assistance.[xcviii] Since GBV is also a particularly relevant topic for women living with HIV,[xcix] greater attention to funding women's initiatives to conduct related research could help to build the evidence base around GBV, as well as broader women's rights in the context of SRH and HIV linkages and integration. Further, increasing funding for women-led initiatives will also help to offset some of the social inequalities, notably economic marginalization, that make women most vulnerable to poor health outcomes.[c]

IV. QUESTIONS FOR DISCUSSION

1. Which issues are largely missing from initiatives right now that might be important to include in a comprehensive linkages and integration agenda? (e.g. abortion, coerced sterilization, safe conception)

2. With increased attention to gender-based violence in the global policy arena, where are there opportune points to connect with linkage initiatives?

    a. What are specific venues where it might be useful to tap in to larger conversations? (e.g. AIDS 2016, FP 2020, Women Deliver)

3. How to hold funders accountable for policies that are gender sensitive, and that broadly uphold principles of SRHR in terms of both the programs and personnel they fund?

4. Where are opportunities to build broad principles of SRHR and human rights into service-level integration?

5. While there is evidence that working with women and men together around SRHR and HIV prevention can be very effective, how do we address what appears to be a gap in SRH services both for couples and for men individually while remaining sensitive to women's particular needs?

    a. What about working with "men who have sex with men," but who do not identify as gay and also have sex with women?

6. What lessons can we learn from other initiatives to integrate complementary services with HIV prevention and treatment, such as Hepatitis C, Tuberculosis, and harm reduction?

Appendix I: Search Terms & Databases

Key Words/Search Terms

HIV OR AIDS

Integration

Linkage/Linking

Reproductive Health

Sexual Health

Sexual and Reproductive Health

Sexual and Reproductive Health and Rights

Family planning

Services

Programs

Health policy

Health systems

Databases/Search Tools

CINAHL

Cochrane

Google Scholar

OneSearch [beta]

ProQuest Social Science

PubMed

SAGE

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