POLICY AND PRACTICE UPDATE 3
April 2009

HIV-SRH CONVERGENCE

Convergence of Sexual and Reproductive Health (SRH) and HIV/AIDS Services in India

PATH
A catalyst for global health

This newsletter provides a bird's-eye view of programs within and outside India that are converging or integrating sexual and reproductive health (SRH) and HIV/AIDS service shares some of the successes and challenges from these programs. This newsletter also highlights best practices in achieving such convergence to increase access to reproductive and family planning services for people most at risk of or living with HIV.

Women participating in Focused Group Discussion

Convergence of SRH-HIV

HIV/AIDS is responsible for more than 20 million deaths; worldwide, nearly 40 million people are battling the epidemic. At the same time, 500 million people worldwide are affected by reproductive health morbidity and lack of contraceptives. Globally, there are half a million pregnancy-related deaths each year.[1] A majority of HIV infections are transmitted through unprotected sexual intercourse or are related to childbirth and unplanned pregnancies. There is an unambiguous connection between sexual and reproductive ill-health and HIV/AIDS. The common fundamental causes behind both include poverty, social marginalization of vulnerable populations, and gender discrimination. The Glion Consultation on Strengthening the Linkages between Reproductive Health and HIV/AIDS said "there is evidence of a clear linkage between reproductive health and HIV care, prevention and treatment."[2] The Consultation reiterated an urgent need to safeguard the reproductive options of women worldwide and to comprehend the importance of family planning as a method to avoid the spread of HIV amongst women and children.

Why are SRH-HIV linkages critical for India?

Both HIV/AIDS and efficient sexual and reproductive health services are challenges facing India. Of the estimated 2.5 million people living with HIV (PLHIV) in India (range: 2 – 3.1 million)[3], 39 percent or one million are women.[4] Most (86 percent) of HIV transmission in the country is through the sexual route, so it is young people who face the greatest burden of unwanted pregnancies and the risk of contracting HIV/AIDS. According to the National Family Health Survey 3rd Round (NFHS-3), nearly 44 percent women in India have never used any contraceptive method.[5] There is therefore a strong argument that controlling the spread of HIV would be enhanced by increasing awareness of and providing counseling to women on a range of SRH issues including HIV and other sexually transmitted infections.

Convergence of SRH and HIV services is further necessary in India to address the widespread stigma and discrimination faced by people most at risk of or living with HIV. It is vital to link the HIV/AIDS interventions with general reproductive health services simply because one can strengthen the other.

1. United Nations Population Fund (UNFPA), Joint United Nations Programme on AIDS (UNAIDS), and Family Care International. The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health, Available at: www.unfpa.org/upload/lib_pub_file/321_filename_New%20York%20Call%20to%20Commitment.pdf. Accessed March 20, 2008.
2. World Health Organization (WHO). Glion Consultation on Strengthening the Linkages between Reproductive Health and HIV/AIDS: Family Planning and HIV/AIDS in Women and Children. Available at www.who.int/reproductive-health/stis/docs/glion_consultationsummary.pdf. Accessed March 19, 2008.
3. HIV Data page. National AIDS Control Organisation (NACO) website. Available at: www.nacoonline.org/Quick_Links/HIV_Data/. Accessed June 26, 2008. Figure ascertained by UNAIDS and WHO.
4. Madeleine Morris. Indian women face peril of HIV. BBC News, Andhra Pradesh. Available at: http://news.bbc.co.uk/1/hi/world/south_asia/4260314.stm. Accessed June 26, 2008.
5. Government of India. 2005–2006 National Family Health Survey (NFHS-3) National Fact Sheet (India). Available at: www.nfhsindia.org/pdf/IN.pdf. Accessed April 2, 2009.

The second National Working Group on Convergence meeting convened by PATH to discuss and learn from the current SRH-HIV convergence programs in India

To further the agenda on convergence of SRH and HIV services in India, PATH convened a National Working Group on Convergence in 2008. The second meeting of the National Working Group was held in New Delhi on March 5, 2009, with 28 participants from national and international organizations working on reproductive health and rights and HIV issues, bilateral and multilateral development partners, and the National AIDS Control Organisation (NACO). Goals for the National Working Group meeting were to:

- Bring together government health officials, national and international nongovernmental organizations (NGOs), and international development partners to discuss convergence of HIV and sexual and reproductive health services.
- Share learnings from field experiences from across India.
- Discuss key challenges.
- Identify steps needed to forward the agenda of HIV and SRH convergence.

Participants presented and discussed the evidence from ongoing programs on convergence of SRH and HIV/AIDS services in India. The sessions included:

- **Integrating HIV counseling and testing in reproductive health services: Family Planning Association of India (FPAI)**
  In a presentation titled "Integrating counseling and testing in reproductive health," Kalpana Apte from FPAI said that they have systematically added HIV Voluntary counseling and testing (VCT) services to their clinics that provide contraception, abortion, child and maternal health, and infertility services. Currently, FPAI has 20 such centers across the country. Sharing service delivery statistics from their centers, she stated that the sharp increase in the number of clients attending their centers that have integrated VCT is an indication of the success of their model. She showed that between 2005 and 2008, HIV-related counseling and testing at FPAI centers increased from 3,170 to 87,619. During the same period, the number of FPAI clinics offering VCT increased from 4 to 17. She added that the other reasons for the success of their model include their "no compromise to quality" policy; their policy of not branding these centers as offering HIV services; and their system of assuring all clients that their anonymity, privacy, and confidentiality shall be maintained.
- **Rolling out integrated counseling and testing centers (ICTCs) in scale: National AIDS Control Organisation (NACO)**
  Presenting on rolling out ICTCs under National AIDS Control Plan III (NACP-III), Dr. Rahul Thakur, World Health Organization (WHO) National Consultant to the NACO, shared the accomplishments so far. By September 2008, about 4,810 ICTCs were operational in the country, and from 2010 onward, NACO plans to expand them further in collaboration with the National Rural Health Mission (NRHM) and the private sector. He added that as part of integration with the NRHM, counseling and testing services were now operating from 24-hour primary health centers in high HIV-prevalence districts. The main challenges faced in rolling out the ICTC program include maintaining quality of counseling and testing; ensuring adequate supply of HIV kits; building capacity of health care providers; reducing stigma and discrimination practiced by some providers; increasing the low number of referrals from targeted intervention sites; and continuing low numbers of clients accessing ICTCs from the most at-risk populations.

Capacity building of private health care providers

- **Opportunities and challenges of integrating family planning and reproductive health (FP/RH) in targeted interventions among female sex workers in Maharashtra: Family Health International (FHI)**
  Bitra George of FHI analyzed the lessons learned from integrating family planning services into the sexually transmitted infection (STI) clinics under the Aastha Project in two urban districts of Maharashtra. As a part of the Avahan Project in India, the FHI-run Aastha Project focuses on reducing the incidence of HIV and STIs among female sex workers and their partners. Responding to the demand for family planning services among sex workers, Aastha started providing integrated STI and family planning (FP) services at their project clinics. In course of implementing these integrated services, protocols were reviewed, services improved, referral mechanisms established, and outreach upgraded. Reporting on the achievements of the program, Dr. George said that the service uptake increased after services were integrated. The proportion of sex workers who attended Aastha clinics relative to the total reached through outreach activities increased from 29 percent in 2008 to 40 percent in 2009, with 59,750 sex workers accessing the STI/HIV services provided by the clinics. Over the same time period, 3,500 pregnancy tests and hemoglobin tests were also conducted. This integration was achieved with minimal additional funding and infrastructure: staff were trained in family planning counseling and a structured evaluation process was put in place to measure effectiveness. The main challenges included addressing sex workers' misconceptions

about FP; changing the stigmatizing attitude of health care providers in FP clinics; and enhancing the project management information system to accurately assess FP activities.

- **Integrating gender within HIV/AIDS programs: International Centre for Research in Women (ICRW) in India**

  Sharing their experiences of integrating gender within HIV programs, Nandita Bhatla and Arpita Mukherjee of ICRW said that their goal was to implement models for gender mainstreaming in HIV/AIDS through two pilot projects—one among slum-dwelling adolescents in Tamil Nadu, and the other among HIV-positive people in Maharashtra.

  Discussing the lessons learned from the two pilots, the presenters said that they found that sources of information and knowledge on SRH were limited for adolescents, especially for boys, and that gender stereotypes and power differentials acted as a barrier to communication and sexual negotiations within couples. They said that violence emerged as an underlying theme and that SRH was a cross-cutting issue across populations. The presenters concluded that the key lessons learned at the end of the pilot projects included the importance of having participatory processes; the need to address gender norms through guidelines that use sexuality, HIV, stigma, and discrimination as points of entry; and the criticality of HIV and SRH convergence to prevention efforts. They recommended conducting operations research to measure the effect of systematically integrating gender in HIV and SRH programs.

Workshop with community mobilizers

- **Addressing provider stigma and community demand to increase access to sexual reproductive health and family planning services: PATH**

  Following up on the lessons learned from formative research PATH had conducted on the options and challenges to HIV and SRH in 2006–2007, Amitrajit Saha of PATH said that the current project was exploring whether addressing provider stigma on the one hand, and increasing awareness of and demand for SRH services among sex workers and HIV-positive people on the other, improved their access to these services. Building partnerships, ensuring buy-in from government and selected private sector providers, and building capacity of community providers and health care service providers are the key interventions that this project is undertaking in one district in Andhra Pradesh and two districts in Bihar. A monitoring and evaluation component, coupled with baseline and endline assessments, is expected to observe change over time, in addition to which the project is expected to document best practices for scale up. The project has been rolled out in the selected sites and the demand-generation and awareness-building component has already been completed, while capacity-building of health care providers is ongoing. In conclusion, Dr. Saha said that key challenges include lack of understanding among health managers and policymakers about how to operationalize HIV-SRH convergence at facility level; the difficulty in motivating health care providers to attend capacity-building sessions consistently; a lack of practice and culture within NGOs/CBOs and HIV-positive networks of discussing other health needs and services beyond HIV with people living with or most at risk of HIV; and frequent transfers of government health managers and bureaucratic delays.

Following the presentations, a panel discussion on the challenges of implementing SRH-HIV convergence within NACPIII and the NRHM and from the point of view of program managers followed. Panelists included Lester Coutinho (David and Lucile Packard Foundation), Sunil Mehra (MAMTA Health Institute for Mother and Child), Vandana Bhatia (UNFPA), and Deepti Varma (Population Council). The session was chaired by Manjula Lusti-Narasimhan of WHO. The panel discussion was followed by a lively Q&A session. The meeting concluded with a vote of thanks from Anjali Nayyar, India Country Program Leader, PATH.

SRH-HIV integration global experiences

A selection of evidence on integrating HIV, family planning, and other sexual and reproductive health services presented at the XVII International AIDS Conference 2008 (Mexico City)

Evidence presented on SRH and HIV integration at AIDS 2008 discussed the continued challenge of social stigma against HIV; lessons from pilot projects integrating HIV, family planning, and reproductive health services for HIV-positive people and female sex workers; and lessons from pilot projects building skills of HIV-positive women in policy advocacy. Two reviews on SRH-HIV integration were also presented.

In a prospective cross-sectional study of contraception and conception issues among PLHIV on antiretroviral therapy in Ibadan, Nigeria, Awolude and colleagues reported that 75 percent of their respondents were sexually active after HIV diagnosis, and that inconsistent condom use was associated with desire to get pregnant—a wish expressed by almost 68 percent of respondents. The study showed that PLHIV are aware of the importance of barrier contraception but decline to use it due to a low number of surviving children, and concluded

A participant at a community workshop

with a call for effective integration of family planning programs and HIV/AIDS care.[6]

In a pilot project in Ghana that aimed to improve strategies for integrating FP into HIV treatment and care, FP providers were trained in stigma reduction and infection prevention practices and were provided updates on contraception for PLHIV. Preliminary findings indicate that clients are beginning to freely access FP services. The authors (Aglah et al.) conclude that initiatives to provide information to clients, coupled with improved access to non-stigmatizing services, are vital for increasing uptake of FP for PLHIV.[7]

Ayisi et al. reported that they found integrating counseling and testing for HIV into FP services in Kenya feasible, acceptable, and effective in increasing VCT uptake and improving the quality of care. Comparing a "testing" model (where providers offered VCT and post-test counseling during the same visit) against a "referral" model (where clients requesting VCT were referred to a specialized VCT facility) in 23 rural and urban facilities in two provinces in Kenya, the authors reported that at endline, among repeat FP clients, there was a significant increase in the proportion of clients reporting that they had ever had an HIV test in the testing (46 to 81 percent) compared to the referral group (41 to 59 percent). The authors concluded that despite constraints such as staff shortages, integration of counseling and testing into FP services was feasible and increased clients' access to STI and HIV testing.[8]

Shannon et al. drew on baseline data from a prospective cohort of street-based female sex workers in Vancouver, Canada, to better understand their neglected reproductive and mothering needs. They found that the mean number of pregnancies were five, with no significant difference between HIV-positive and HIV-negative women. They reported that 47 percent of the women had lost at least one pregnancy through miscarriage/birth complications and half reported induced abortion. Whereas condom use for sexual services was fairly high, women reported extremely low rates (6 percent) of other contraceptive usage, and 47 percent reported an irregular menstrual cycle over the past year. In conclusion, the authors said their study "suggest[s] a desperate need for integration of reproductive health and HIV prevention and treatment services for sex workers."[9]

A pilot project initiated to prevent unintended pregnancies among PLHIV in Uganda found that providers rarely discussed FP with clients; only 1 of 55 providers had been trained in FP; and PLHIV preferred to receive FP services from their usual HIV service providers. Interventions included training of providers in FP-HIV integration and development of job aids. Evaluating the project, Farrell et al. showed that 69 percent (n=105) of sexually active women were using effective FP methods; clients including men were better informed of FP benefits and were satisfied to be getting FP service from their usual HIV service providers; and NGO providers who have been trained in FP respected clients' rights to sex and child bearing.[10]

In Indonesia, female sex workers, female injecting-drug users, partners and wives of male injecting-drug users, and partners and wives of men who buy sex make up the vulnerable group of HIV-infected people. Documenting the role of these women, Sebayang showed that building HIV-positive women leaders' strength in developing and implementing an advocacy strategy resulted in these groups being able to advocate in support for the integration of HIV information and services into existing SRH services.[11]

Kennedy et al. conducted a systematic review of interventions linking SRH services with clinical care for PLHIV. The authors commented that most studies assessed process outcomes and showed that clinic attendance and uptake of HIV testing improved post-intervention. The few published evaluations showed that linking SRH services with HIV care is feasible, inexpensive, and recommended; but none of the included studies had examined impacts on health and behavior. In conclusion, they recommended there was further need of evidence, including randomized control trials on SRH/HIV linkages.[12] A literature and experience review by Reynolds focused on the need for contraception among care and treatment (C&T) clients, the evidence of effectiveness of integrated strategies, and the key challenges. The author reported that incorporating contraceptive services into C&T is an appropriate approach to integration. Key challenges include the lack of incentive for C&T providers in providing additional RH/FP services.[13]

6. Awolude OA, Adesina OA, Oladokun A, Aken'Ova YA, et al. Contraception and conception issues among people living with HIV in Ibadan, Nigeria. Presented at: XVII International AIDS Conference 2008, Mexico City.
7. Aglah O, Bruce K, Preko P, Bonku E, et al. Improving strategies for integrating family planning into HIV treatment and care: preliminary findings from Ghana. Presented at: XVII International AIDS Conference 2008, Mexico City.
8. Ayisi R, Liambila W. Integrating counselling and testing for HIV into FP services in Kenya is feasible, acceptable, and effective in increasing VCT uptake and improving the quality of care. Presented at: XVII International AIDS Conference 2008, Mexico City.
9. Shannon K, Parsad D, Alexson D, Gibson K, et al. The neglected reproductive and mothering needs of street-based sex workers who use substances: reframing HIV prevention and treatment strategies. Presented at: XVII International AIDS Conference 2008, Mexico City.
10. Farrell B, Johri N, Ngobi C, Achwal I, et al. Preventing unintended pregnancies among people living with HIV and AIDS through provision of family planning services. Presented at: XVII International AIDS Conference 2008, Mexico City.
11. Sebayang M. Strengthening woman's leadership in the AIDS response. Presented at XVII International AIDS Conference 2008, Mexico City.
12. Kennedy C, Spaulding A, Almers L, Bain Brickley D, et al. Integrating sexual and reproductive health (SRH) services with clinical care for people living with HIV: a systematic review. Presented at XVII International AIDS Conference 2008, Mexico City.
13. Reynolds HW. State of the evidence for the practice of integration of contraceptive services into HIV care and treatment settings. Presented at XVII International AIDS Conference 2008, Mexico City.

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