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HIV SERVICES INTEGRATION WITH SEXUALLY TRANSMITTED INFECTION/TUBERCULOSIS/ REPRODUCTIVE TRACT INFECTION SERVICES

DESK REVIEW

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

SEPTEMBER 2010

This publication was produced by the AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector I, Task Order I, USAID Contract # GHH-I-00-07-00059-00, funded January 31, 2008.

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The AIDS Support and Technical Assistance Resources (AIDSTAR-One) project is funded by the U.S. Agency for International Development under contract no. GHH-I-00-07-00059-00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with Broad Reach Healthcare, Encompass, LLC, International Center for Research on Women, MAP International, Mothers 2 Mothers, Social and Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in PEPFAR non-focus countries in knowledge management, technical leadership, program sustainability, strategic planning and program implementation support.

Recommended Citation

Shinde, Krupa L., and David S. Hausner. 2010. *HIV Services Integration with Sexually Transmitted Infection/Tuberculosis/Reproductive Tract Infection Services, Desk Review*. Arlington, Va.: USAID | AIDSTAR-One Project, Task Order 1, 2010.

Abstract

The HIV/AIDS pandemic has compelled the fields of sexual and reproductive health (SRH) and HIV/AIDS to better leverage their strengths. This paper reviews the literature of the subject with a special focus on identifying experiences, models, and good practices. Experiences from India are also highlighted. The feasibility of integration, in light of India's governmental policies and health system, is outlined through an examination of the potential opportunities and existing barriers to different types of linkages between SRH and HIV services.

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ACRONYMS

ANC	antenatal care
ART	antiretroviral therapy
CDC	Centers for Disease Control and Prevention
FP	family planning
FPAI	Family Planning Association of India
FRU	First Referral Unit
IDU	injecting drug user
IPPF	International Planned Parenthood Federation
MARP	most-at-risk population
MCH	maternal and child health
MSM	men who have sex with men
NGO	nongovernmental organization
NRHM	National Rural Health Mission
NTP	National Tuberculosis Program
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
PSS	Parivar Seva Sanstha
RH	reproductive health
RTI	reproductive tract infection
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UNFPA	U.N. Population Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

SUMMARY

Integration of SRH, tuberculosis (TB), maternal and child health (MCH), and HIV referrals, communications, and services can provide opportunities for increased value to clients, providers, and programs. Existing barriers to integration that have been identified include weakened health systems, vertical programs, and administrative bureaucracies (PATH India 2006). Stigma and discrimination against people living with HIV is also an issue. Successful integration of HIV, SRH, TB, reproductive tract infection (RTI), and sexually transmitted infection (STI) services necessitates strengthened commitment by governments, donors, nongovernmental organizations (NGOs), and civil society alike to identify and scale-up effective models. Integration should not be seen as an end goal in and of itself, but rather as a means to achieve better health outcomes among targeted populations. Integration may not always be the best way forward to achieve better health outcomes, and each target group and situation needs to be analyzed before jumping ahead. Most literature points to a health system reform in order to achieve effective integration.

There is ample material and a growing body of knowledge about the integration of HIV and SRH services; there are also a few good studies about HIV and TB integration. Most literature points to the significance of why this integration is essential and how it could be useful to all stakeholders involved. However, there is a significant lack of material documenting actual experiences or models that show how this integration has been done.

KEY THEMES FROM LITERATURE

Several key themes emerging from the literature include the following:

- Integration of family planning and HIV services requires political commitment at the highest levels of government and needs to be nationally driven. Although policy continues to be a neglected area of enquiry, policy formulation will have to be participative and inclusive to reconcile diverse viewpoints (Druce and Dickinson 2006).
- The similarities and differences between the epidemiology of reproductive morbidities and HIV, and between reproductive health (RH) family planning services and HIV services, need to be understood in order to introduce appropriate integration strategies.
- Through the lens of health sector reform, it is clear that integration must involve much more than the content of policies and types of services delivered (Berer 2003a).
- Policymakers and program managers should carefully consider the characteristics, RH, and other needs of target populations when making decisions about service integration (Gillespie et al. 2009). It is important to understand the growth and location of the epidemic so that the right people are targeted and the right integration takes place. Ultimately, if the right decisions are made, the health outcomes of the target population will be improved.
- There is growing evidence and much research showing how the overall impact of services is improved as integration takes place. Many studies reported an increase or improvement in the

following: access to and uptake of services, including HIV testing, health, and behavioral outcomes; condom use; HIV and STI knowledge; and overall quality of service.

- However, “full” integration of all services may not be advisable (PATH India 2007b) in situations where there is a lot of stigma and discrimination from health care providers and the general population. In these situations, private access to services is needed, which can only be maintained with separate services.
- Integrating the topic of HIV into family planning (FP) programming presents an opportunity to provide HIV-negative individuals with information on how to prevent infection, and also allows for HIV messages to reach married women, who are frequently less exposed to them. Linking SRH and HIV is considered beneficial and feasible, especially in FP clinics, HIV testing and counseling centers, and HIV clinics. (Family Planning Association of India [FPAI] experience confirms this link.)
- Key factors, such as training of frontline workers and assessing the burden that integration will cause, should be carefully considered before taking any steps toward this goal (Berer 2003b).
- Interventions that successfully implemented provider training resulted in improved provider knowledge and attitudes, leading to better SRH and HIV service provision. (This is a crucial factor in all types of integration and convergence of services that *must* be addressed for good outcomes!)
- There is little evidence that shows how integration affects services addressed toward men. According to a U.N. Population Fund (UNFPA) review, few or no studies addressed issues such as HIV-linked services targeting men and boys.
- Likewise, there were no studies that addressed the crucial issues of stigma and discrimination (UNFPA 2009).
- Government policy in India promotes integration and there are many opportunities to be explored within this policy framework (PATH India 2007a).
- “Approaches to providing access to prevention, treatment and care for vulnerable groups such as sex workers have largely been HIV focused and rarely take wider RH issues into account” (Druce and Dickinson 2006, p.21).
- Globally, UNFPA has done a significant amount of research studying various types of integration and shows over 21 promising practices in six areas of integration. PATH India has done a significant amount of work while conducting an assessment in India to find provider and client interest about SRH and HIV integration. Their assessment reviews opportunities and barriers for such integration.

DEFINITION OF INTEGRATION

Current literature provides a variety of definitions to understand the complex phenomenon of integration and linkages, or as PATH India calls it, “convergence.” “Linkages” is defined as bidirectional synergies in policy, programs, services, and advocacy between RH and HIV, TB and HIV, etc. “Integration” is combining different types of RH and HIV services or operational programs to ensure and maximize collective outcomes. Integration includes referrals from one service to another and is based on the need to offer comprehensive services. Integration refers

exclusively to health service provision and is therefore a subset of linkages (WHO, USAID, and FHI 2009).

TYPES OF INTEGRATION

Several types of integration, or convergence, have been identified by the World Health Organization (WHO; 1996).

HORIZONTAL

Horizontal integration is the integration of existing health programs (e.g., FP and MCH) or the addition of new programs into existing activities. For example, projects in the Philippines, Bangladesh, and Indonesia have successfully integrated STI services into FP services, and thereby increased treatment of STIs and clinic attendance.

VERTICAL

Vertical integration is the integrated provision of different health services at primary, secondary, and tertiary administrative levels (PATH India 2006), provision of health services to integrated population groups (e.g., provision of FP to adolescents, in addition to adults), or a combination of the these. For example, the governments of Pakistan, China, Sri Lanka, and Indonesia have sought to provide RH services through multiple delivery points (e.g., primary health clinics, FP and MCH clinics, and RTI clinics), with implementation varying across these types of clinics (PATH India 2006; Sayeed 1999).

INTEGRATION OF MANAGEMENT, ADMINISTRATION, AND SUPPORT FUNCTIONS

This involves integration of planning, budgeting, information systems, human resource development, and research. Administrative integration may occur at national, provincial, district, local, or other levels. It may be accompanied by a merger of different health departments (e.g., family welfare with public health departments).

INTEGRATION OF ACTIVITIES OF DIFFERENT SECTORS

This involves either the integration of activities of different sectors within health services (public and private health sectors) or across sectors (health, water, housing, social welfare, etc.). For example, health reforms in the Philippines have promoted inter-sectoral (e.g., health, water, roads, and bridges) planning at the district level in the context of decentralization. However, evidence from the Philippines suggests that while decentralization may be important for convergence and integration, district level governance may not always prioritize SRH issues appropriately or promote effective integration across all levels of health care as a consequence of decentralization (Murthy 2005; PATH India 2006).

COUNTRY EXPERIENCE

INDIA

NGOs in India started talking about integration of HIV, STD, and RTI services as early as 1994. As a result of a consultation of service providers of FP services, a New Delhi-based NGO, Parivar Seva Sanstha (PSS), developed a model for integrated services for implementation, evaluation, and eventual replication. PSS has increased its focus on the use of condoms for contraception, HIV, and STI prevention. Through this integration, all female clients were given access to standard screening, diagnosis, and treatment (Sharma 1996).

FAMILY PLANNING ASSOCIATION OF INDIA: ADDING VOLUNTARY COUNSELING AND TESTING SERVICES TO TRADITIONAL FAMILY PLANNING SERVICES

FPAI has systematically added HIV voluntary counseling and testing (VCT) services to their clinics that provide contraception, abortion, MCH, and infertility services. Currently, FPAI has 20 such centers across the country. Sharing service delivery statistics from their centers at a provider's meeting, Dr. Kalpana Apte, Assistant Medical Director of the FPAI, stated that the sharp increase in the number of clients attending the 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 was continuously maintained (PATH India 2009).

THE AVAHAN PROJECT IN MUMBAI, INDIA: ADDING FAMILY PLANNING SERVICES TO SEXUALLY TRANSMITTED INFECTION CLINICS

Aastha Project, which exists in two urban districts of Maharashtra, has integrated FP services into their STI clinics. As a part of the Avahan Project in India, the Family Health International run Aastha Project focuses on reducing the incidence of HIV and STIs among female sex workers and their partners. Responding to the demand for FP services among sex workers, Aastha started providing integrated STI and FP services at their project clinics. It was reported that the service uptake increased after services were integrated. The proportion of sex workers who attended Aastha clinics relative to the total number of sex workers reached through outreach activities increased from 29 percent in 2008 to 40 percent in 2009, with 59,750 sex workers accessing the STI and 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. The staff was trained in FP 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.

GOVERNMENT OF INDIA: SCALING UP COUNSELING AND TESTING CENTERS THROUGH INTEGRATION

By September 2008, the Government of India, under the National AIDS Control Program (NACP), integrated approximately 4,810 counseling and testing centers that were operational in the country. As part of integration with the National Rural Health Mission (NRHM), counseling and testing services have started operating as 24-hour primary health centers in districts with a high prevalence of HIV.

Uttar Pradesh and Bihar state government representatives participating in the PATH assessment have expressed interest in integrating different services and have acknowledged the need to offer various services. For state governments, implementing NRHM is a priority where provision of treatment of RTIs and STIs at the level of First Referral Units (FRUs) is already being introduced. FRU is a new name given to the local community health centers and subdistrict hospitals that are the closest to the communities.

KENYA

SEXUAL AND REPRODUCTIVE HEALTH AND HIV INTEGRATION

The Department for International Development conducted a broad assessment and highlighted the Kenyan experience as a major success story for service integration, which could be used as a model for India.

Kenya has made progress with scaling up linkages between SRH, HIV, and AIDS in several key areas, although institutional and financial challenges continue. The need for integration is referred to in a number of Kenya's new key policy documents, including the National Health Strategic Plan, the Health Sector Plan for HIV/AIDS, and the New National HIV/AIDS Strategic Plan (mainly in the area of prevention). The RH strategy and FP/RH guidelines highlight the relationship between HIV and maternal health, and emphasize safe sex practices including abstinence, dual protection, and the use of barrier methods to prevent infection.

Progress with key priorities:

- STI counseling, treatment, and referrals have been integrated with antenatal care (ANC), FP, and general curative services, thereby increasing the availability of STI services.
- National access to VCT has improved dramatically due to increased number of sites and improved rate of service uptake; and FP information and services are now included in VCT guidelines.
- The prevention of mother-to-child transmission (PMTCT) strategy and its implementation represent a degree of integration with existing RH services. PMTCT services are available nationwide and at all levels of the health system. However, PMTCT coverage remains low at 10 percent of all pregnant women living with HIV. Strengthening basic ANC infrastructure and services, as well as community education, can improve both PMTCT and ANC uptake.

- Although AIDS treatment centers have focused on providing antiretroviral therapy (ART), they include a good referral system for other services.

While a sector wide approach is emerging, Kenya's Ministry of Health is still dominated by vertically run, parallel service delivery programs that limit the involvement of RH staff in HIV program development and planning. The HIV/AIDS program receives earmarked support from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and Centers for Disease Control and Prevention (CDC), which has limited opportunities for strengthening MCH infrastructure. Annual AIDS funding to the health sector has risen from \$12 million in 2001 to \$71.4 million in 2004. SRH funding has fluctuated but remains under \$10 million. Off-budget support to AIDS, according to a recent public expenditure review, is "nearly two-thirds of total on-budget support to health" (Druce and Dickinson 2006, p.22).

INTERNATIONAL PLANNED PARENTHOOD FEDERATION

The International Planned Parenthood Federation (IPPF) experience of integrating HIV services into the traditional RH setting is another example of successful integration. This project is pioneering the integration of HIV and sexual and RH services as a sustainable and cost-effective way of expanding access to HIV prevention, treatment, and care. Functional integration of HIV and SRH services means that one doctor or nurse can provide all of the services without the need for referral. This has significantly increased utilization of both types of services because it reduces the stigma around HIV and builds trust between the client and the provider.

Improved testing, an increase in coverage, an increase in the number of people living with HIV accessing treatment for opportunistic infections, and an increase in the number of clients receiving ART are several outcomes of this success story of integration (IPPF 2010).

CAMBODIA

HIV AND TUBERCULOSIS INTEGRATION

There may be several key lessons to be learned from the Cambodia experience about the realities of integrating HIV and TB care. In response to these dual epidemics and the separate national programs that deal with each disease, the Cambodian Ministry of Health established the subcommittee on TB and HIV in 1999 and two frameworks in 2002: the Framework for TB and HIV in Cambodia and the Continuum of Care for People Living with HIV/AIDS Operational Framework. Four sites were selected to implement these frameworks, including two funded by the U.S. Government (one by the U.S. Agency for International Development [USAID] and one by the CDC), and standard operating procedures were developed for HIV and TB testing.

Subsequently, access to ART for TB patients living with HIV became available. Following implementation at the four pilot sites, the National TB Program (NTP) called for expanded access to ART for all eligible TB patients living with HIV. Surveillance of co-infected patients was strengthened, district TB registers were revised to capture HIV information, and patient referrals were made to VCT centers, home-based care programs, and ART clinics where cotrimoxazole prophylactic therapy is also provided.

In 2005, the sites were able to screen from 70 to 100 percent of all newly HIV-diagnosed persons, but only 14 to 83 percent of TB patients were tested for HIV co-infection (NTP surveillance data; WHO 2007). The rate of active disease found after screening ranged from 9 to 26 percent.

From the perspective of the TB control program, the main challenges to TB and HIV co-management and linkage can be divided between issues regarding health systems, infrastructure, and human resource capacities. Key conclusions point to how this integration was feasible, but sustaining and expanding the integration process will require long-term commitment on the part of donors and government agencies. The importance of other stakeholders, such as NGOs and other health partners, was highlighted.

FACTORS, BENEFITS AND OUTCOMES

FACTORS PROMOTING AND INHIBITING INTEGRATION

Most literature suggests that a positive attitude and client-friendly approach from staff and providers and enhanced efforts to build capacity and train staff are factors necessary to achieve successful integration. Ownership and community involvement of key stakeholders such as community members, leaders, decision makers, and local NGOs and government is also essential. Engaging key populations in decision making and the inclusion of male partners when services were directed toward women are also essential to the success of integration.

Factors such as lack of commitment from stakeholders, non-sustainable funding, low morale, high turnover of staff, understaffed clinics and services, and stigma and discrimination were major human resource factors that hindered the success of integration of services. Cultural and literacy issues, transportation issues, social norms, and stigma are also cited as inhibiting factors caused by the community. Poor program management and lack of supervision were also factors that were detrimental to the success of integration.

BENEFITS AND OUTCOMES OF INTEGRATION

Current literature is full of examples showing how integrating services will enhance program and impact outcomes. A recent paper published by Alliance captures the experiences of the International HIV/AIDS Alliance and describes the following benefits of integrated services (International HIV/AIDS Alliance 2009):

- Integrated services can contribute to more people getting tested for HIV.
- Integration promotes safer sex.
 - Integration increases opportunities and support for safer sex practices.
 - Integration of SRH and HIV services can improve and increase condom usage, and helps offer “dual protection” interventions.
 - Male circumcision integrated into sexual and RH settings can reduce HIV transmission from women to men.
- Integration optimizes the connection between STI and HIV services.
- Integration improves health and programmatic outcomes for targeted communities.
 - HIV and STI prevention in adolescents and all men and women contributes to reduced maternal and child mortality from HIV.

- Integration of FP contributes to reducing unintended pregnancy, maternal mortality, and perinatal transmission.
- Integration contributes to preventing HIV transmission from mother to child.
- Integration reduces maternal and child mortality from HIV and AIDS.

RECOMMENDATIONS TO PROGRAM MANAGERS

It is important to keep the needs and problems of the specific target group in mind while planning an integration program. PATH India's research provides ample insights into the needs and issues of the stakeholder. For example, clients living with HIV want to go to a "safe" place, sex workers want less stigma and discrimination against them when they obtain services from government facilities, and program managers want efficiency in implementing programs (PATH India 2007c).

It is important to look at the target population to determine where integration could be useful to improve their service uptake and overall impact and outcomes. This will differ by target population. For example, men who have sex with men (MSM) do not need FP services. Injecting drug users (IDUs) need detoxification services and management of complications due to unsafe injecting practices. These services are not needed by pregnant women who do not inject drugs. In addition, the location of integrated services needs to vary by target population. Pregnant women need HIV testing in maternity clinics and hospitals. IDUs need VCT in clinics where they can get medical services for drug use-related complications or in mobile or stationary needle exchange units. Sex workers need friendly, non-stigmatizing STI clinics and are less likely to feel comfortable visiting general primary health clinics.

In India, PATH has already initiated good dialogue among key stakeholders and has issued a report that highlights good directions for future work on the issue of integration. The UNFPA study advises program managers to strengthen linked SRH and HIV responses in both directions through the following:

- Stakeholder commitment
- Human resources and planning
- Health provider training
- Client education involvement
- Quality of services
- Infrastructure
- Supply management (including commodity security).

Integration of various HIV/AIDS services with other health services can be useful to improve access to and efficiency of HIV services to the general population (HIV prevention and VCT, for example) and AIDS services to targeted most-at-risk populations (MARPs). However, it is also possible that integration can reduce access to services, especially for MARPs, due to stigma and discrimination or general discomfort in attending general health clinics. Integration can also decrease efficiency if the wrong services are being integrated (such as FP services for MSM), if integration results in services being offered at the wrong sites (e.g., oral substitution therapy in maternity

clinics), or if integration is conducted in the wrong direction (for example, needle and syringe exchange may not be useful in FP clinics, but FP in needle and syringe exchange sites may be appropriate). Thus, care needs to be taken before integration is implemented.

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