WHO/RHR/10.02

Making the case for

Interventions linking sexual and reproductive health and HIV

in proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria

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Abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
BCC	behaviour change and communication
CCM	country coordinating mechanisms
DHS	demographic and health surveys
GBV	gender-based violence
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HPV	Human papillomavirus
IDU	injecting drug user
IEC	information, education, and communication
MDGs	Millennium Development Goals
MoH	ministry of health
M&E	monitoring and evaluation
MARPs	most-at-risk populations
MSM	men who have sex with men
MTCT	mother-to-child transmission
NAFCI	National Adolescent-Friendly Clinic Initiative
NGO	Nongovernmental organization
PEPFAR	President's Emergency Program for AIDS Relief
PITC	provider-initiated testing and counselling
PMTCT	prevention of mother-to-child transmission
SRH	sexual and reproductive health
STI	sexually transmitted infection
SW	sex workers
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization

Introduction

This document is designed to provide support for those who are writing HIV-related proposals to be submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). It focuses upon specific sexual and reproductive health interventions that build upon successes and make good programmes even better through a holistic approach to HIV. This approach provides opportunities to reduce unintended pregnancy and sexually transmitted infections (STIs), including HIV, as well as maternal and newborn morbidity and mortality. It also helps people to know their HIV status and helps to ensure that the sexual and reproductive health and rights of people living with HIV are respected.[2]

Sexual and reproductive health care is defined here as not merely counselling and care related to reproduction and sexually transmitted infections,[3] including HIV, but rather as a constellation of methods, techniques and services, the purpose of which is to enhance life and personal relations.

A recent analysis by UNAIDS and the World Bank has shown that the current financial and economic crisis is affecting HIV programmes at the country level. In parallel, there is a greater appreciation of the need to take the response towards the HIV epidemic out of isolation and leverage it for the broader range of health outcomes of people.[4,5] The public health community is therefore in a time of unprecedented opportunity for prioritizing activities and evaluating the outcomes of processes such as the funding of HIV programmes. A key opportunity exists to attain internationally agreed commitments by linking Millennium Development Goals 3, 4, 5 and 6,[6] and providing strong support to sexual and reproductive health services. The 2008 Technical Review Panel (TRP) of the Global Fund has recommended that "*opportunities for synergy/integration . . . be emphasized during technical assistance*"[7]: [7]

In both HIV and Tuberculosis proposals, the TRP found that there were many missed opportunities for integration. The Global Fund's position, fully endorsed by the TRP, . . . is that . . . there is an increasing body of technical guidance on the benefits of providing access to prevention services, especially for women and adolescents, through reproductive health care.

Sexual and reproductive health and HIV are intimately linked.[8] This document suggests that in almost every country eligible for financing by the Global Fund, strategies and programmes to reduce the prevalence of HIV could be enhanced by strengthening linkages with existing sexual and reproductive health-related interventions and programmes. It is designed to be used in conjunction with the *Guidance Paper: WHO support to countries in accessing and utilizing resources from the Global Fund to Fight AIDS, TB and Malaria*. Geneva, World Health Organization, 2009.

Making the case

Within HIV proposals to the Global Fund, proposed Interventions related to sexual and reproductive health should:

- fit within overall national health policy, plans and strategies;
- show they are needed to improve or sustain HIV outcomes;
- have been defined in consultation with key stakeholders in reproductive health and HIV;
- include a cost estimate and time frame for activities;
- include a set of measurable health indicators for monitoring and evaluating progress;
- address gender inequalities, including gender-based violence, as underlying determinants of sexual and reproductive health and HIV.

Target groups largely the same

Unsafe sex can put people at risk for HIV and other STIs, as well as for unwanted pregnancy. Adolescents are the target of sex education and life skills programmes to delay sexual debt, have healthy relationships, prevent unplanned pregnancies, and prevent STIs, including HIV. In every country pregnant women are the key target group for antenatal care and safe delivery, and are also a primary target group for HIV testing and counselling. Pregnant women who test positive for HIV are also the target group for services to prevent mother-to-child transmission (MTCT) of HIV.

Target behaviours largely the same

Correct knowledge, access to commodities and services, and the confidence and skills to negotiate safe sex are the objectives of sex education, family planning, STI programmes, and HIV interventions. It has been known for many years that couples talking with each other about family planning is an essential precursor to their making informed decisions. This is particularly important for HIV prevention. In some countries, for example[8], nearly half of all new HIV infections now occur between men and women who are already married or in a stable partnership.[9]

Messages often the same

People do not separate their sexual behaviours and the consequences of these into neat boxes marked "HIV," "pregnancy" and "other STIs." To be effective, messages about the risk of exposure to HIV should address the world in which people live. This means taking a holistic approach that meets people's sexual and reproductive health needs and respects their rights, irrespective of HIV status. It also means addressing underlying gender norms related to sexuality, masculinity and femininity, as well as harmful practices that influence sexual and reproductive health and HIV status (e.g. violence against women and widow inheritance).

Services delivered to target groups often the same

In most countries, interventions to prevent MTCT of HIV during delivery as well as those to promote newborn health already reside within maternal and reproductive health programmes. Such integration makes sense to the pregnant women who access maternity care. Irrespective of their HIV status, men and women seeking advice on fertility, contraception and STIs are all looking for the same thing – sound advice from well-trained and informed professionals, at a place that is easily accessible.

Many management and procurement issues the same

In many developing countries management and commodities are two of the weakest links in health programmes. Middle management, particularly at the district and clinic levels, is weakest. As HIV programmes are scaled up to provide high levels of coverage, it makes sense to do everything possible to reduce duplication of scarce resources.

The same problems that are encountered in the procurement, logistics and distribution of HIV-related commodities (such as male and female condoms, testing kits and antiretroviral drugs (ARV) are also applicable to reproductive health supplies such as condoms and hormonal contraceptives.

More effective use of trained personnel

Health care workers play a crucial role in meeting the sexual and reproductive health needs of people at risk of acquiring, or who are living with, HIV, particularly in reducing stigma and discrimination. Health care workers need to be supported in their working conditions and provided with information and training about HIV, sexual and reproductive health and human rights. Health services delivered by knowledgeable, competent and non-judgemental health care workers will promote beneficial results for clients of both HIV-related and sexual and reproductive health services. Furthermore, since many of the core skills are common to both services it is not cost effective to duplicate the training health care workers in both these areas receive. In addition, health care workers also have sexual and reproductive health needs themselves, and may be at risk for, or be already living with, HIV.

Supporting implementation of the Global Fund's Gender Equality Strategy

Gender norms and roles, and gender-related harmful practices such as violence against women, are factors that affect interventions aimed at improving sexual and reproductive health as well as those designed to decrease the rate of HIV infection. For example, norms related to masculinity prevent men from seeking timely services for both STI and HIV testing and counselling. Similarly, norms dictating that young women should remain virgins prevent them from accessing information and services related to both sexual and reproductive and HIV.

In 2008, the Global Fund Board endorsed the Gender Equality Strategy. This document states that the Global Fund will support proposals that include "public health interventions that address social and gender inequalities." The Global Fund's **Gender Decision Point (DP26)**[10] and new gender strategy must be integrated into sexual and reproductive health services. Addressing gender inequalities in sexual and reproductive health services as well as HIV/AIDS programmes increases women's and girls' access to and use of these services, as well as the quality of care they receive.

Global Fund policies and commitments support linkages

Many obstacles to universal access to HIV-related and sexual and reproductive health services are systemic. Since 2006 the Global Fund has shown increased support for evidence-based interventions that integrate HIV-related services with sexual and reproductive health services that would have an effect on the prevalence of HIV at the national level. The Global Fund's strategic approach to **Health System Strengthening (DP10)** explicitly acknowledges the limitations of vertical, disease-specific programming, and encourages country coordinating mechanisms (CCMs) to submit applications that address cross-cutting issues such as those outlined above.

Lastly, the long tradition of nongovernmental organizations (NGOs) working in the sexual and reproductive health field makes them strong candidates to fulfil the Global Fund's commitment to expanding the role of civil society. **Strengthening the Role of Civil Society and the Private Sector (DP14)** calls for this, and requires CCMs to propose a community-based or NGO as a Principal Recipient for funding (Dual-Track Financing), including greater representation and meaningful involvement of women's groups, young people and women living with HIV.

Interventions that can make a difference

Prevention of mother-to-child transmission (PMTCT) Plus

In its 2001 Declaration of Commitment on HIV/AIDS, the United Nations General Assembly Special Session (UNGASS) pledged to halve the number of infants infected with HIV by 2010 by ensuring that 80% of pregnant women receiving antenatal care would have access to PMTCT.[11]

Rationale

In most high-income countries, widespread implementation of an evidence-based package of interventions built on the use of antiretroviral drugs, the avoidance of breastfeeding and elective caesarean section has virtually eliminated new HIV infections among children. Global access to PMTCT services is, however, still low. In 2005, only about 11% of pregnant women living with HIV gained access to HIV testing and counselling and antiretroviral prophylaxis interventions,[12] despite the fact that as many as 70% of pregnant women managed to attend an antenatal service at least once, even in countries where health systems are less well developed.[13] Clearly, there have been missed opportunities for treating and caring for women, their infants and their partners.

Antenatal visits present a critical opportunity to introduce provider-initiated testing and counselling (PITC) and access to HIV-related services, including ART, if needed. However, many PMTCT programmes are narrowly defined, and are planned and delivered as separate interventions that are not part of routine antenatal and maternal health care.

The four elements of comprehensive PMTCT are: (1) primary prevention of HIV infection among women; (2) prevention of unintended pregnancies among women with HIV; (3) prevention of HIV transmission from women with HIV to their infants; and (4) provision of treatment, care, and support to mothers with HIV, their infants and families. PMTCT Plus programmes expand on this by providing comprehensive clinical services, including ART as appropriate, to women during pregnancy and the postpartum period, and extending a package of HIV prevention, treatment, care, and support interventions to mothers, children and their families.

Just as the human rights of HIV-positive women must be respected, including the right to sexual and reproductive health and the right to have children, all women have the right to family planning in order to decide freely and responsibly on the number and spacing of their children. They also have the right to the information, education and means to enable them to exercise these rights[14]. These rights are violated in healthcare settings where women are coerced into accepting sterilization or abortion. For example, in a study conducted in four countries in the Asia-Pacific region, pregnant women living with HIV were subjected to more discriminatory behaviours by providers, including coercion to accept sterilization, as compared to HIV-negative women.

Access to contraception plays a key role in PMTCT. In some settings where family planning is not available or acceptable, over 25% of pregnancies are unplanned, a figure that may be higher among HIV-positive women. Provision of family planning services in postpartum care also provides opportunities to prevent unintended pregnancies.

Evidence

Without interventions to prevent HIV transmission, between 20% and 45% of infants born to HIV-positive women are likely to be infected. With effective interventions, the risk can be reduced to less than 2%.[15]

However, PMTCT programmes are failing to reach women in need. Coverage varies considerably between countries, but, overall, less than 30% of

HIV-positive women received preventive treatment through PMTCT services in 2006. Experience has shown that the timely and appropriate use of services can be increased by interventions that promote prevention of HIV transmission as the shared responsibility of pregnant women and their partners. For example, an evaluation of pilot interventions sponsored by the UN indicated that, among other factors, increasing male involvement led to an improvement in women's uptake of services in many countries.

Although family planning and PITC services may be available in the same facility (and therefore defined as integrated), these services are not always incorporated into routine care and therefore are not consistently accessible.

Evidence from programmes shows that uptake of antenatal care, PITC, PMTCT and ART all improve when PMTCT Plus is integrated into routine neonatal and maternal health care. Some countries, such as Botswana, have reduced HIV infection rates in children to less than 5%.

Integrating family planning into PMTCT services could double the effect of PMTCT by preventing pregnancies and infant HIV infections, as well as contributing to women's health.

Universal institution of an effective intervention to prevent congenital syphilis could reduce untreated early syphilis in pregnant women. (Among pregnant women with this condition, 25% of pregnancies result in stillbirth and 14% in neonatal death – an overall perinatal mortality of about 40%).

Making the case for proposed interventions

The following are strategies that facilitate access to family planning and HIV-related services for women at risk of HIV: counselling on STI prevention, including HIV; counselling on unintended pregnancy; couples counselling; partner testing; postpartum care, safe abortion and post abortion care services, and male involvement in PMTCT. For example, an intervention in Kenya to involve male partners in a PMTCT programme showed that where men were involved as partners in testing, and subsequently in counselling for ARV prophylaxis and risk reduction, there was increased practice of ARV prophylaxis and safer sex.

- Consider integrating HIV counselling and testing, and diagnosis and treatment of other STIs, into family planning services and routine antenatal care services; such counselling and services would include advice about HIV prevention during pregnancy as well as provision of male and female condoms.

- Introduce PMTCT Plus for women who are HIV-positive, and ensure that they have access to other sexual and reproductive health services, including counselling on contraception, pregnancy and safe abortion, where legal, as well as counselling and support on infant feeding options.

- Address the fear of disclosure of HIV status as well as the fear of the potential negative consequences of disclosure, such as the possibility of violence, abandonment and other forms of discrimination. This may include strategies such as mediated disclosure safety tips for women who may be at risk of violence related to disclosure, or couples testing and counselling.

- Ensure that referral linkages are in place for care and treatment for women who have HIV-positive test results, including clinical (staging) and immunological (CD4) assessment of pregnant women, as well as provision of ARVs for eligible pregnant women.

- As part of strengthening maternal health care, consider how to introduce safer obstetric practices and postnatal care. Such practices include: early diagnosis testing for HIV infection

at 6 weeks postpartum where virological tests are available, or antibody testing for young children at 9–12 months where virological testing is not available; co-trimoxazole prophylaxis; nutritional counselling and support; and psychosocial support.

- Control congenital syphilis as a step towards its elimination.

- Train health-care providers to prevent stigma and discrimination towards women living with HIV, and establish mechanisms for preventing such discrimination.

- Include community-based activities with community-based organizations to increase uptake of PMTCT and reduce stigma, thereby strengthening activities related to sexual and reproductive health and HIV through civil society participation.

Examples

Rwanda's Round 7 proposal[16] reflects WHO's technical guidance regarding comprehensive integration of sexual and reproductive health services and programmes with those related to HIV. Based upon Rwanda's National Reproductive Health Policy, which links with its National Policy on HIV and AIDS, the HIV prevention section of the full proposal includes consideration of sexual and reproductive health at every level, from ministry coordination and support to training and support for community health workers. The proposal places a strong emphasis on increasing access to PMTCT Plus and on the promotion and provision of condoms for preventing unintended pregnancy and STIs, including HIV.

Significant attention is paid to maternal and child health, including counselling on exclusive breastfeeding, efforts to increase the number of births attended by trained assistants and check-ups in the first few months of infants' lives. Services for STI management are significantly increased and are integrated into the health centres already supported by the Global Fund. Health care workers' capacity to provide sexual and reproductive health counselling and services, including comprehensive family planning, is bolstered through ongoing trainings that continue throughout the grant period, and through direct support to new health-care workers.

Zambia's Round 8 proposal[17] describes support to PMTCT interventions as one of several proposal components in the context of the national health sector, HIV-related and other relevant programme plans, and the national plan for human resources. In the situation analysis, key gaps include the inadequate integration of PMTCT in reproductive health services, lack of infrastructure and equipment to support scale-up of PMTCT and infant and young child feeding services, weak linkages between PMTCT and HIV-related services, and limited access to both male and female condoms, particularly in rural areas. The proposal's gender analysis includes the needs of younger women, financial and other barriers to care, cultural norms and stigma, strategies to enable women to access and utilize services without requirement of spousal approval, and male behaviours such as avoiding counselling and testing.

The proposal argues that there are many ways of delivering HIV-related services including through focused antenatal care, delivery by skilled birth attendants, postnatal services, family planning, immunization programmes, counselling on infant and young child feeding, integrated management of acute malnutrition, community outreach and systems strengthening.[17] The proposed interventions therefore address gaps in both HIV-related and other relevant programmes (including tuberculosis and malaria), as well as in the wider health system.

The PMTCT component includes: supporting districts and provinces to integrate PMTCT and infant and young child feeding counselling in all

reproductive health and family planning services, including antenatal care and all mobile services; building capacity among planners and health workers; the procurement and provision of family planning commodities; and carrying out research to establish best practices and strategies for integration of services.

Health commodities

Rationale

Male and female condoms play a central role in sexual and reproductive health because they are currently the only devices that can protect against both STIs, including HIV, and unintended pregnancy.

In some countries, such as Nigeria, condoms are perceived as much as a means of family planning as for preventing STIs. This not only helps young, single women persuade their partners to use them, but also makes it easier for couples in long-term relationships to continue using them. Such repositioning of condoms is now part of prevention strategies in some regions with a high prevalence of HIV, such as eastern and southern Africa, where half of all new infections occur within stable partnerships.

Many sexual and reproductive health programmes that help to reduce HIV transmission rely for their effectiveness on sexual and reproductive health commodities being affordable, available and used. Drugs for treating STIs are an obvious example; another is hormonal contraceptives that prevent an HIV-positive woman having an unplanned pregnancy (and thus remove the need for subsequent PMTCT). A common weakness of sexual and reproductive health programmes is that these commodities are not consistently available, and that potential users face barriers in accessing them. Strengthening the supply of these commodities is thus an essential part of an effective HIV-related strategy.[18]

Even if sexual and reproductive health commodities are available at central medical stores, their distribution to facilities is often erratic because of poor planning, weak management of logistics or insufficient transport resources. These problems can be overcome by integrating the distribution of sexual and reproductive health products with that of ARVs and, ideally, that of other essential health products through an integrated supply management system. Such integration can also reduce costs in the medium term.[19]

Inadequate physical distribution of sexual and reproductive health products is not the only barrier to their proper and consistent use. The price may be too high, for female condoms, for example, and they may be of poor quality. Staff at facilities may be judgemental in their attitudes and refuse to serve unmarried people or people who are HIV-positive. With regard to treatment of STIs, many young people with STIs buy inappropriate drugs from medicine shops or drug peddlers, or fail to take the proper dose if they do manage to get the correct drugs.[20] The high cost of certain commodities may particularly affect women, as they often do not have access to and/or control over financial resources.

Where HIV prevalence is high and use of modern contraceptives is low (as in much of sub-Saharan Africa), making family planning commodities more widely available and promoting their use are key components of universal access to HIV prevention.

A wider choice of contraceptive methods increases client uptake of these, as well as subsequent satisfaction with the product chosen. Uptake and continued use will be higher if couples, women, men and young people are offered choices, information and counselling on contraceptive methods.

Provision of emergency contraceptive pills along with condoms is also an important additional backup strategy to help women prevent pregnancy, in case condoms were not used or were used

incorrectly. Along with condoms for prevention of HIV or other STIs, some women may wish to use an additional method for pregnancy prevention that is more effective and within their control.

Evidence

With few exceptions, women living with HIV can use almost any family planning method. Current data do not show that hormonal contraceptives increase the risk of HIV transmission, or that they affect the progression of HIV. Further, hormonal methods of contraception can safely and effectively be used by women taking antiretroviral therapy. Providers' lack of knowledge about this has limited the choice of contraceptive methods for people living with HIV, and dissemination of up-to-date information is vital.[21]

A study of eight countries in sub-Saharan Africa demonstrated that reducing unintended pregnancies can have as much of an effect on preventing mother-to-child transmission of HIV as PMTCT programmes using nevirapine. It costs about US$ 500 to provide family planning to prevent the birth of one HIV-positive infant, but more than US$ 650 to prevent one case of mother-to-child transmission with nevirapine.[22]

How to make the case

- The Global Fund's **Gender Decision Point (DP26)** encourages proposals that include procurement, promotion and distribution of contraceptives, including but not limited to condoms and injectables, as budget line items and programmatic interventions.

- Likewise, the Global Fund's strategic approach to **Health System Strengthening (DP10)** gives CCMs the opportunity to improve the procurement and distribution mechanisms of all health commodities, including reproductive health supplies such as contraceptives, STI testing kits, STI drugs and rape kits where forensic DNA testing is available.

- The Global Fund's recognition of the important role played by the private sector can be harnessed by including interventions that will improve the availability and quality of sexual and reproductive health products, which most people get from shops rather than from clinics.

- Most HIV proposals do not reflect the fact that many people get STI drugs, condoms and contraceptive pills from shops.

- Develop a comprehensive and integrated national programme strategy for procurement, distribution and promotion of male and female condoms, and include the cost of each component. Such a strategy with regard to female condoms, being a female-initiated method, may also be considered a gender-responsive approach.

- Develop a Commodity Security Plan to strengthen links to the existing logistics system for essential drugs and family planning and HIV-related commodities, including systems for forecasting, procurement, distribution and warehousing.

Examples

Zambia's successful **Round 8 proposal**[17] included reproductive health commodity security as an important component, requesting 30% of the total financial gap for family planning commodities, including a variety of contraceptives and supplies for safe delivery.

In October 2008 the CCM in **Rwanda** decided to use Round 7 funding to pay for contraceptives, allocating US $ 800 000 per annum for three years. Rwanda is believed to be the first country to fund contraceptives in this way. The funds will be channelled through the Ministry of Health. The contraceptives will be distributed as part of the national family planning programme and will not be "ring-fenced" for specific HIV-related programmes. This funding is additional to the support already provided by a number of partners,

including the government of Rwanda, and is equivalent to about 20% of the total funds required for public sector contraceptives for 2006–2008.[23]

HIV prevention and services for young people

To meet the target of reducing by 25% the prevalence of HIV among young men and women ages 15–24 by the year 2010, in the UNGASS Declaration 192 Member States committed to ensure that 95% of youths aged 15 to 24 have information, education, services and life skills that enable them to reduce their vulnerability to HIV infection.[24]

Rationale

Today, more than half of those people newly infected with HIV are between 15 and 24 years of age. In sub-Saharan Africa, young women 15–24 years of age are three to six times more likely to be infected than men in the same age group. Yet the needs of the world's one billion young people are routinely disregarded when HIV-related strategies are drafted, policies made and budgets allocated. For those young people who are living with HIV, services are needed not only for their own health, but also for that of their families and communities.

Sufficient evidence exists on the effectiveness of specific interventions to prevent HIV infections among young people. There are four core areas of action that target both risk and vulnerability reduction among young people: information to develop knowledge; opportunities and support to develop life skills; appropriate and accessible health services for young people; and the creation of a safe and supportive environment, including promotion of gender equality.

Parents, teachers and other adults usually frown on and/or deny the reality of adolescent sexual activity, and young people are often ill-informed about services and are discouraged from seeking advice or help. If they do seek out services, young people are often made to feel unwelcome. A review of 34 DHS-type surveys in sub-Saharan Africa between 2000 and 2004 found that in every country more than half the young women between the ages of 15 and 24 were not fully aware of the modes of HIV transmission or of the means of HIV prevention.[25] Moreover, certain gender norms increase vulnerability to HIV infection, e.g. studies conducted in Brazil, India, Mauritius and Thailand found that many young women reported fear of seeking information on sex or condoms, as this would label them as sexually active, regardless of the true extent of their sexual experience.

Even if service providers are trained to work with young people and are sympathetic, they often face legal barriers, such as being prohibited from supplying contraceptives to clients who are below a certain age, or rules stating that underage clients are not entitled to confidentiality.

If interventions are to be effective in changing HIV-related behaviours, they must address the world in which young people live, including the effect of gender norms on young people's risk and vulnerabilities. Even in countries with a high prevalence of HIV, many sexually active young women regard the risk of becoming pregnant as higher and more serious than the risk of contracting HIV. In addition, some young women have sexual partners who are much older and are often HIV positive; in such relationships the women may not have the power to negotiate safer sex.

Sexually active young people may acquire other STIs before an HIV infection, and many HIV-positive people had a different STI before they became infected with HIV. Not only do some STIs make people more vulnerable to HIV infection, but also young men with STIs often prefer the anonymity of seeking advice from a private health care provider or buying medicines from a shop. These two channels are rarely reached by services that are government-approved and trained or quality assured.[26] Women with STIs may experience non-specific gynaecological symptoms, or they may not seek treatment because of not having the

resources to do so, or not wanting to be seen by a provider of the opposite sex. They may also refrain from seeking treatment because of being ashamed to do so for reasons such as not wanting to be stigmatized by providers as being "immoral."

Persuading young men and women that STIs are serious, providing effective treatment, and encouraging condom use as a means to prevent STIs, all involve the same behaviours that also prevent HIV infection. Gender norms, inequalities and power relations in safer sex negotiation are underlying factors that shape both STI- and HIV-related behaviours. Addressing these factors ensures that both sexual and reproductive health and HIV prevention interventions are more effective.

In addition, an estimated 90% of all young people living with HIV have been infected perinatally.[27] Roll-out of ARVs has created opportunities for infants born with HIV to live through adolescence and into adulthood. However, there is an overall failure to acknowledge their sexual and reproductive health needs, and there is very little knowledge of these needs. Work is needed to understand the fertility desires and aspirations of young people perinatally infected with HIV and to propose possible solutions for integrating these needs into HIV treatment, care and support programmes.

Young girls in particular face additional barriers in accessing HIV/AIDS information and services, such as: limited mobility and autonomy in making health decisions, including whether to become pregnant; prioritization of health needs of male family members and children over their own; lack of access to economic resources; childcare and caregiving responsibilities; and a culture of silence related to sexual and reproductive health, including HIV-related needs.[28]

Attending school makes young people significantly less likely to contract HIV.[29] This is especially true for girls, who with each additional year of education gain greater independence, are better equipped to make decisions affecting their sexual lives, and have higher income-earning potential – all of which help them to remain HIV-negative. Schools also provide an opportunity to teach comprehensive, age-appropriate, life-skills-based HIV education that addresses gender norms, sexual decision-making and gender-based violence.[30]

School can also be a place where violence and sexual coercion occur, and hence it is important that school-based interventions also address the need to make schools safer for girls and boys.

Evidence

There is good evidence that facility-based interventions aimed at young people most at risk of HIV infection work if they also have an outreach component, and if outreach provides information as well as services or referral to services. Key features include:[27]

- the creation of a safe and supportive environment, which often requires the support of political and religious leaders;
- information to develop knowledge, especially if part of well designed in-school and mass media campaigns based on audience research;
- opportunities and support to develop life skills, especially well designed curriculum-based interventions in schools, led by adults, and interventions that target young people using existing structures and organizations;
- appropriate and accessible health services for young people, including training for service providers, changes to the modus operandi of facilities, such as changes to opening times, and promotion of these services with young people and community gatekeepers.

- peer education, sex education and prevention programmes for adolescents that incorporate gender equality issues into their framework. These programmes give young people a better understanding of how norms related to masculinity and femininity may increase risk-taking sexual behaviours, and help them begin to work towards equal and responsible relationships.

- interventions aimed at ensuring that health care settings are adolescent-friendly in that they do not stigmatize young women and men who seek services.

How to make the case

- Identify which young people do or do not have the information or the services they need, and quantify the results. Segment this target group, not just by age (e.g. 15–16 year-olds are very different from 23–24 year-olds) but also by sex, urban/rural setting, school attendance status (whether in or out of school), marital status, sexual orientation, employment, income, and exposure to and preference for different media and types of services.

- Present analysis of data showing sexual and other possible risk behaviours such as alcohol or drug use. Support this with qualitative analysis, if available.

- Present analysis of the effects of gender inequality on young people's risk of and vulnerability to HIV.

- Explicitly target those segments of young people who are most at risk and provide them with services that meet their needs and respect their human rights. This can be challenging, as sexual and reproductive health service providers are often reluctant to deal with these clients. In addition, these clients may need protection from controllers, the police or religious authorities.

- Interventions to address the needs of these target groups are generally more difficult, more costly and more politically challenging than simply raising awareness through mass campaigning, though that remains important.

- Show how to test the cost–effectiveness of different approaches. School-based interventions can be scaled up, and may be very effective – but they can also be expensive, and, if poorly implemented, have little effect.

- Gather the views of young people themselves, and involve them in the evaluation of existing challenges and the design of interventions. Make sure proposals reflect the differing needs of young men and women of different ages.

- DHS-type data will often show the gaps in young men's and women's knowledge and exposure to risk. Further analysis may show that access to services is a characteristic of those with better knowledge and lower risk. Recognize that just providing a service is not enough. It is necessary to generate demand in those people who may be unaware of the services or reluctant to use them.

- Recognize that generating demand for adolescent sexual and reproductive health services and programmes can generate opposition from parents and community leaders.

- Scale up what is already working. Statistics on the age profile and sex ratios of clients using existing facilities are likely to show that in some areas young people make up a larger proportion of clients than in others, showing where it is possible to improve uptake of services.

- Collect and use sex- and age-disaggregated data for all key epidemiological and programme indicators, in order to shape programming and facilitate improved monitoring and evaluation of the effects of programmes.

- In order to reduce gender inequalities, including gender-based violence, promote interventions that transform gender norms, such as those that work with men and boys to promote gender equity in norms and attitudes relating to fatherhood and sexual responsibility.

- Develop and strengthen strategies to keep girls in school and make schools safe for them.

Examples

Cameroon's Round 4 grant supported HIV prevention for young people, though interventions did not reach young people living in rural areas or those working in the informal sector. The Round 8 proposal includes plans for behavioural change communication activities, targeting both populations not addressed in Round 4.

Madagascar's Round 8 proposal included behavioural change communication interventions that focus on improving knowledge of HIV and promoting safer HIV-related behaviours using home- and community-based peer education and outreach.

The Soul City and Sesto Sentido BCC campaigns in South Africa and Nicaragua, respectively, have been shown to be gender-sensitive sexual and reproductive health and HIV education campaigns targeted towards young people.

In South Africa, the National Adolescent Friendly Clinic Initiative (NAFCI) aims to make health care more accessible to adolescents. Clinics sign up for a Going for Gold programme that sets quality criteria for sexual and reproductive health services. To achieve accreditation clinics must have:

- management systems that support adolescent-friendly health services;

- policies and processes that support adolescents' rights;

- appropriate, available and accessible adolescent health services;

- a conducive physical environment;

- appropriate drugs, supplies and equipment;

- information, education and communication materials on adolescent sexual and reproductive health;

- systems to train and supervise staff;

- guidelines and protocols for psychosocial and physical assessment and care; and

- continuity of care.

While the programme sets standards and criteria, it is the young people and clinic staff who give the programme its vibrancy. An evaluation by Family Health International found that "the longer NAFCI is implemented at clinics the more client visits are recorded at clinics. Clinics where NAFCI was implemented for less than ten months saw on average 125 clients per month while clinics where NAFCI was implemented for more than 30 months saw 598 youth clients on average per month."[26]

Meeting the sexual and reproductive health needs of people living with HIV

Antiretroviral therapy is becoming more available in developing countries, and people living with HIV who know their status and can access appropriate health care and treatment are experiencing better health and living longer.

Rationale

Human rights and public health require that health care and legal systems support the sexual and reproductive health and rights of people living with HIV, who have the right to healthy, satisfying sex lives. Laws are needed to protect this right

and to ensure appropriate services for the sexual and reproductive health of people living with HIV. From a public health perspective, decision-makers and service providers must recognize that people living with HIV do enter into relationships, have sex and bear children. Ensuring that they can do these things safely is key to maintaining their health and that of their partners and families.[31]

The overall weakness of health systems contributes to many of the gaps in information and service that impede people living with HIV from fully enjoying their sexual and reproductive health and rights. Building health systems and improving access to widely needed sexual and reproductive health services and commodities – for example, male and female condoms – is critical. People living with HIV also need special sexual and reproductive health-related services such as guidance on using hormonal contraceptives while on antiretroviral therapy. Furthermore, stigmatization and discrimination, particularly by health-care workers, may make it difficult for people who are HIV-positive to access health services. Health workers need resources, information, skills and sensitivity training on the specific needs of HIV-positive people, including the importance of confidentiality and how to further minimize the small risk of occupational exposure to HIV infection.

HIV-positive women are more susceptible during pregnancy to malaria and anaemia, and HIV increases the risk of preterm birth and low birth weight.

HIV-positive women can safely and effectively use most contraceptive methods. However, data suggests that the presence of HIV and other STIs may increase the risk of complications when using an intrauterine device.

Evidence

Most programmes for HIV care and treatment currently include voluntary testing and counselling as well as PITC, access to ARVs and other HIV-related treatments, and hospital and home-based care for people with HIV-related illnesses. In sexual and reproductive health care the HIV-related component is often perceived to be primarily about HIV prevention; condom use, promotion of other safer sex techniques, and PMTCT in antenatal and delivery care, predominate. Management of STIs often sits uncomfortably between programmes. Thus, health services rarely deal with the full range of sexual and reproductive health needs of people living with HIV.[32]

HIV-positive women are more likely to be affected by reproductive health complications such as miscarriage, postpartum haemorrhage, puerperal sepsis and complications of caesarean section and unsafe abortion.

People living with HIV may be at greater risk of STIs such as Human papillomavirus (HPV), which is a risk factor for cervical cancer and anal cancer. STIs such as syphilis may manifest differently in people with HIV and require more aggressive treatment.

Some antiretroviral drugs and drugs used to treat opportunistic infections, such as rifampicin for tuberculosis, reduce the effectiveness of certain oral contraceptives, and some ARVs are contraindicated during pregnancy because of the potential risk to the foetus. Some ARVs can affect the bioavailability of steroid hormones.

How to make the case

- Spell out the unmet needs of people living with HIV, which are likely to include sexual and reproductive health services, and tailor services to meet their needs. People's needs will differ by age, socioeconomic status, sex and sexual orientation.

- Health workers themselves may belong to an affected subgroup, which has implications for training, access to services, and rights and responsibilities at work.

- Consider how to reach and provide services to men as well as women. Women often have higher rates of counselling and testing, and there are generally more sexual and reproductive health services directed to them.

- Integrating HIV-related interventions into existing sexual and reproductive health services can increase uptake of PITC and ARVs. Include malaria-related interventions, such as prophylactic treatment for pregnant women.

- If permitted, include access to safe abortion for women who choose this option. In many countries where abortion is legal HIV infection is grounds for termination of pregnancy.

- Include capacity-building for networks of people living with HIV. As community-based peer educators and outreach workers, they are well placed to build trust and increase uptake of services and adherence to ARV protocols.

- Consider the role of civil and community-based organizations that may already be providing HIV-related services.

Examples

In the **Round 8 Global Fund proposal for Burundi**, the Burundi Network for People Living with HIV/AIDS was nominated as the civil society Principal Recipient of the Global Fund grant. The proposal argues that the prominent role of civil society organizations with experience in community-based approaches will ensure the transition from an emergency response to a community-based one, enabling the most vulnerable people living with HIV to access a basic minimum health care package.

The proposal refers to the National Health Development Program, and includes cross references to the STI/HIV/AIDS strategic plan for 2007–2011 and the National Reproductive Health Policy. The proposal cites one challenge as "the capacity of the reproductive health program and the national health system to be able to integrate implementation" of HIV interventions at health facilities at different levels.

The proposal explicitly states that "access by people living with HIV to ARVs increases life expectancy and gives couples the legitimate right to experience father and motherhood under safe conditions and with social and psychological support." It also argues the case for HIV-positive couples or discordant couples to prevent unwanted pregnancy.

The proposal further explains that activities related to sexual and reproductive health will be integrated in prenatal care and HIV case management sites, and the capacity of care providers and community actors to will be strengthened to ensure access to information and reproductive health services. Eighty-five province-based civil society organizations will be trained to play an active part in increasing family planning awareness among women of reproductive age. The proposal also includes integration of PMTCT Plus into reproductive health services, stating that "safer pregnancy defines promotional, preventive and treatment care during pregnancy, birth and the immediate postpartum period to protect the mother and newborn, which obviously includes HIV prevention and appropriate case management in the event of infection."

Sexually transmitted infections

Worldwide, there are 340 million cases of STIs annually. Some STIs facilitate HIV transmission, particularly those that cause genital ulceration. Four of the top ten priorities in WHO's global strategy on STIs have a direct effect on HIV: syndromic management, control of congenital syphilis, STI treatment for those who are HIV-positive, and surveillance.[20]

Rationale

STIs are the third most common cause of healthy life years lost by women of reproductive age, exceeded only by maternity-related causes and HIV.

Screening and treatment for syphilis is one of the most cost-effective interventions available. Many interventions for the control of STIs have been effective in reducing the prevalence of infections such as syphilis, and have contributed to a decline in HIV incidence rates in a number of countries.

Historically STI management has lacked an institutional home, although consistently cited as a key service within the concept of sexual and reproductive health. The provision of services related to STIs and reproductive tract infections is frequently disorganized and not widely integrated into programmes addressing maternal and child health, family planning or HIV, although all have an obvious role to play in terms of targeting different audiences.

Evidence

In a randomized control trial in Mwanza, Tanzania, improved management of STIs resulted in a 38% reduction in HIV incidence[33]. There is increasing evidence that sexual and reproductive health services are contributing to HIV prevention by educating service users about STI prevention, detection and management.

A comprehensive review found that efforts to integrate STI prevention activities with reproductive health services have improved providers' attitudes, counselling skills and performance of family planning services.[34] Evidence from Mexico and Nigeria shows that when STI and self-risk assessment were central features of family planning consultations, this resulted in increased acceptance and use of condoms. Results from programmes that introduced on-site syphilis screening in reproductive health clinics in Nairobi, Kenya, show this is both feasible and effective in improving the proportions of women tested and treated, adding only slightly to the cost of an antenatal visit. Smaller scale studies on the effectiveness of community-level STI services in two areas of Nairobi have shown impressive improvements in the practice of safer sex and the reduction of reported STI incidence.

How to make the case

- Provide accurate data showing which population groups are most at risk of infections, as well as data on the most prevalent STIs in particular settings, among specific populations, e.g. the prevalence of syphilis among pregnant women. Justify interventions using data on the behaviours or circumstances that put these population groups at risk.

- Collect and use data on health-seeking behaviour to show which providers people choose for services, including how many people use private and informal sector services.

- Ensure that calculations of coverage include data on the number of private sector sexual and reproductive health providers offering STI services (shops and informal providers as well as those that are trained and registered). Also include data on the number of antenatal care, maternal health, family planning and HIV clinics currently providing STI prevention and management services.

- Separate out the number of male-only and youth-friendly sexual and reproductive health clinics offering STI services, in order to develop separate coverage targets for these groups.

- Scale up internationally recognized, evidence-based and cost-effective interventions such as routine syphilis screening in antenatal services. Establish baselines and targets for the number of private and public clinics currently offering this service.

- Interventions to promote the integration of STIs into sexual and reproductive health service settings have historically focused on staff training, HIV testing and counselling, and condom promotion. They have often neglected important systems issues. Consider making the case for health systems strengthening through improved procurement and distribution systems, so that STI drugs are integrated with the provision of drugs and supplies for broader sexual and reproductive health and HIV-related services. Also consider doing so by strengthening national laboratory capacity, so that it can support integrated programmes.

Examples

Several countries made successful Global Fund proposals on STIs.

The **Madagascar Round 8** HIV grant seeks to reduce STI prevalence as a strategy for containing HIV, with an emphasis on integrating comprehensive sexual and reproductive health services. Resources will be used for strengthening the procurement and management of STI- and HIV-related supplies, as well as improving the surveillance, monitoring and evaluation of HIV and other STIs.

The **Tanzania Round 7** HIV grant aims to integrate STI and sexual and reproductive health services at the point of delivery by training health workers and facilities to offer family planning, antenatal care, PITC, ARVs and STI diagnosis and treatment. STI-related activities include services related to gender-based violence and mass media campaigns to raise awareness of STIs.

Testing and Counselling

The number of men and women in the general population who have been tested for HIV and have received their results remains very low in many high-prevalence countries. Surveys in 12 sub-Saharan African countries showed that a median of 12% of men and 10% of women in the general population had been tested for HIV and received the results.[35] Due to low coverage and uptake of HIV testing and counselling, the majority of people living with HIV only access HIV services when they have advanced disease.

Rationale

Early knowledge of a person's HIV status enables the person to prevent HIV transmission, access HIV care services, including ARVs, and prevent opportunistic infections. All these steps help to ensure a better prognosis and quality of life for the person.

Many people who are HIV-positive but do not know it seek care and advice for other sexual and reproductive health needs. This presents an opportunity for the provider to offer HIV testing and counselling. Opportunities for testing also arise for adolescents looking for advice on contraception, pregnant women attending antenatal clinics, women buying the morning-after pill, and men and women with symptoms of STIs who consult government- or non-government-run clinics, or private providers.

To encourage people who are thinking about being tested to make the decision to do so, it is necessary to offer them as wide a choice as possible. This is especially the case when the 10–20% of early adopters have already stepped forward, and extending coverage means attracting the next 20%, and the 20% after that.[34] Early adopters of almost any product or service will go out of their way to attain it, overcoming obstacles such as distance or inconvenient opening hours, but later adopters will find these barriers much harder to overcome, and scaling up must address their needs.

Evidence

Evidence from both developed and developing countries suggests that PITC – in which the health-care provider recommends HIV testing as part of the normal care provided to a patient – can facilitate increased rates of HIV testing. In Botswana,

Kenya, Malawi and Uganda, PITC was offered in antenatal clinics, and pregnant women were inclined to accept testing if they thought it could benefit their baby.[37]

The decision to adopt PITC is dependent on the epidemic's context. In generalized epidemics, PITC is recommended for all adolescents and adults seen in all health facilities – including antenatal, childbirth, postpartum and STI services, as well as health services for marginalized and at-risk populations.

Integrating HIV testing and counselling with sexual and reproductive health services increases coverage and uptake. A recent systematic review concluded that linking sexual and reproductive health with HIV-related services is feasible and beneficial in antenatal and family planning clinics, and in STI and primary health-care clinics. It also improves access to and uptake of testing and counselling, increases condom use, and improves provider knowledge about HIV service provision[38].

How to make the case

- Use HIV prevalence and incidence data, universal access targets and progress indicators to set out the argument for decreasing the percentage of HIV-positive people who do not know their status and need to be tested.
- Present an analysis of the number of men, women and children on ARV treatment and the unmet need for HIV treatment services.
- Identify the number of existing and potential antenatal, family planning, STI and tuberculosis clinics capable of providing HIV testing and counselling services.
- Know the status of implementation of existing national programmes and services such as maternal and child health, family planning, HIV testing and care, STI services, and links with tuberculosis programmes.

Examples

Mozambique's Round 8 HIV proposal supports: the integration of PITC into all primary health-care facilities, with funding sought for the procurement and distribution of HIV rapid test kits; communication initiatives to increase demand for PITC; and educational activities addressing "positive living" and sero-discordance. The proposal also includes scaling up of testing and counselling for most-at-risk populations, aiming for 90% PITC coverage for high-risk populations such as sex workers, prisoners and men who have sex with men.

Most-at-risk populations

Rationale

In most regions outside of sub-Saharan Africa, HIV disproportionately affects injecting drug users, men who have sex with men (MSM), transgendered people, prisoners and sex workers (both male and female). These populations, in which HIV infection rates are high, also exist in sub-Saharan Africa.

Studies indicate increasing numbers of female injecting drug users in, for example, Central Europe and India. Their needs are rarely met by programmes targeting injecting drug users. Sex work and injecting drug use often take place among the same populations. Certain behaviours and beliefs, such as the belief that drug use prevents pregnancy, may increase the risk of HIV infection.[39]

Few programmes are reaching the female partners of male injecting drug users or those of men who have sex with men. In concentrated epidemics high HIV prevalence among most-at-risk populations and bridge populations can lead to a generalized epidemic.[40]

HIV programmes targeting most-at-risk populations tend to be limited to HIV prevention interventions (information, condoms and harm reduction). All people, including members of these groups, have

sexual and reproductive health needs. Limited interventions miss opportunities for family planning, prevention of unplanned pregnancy, PMTCT, STI diagnosis and treatment, and access to HIV treatment and care.

Evidence

Harm reduction and HIV prevention programmes for injecting drug users are used mainly by men, and are not reaching women or catering to their needs.

Some services for female sex workers in regions where injecting drug use may be a further risk factor fail to include harm reduction interventions. Programmes often only provide condoms and education, and may not meet clients' broader sexual and reproductive health needs, such as family planning, and may not offer support for pregnant women or women with children.[39]

HIV transmission among injecting drug users and their partners can be halted with a comprehensive approach that includes: ARVs; information and education; needle, syringe and condom provision; drug use treatment; opioid substitution therapies; treatment of STIs; demand reduction; and meeting sexual and reproductive health needs, including those of people who are HIV-positive.

Where programmes are tailored to meet the specific needs of women or men, participation and uptake increase. For example, programme reviews report that the adding sexual and reproductive health services, and tailoring these to meet the needs of female service users, increases uptake of PITC and PMTCT, and use of female condoms.

Violence is a particular problem faced by sex workers and injecting drug users, as the activities of these populations are criminalized in many settings, preventing effective harm reduction efforts, including condom promotion and needle exchange programmes. For many sex workers, avoiding violence from law enforcement, clients, partners and pimps is often a more urgent problem than the risk of STI and HIV.

How to make the case

- Use qualitative and quantitative data, including data from local mapping studies, to identify the needs of most-at-risk populations for sexual and reproductive health services. For example, track the prevalence of female versus male injecting drug users, men who have sex with men reporting sex with female partners, and unwanted and wanted pregnancies among female sex workers.

- Ensure that indicators are disaggregated by age, sex and risk behaviours.

- Make sure that services for injecting drug users provide for the needs of female as well as male clients, and that the basic package includes on-site services or referral for STI management, safe abortion (where legal), post-abortion care, PITC and PMTCT, as well as diagnosis for tuberculosis.

- Tailor services to meet women's needs. For example, employ female staff and outreach workers, establish women's drop-in centres or mobile services in appropriate locations with appropriate opening hours, and provide female condoms. Establishing legal and social support services may be valued components of services for these women.

- Include analysis of how stigma and discrimination affect the uptake of services, and design advocacy and education campaigns opposing HIV-related stigma and discrimination. Strengthen training for health-care providers in relation to reducing discrimination against people living with HIV and most-at-risk populations, as well as training on sexual violence and exploitation.

- Build linkages between services delivering health care and drug-related and social welfare interventions, as well as with the police and legal system.

- Promote access to convenient and non-stigmatizing STI services that are integrated with referrals to family planning and PITC services.

- Include capacity building for self-organization among most-at-risk populations. Community-based peer educators and outreach workers are well placed to build trust, increase uptake of services, and promote treatment literacy and adherence.

- Ensure that interventions targeting most-at-risk populations include violence prevention strategies.

Example

Madagascar has a concentrated HIV epidemic, with a population prevalence of 0.13%, and higher prevalence of HIV and STIs in most-at-risk populations. **Madagascar's Round 8** proposal sought to reduce STI prevalence through an emphasis on integrating comprehensive sexual and reproductive health and HIV services. One important goal is to expand STI treatment coverage to 85% of most-at-risk populations: men who have sex with men, injecting drug users, prisoners, sex workers and clients of sex workers.

Plans to scale up PITC emphasized the needs of most-at-risk populations, with a five-year goal of 90% PITC coverage among men who have sex with men, injecting drug users, prisoners, sex workers and their clients. Public primary health-care centres offer PITC, while mobile PITC centres and teams will help expand PITC coverage. Information and behavioural change communication interventions for vulnerable populations focus on improving knowledge and promoting safer behaviours. Home- and community-based peer education and outreach services are tailored to men who have sex with men, injecting drug users, HIV-positive people, young people, and sex workers and their clients. Funding would also be used to support an existing telephone hotline and a website that provide information to men who have sex with men and sex workers. Support on issues related to sexual identity and sexuality are at the core of all services for men who have sex with men. A pilot harm reduction programme for people who use drugs would advocate for their access to services, as well as providing clean needles, PITC, and legal and social support.

Advocacy, policy and awareness-raising activities will foster a supportive environment for populations at higher risk of HIV infection. This agenda would include developing a harm reduction policy; providing legal advice to marginalized groups; and raising awareness among health service providers, local decision-makers, law enforcement personnel, prison officials and prison guards. Law enforcement personnel would be encouraged to address violence against men who have sex with men and sex workers. A broad campaign opposing HIV-related stigma and discrimination would also address discrimination against men who have sex with men on the basis of their sexuality.

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