Maternal health is an SRH service, which is often clustered with newborn and child health services.
Linkages versus integration

**Linkages** refer to bi-directional synergies in policy, systems, and services between SRH and HIV. It refers to a broader human rights-based approach, of which service integration is a subset.

**Integration** refers to the service delivery level and can be understood as joining operational programmes to ensure effective outcomes through many modalities (multi-tasked providers, referral, one-stop shop services under one roof, etc.).

---

**Theory of change for SRHR and HIV linkages**

**Output**

- More enabling environment for a linked SRHR and HIV response
- Stronger health systems that support SRHR and HIV integration
- More integrated delivery of SRHR and HIV services

**Outcome**

- Reduced HIV-related stigma and discrimination
- Increased access to and utilization of quality integrated HIV and SRHR services
- Reduced gender-based violence*
- Improved programme efficiency and value for money

**Impact**

- Improved health, human rights, and quality of life

---


*- It is recognized that reducing stigma and discrimination and gender-based violence are also impact level measures and the outcome measures influence each other.

---

To find indicators and tools to measure progress

To find out more about linkages/integration
Visit [http://srhhivlinkages.org](http://srhhivlinkages.org) - a collection of SRHR and HIV linkages resources.
The intrinsic connections between HIV and SRHR are well-established, especially as HIV is predominantly sexually transmitted or associated with pregnancy, childbirth and breastfeeding.\(^4\)

### Key HIV and SRHR intersections: Chad data\(^{3a}\)

The intrinsic connections between HIV and SRHR are well-established, especially as HIV is predominantly sexually transmitted or associated with pregnancy, childbirth and breastfeeding.\(^4\)

**Population size** 13.59 million\(^{4a}\)  
**Life expectancy at birth** 51.2\(^{4b}\)  
**Fertility rate** 6.4\(^{4c}\)

**HIV is a leading cause of death in women of reproductive age (globally)**\(^5\)

<table>
<thead>
<tr>
<th>New adult HIV infections(^6)</th>
<th>3,600</th>
<th>2,700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HIV prevalence (ages 15-49)**\(^8\)

<table>
<thead>
<tr>
<th>People living with HIV(^9)</th>
<th>88,000</th>
<th>62,000</th>
<th>18,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**People living with HIV receiving ART\(^{10}\)**

- 15 years+ 40%
- 0-14 years 22%
- 15 years+ 23%

**AIDS-related deaths among adults (ages 15+)**\(^7\)

<table>
<thead>
<tr>
<th>AIDS-related deaths among adults (ages 15+)(^7)</th>
<th>3,700</th>
<th>3,300</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HIV-associated maternal death contributes to maternal mortality**\(^{12}\)

**Maternal mortality ratio\(^{13}\)**

- 860 per 100,000 live births

**Maternal deaths attributed to HIV\(^{14}\)**

**Gender-based violence is a cause and consequence of HIV**\(^{15}\)  
\(^\text{▲ also } p.5 \& 7\)

**Prevalence of recent intimate partner violence**\(^{16}\)

- 15%

**HIV transmission to infants can occur during pregnancy, childbirth, and breastfeeding. This is more likely where there is acute maternal HIV infection.**\(^{17}\)  
\(^\text{▲ also } p.5\)

**Mother-to-child HIV transmission rate (after breastfeeding)**\(^{18}\)

- 34%

**Pregnant women who know their HIV status**\(^{19}\)

- 13%

**Demand for family planning satisfied with a modern method of contraception (15–49)**\(^{20}\)

- 20.0%

**Certain sexually transmitted infections (STIs) significantly increase the risk of acquiring and transmitting HIV**\(^{22}\)  
\(^\text{▲ also } p.7\)

**Number of adults reported with syphilis**\(^{23}\)

- 1,183

**Condom use at last sex**\(^{24}\)

- 15%

**Demand for family planning satisfied with a modern method of contraception for women living with HIV (15–49)**\(^{21}\)

Where data is not available this is marked with **DATA NOT AVAILABLE**.
Enabling environment (policy and legal)

SRHR and HIV strategies and policies should be interconnected to increase service provision and uptake. Effective responses also must go beyond health services to address human rights and development.

### Strategies and policies

**Is there a national HIV strategy?**

If yes, have the following SRHR components been included as a measurable target:

- Condoms (with reference to STI prevention / contraceptive method)?
  - Yes

- Prevention / elimination of mother-to-child transmission of HIV?
  - Yes

- SRHR of people living with HIV?
  - Yes

- Sexually transmitted infections?
  - Yes

- Gender based violence?
  - Yes

**Is there a national SRHR strategy?**

If yes, have the following HIV components been included as a measurable target:

- Condoms (with reference to HIV prevention)?
  - Yes

- Prevention / elimination of mother to child transmission of HIV?
  - Mentioned

- SRHR of people living with HIV?
  - Mentioned

- Sexually transmitted infections?
  - Mentioned

- HIV counselling and testing?
  - Mentioned

**Is there a national SRHR and HIV integration policy or strategy?**

### Laws

#### People living with HIV

Are there laws that:

- Criminalise HIV transmission or exposure?  
  - Yes

- Impose HIV specific restrictions on entry, stay or residence?  
  - No

- Address HIV-related discrimination and protect people living with HIV?  
  - Yes

#### Key populations

Are there laws that:

- Criminalise same-sex sexual activities?  
  - No

- Deem sex work as illegal?  
  - Yes

- Mandate the death penalty for drug offences?  
  - No

- Demand compulsory detention for people who use drugs?  
  - No

- Recognise a third, neutral and non-specific gender besides male and female?  
  - No

#### Gender-based violence

Are there laws that:

- Address gender-based violence?  
  - Yes

- Penalise rape in marriage?  
  - Data not available

- Allow free entry into marriage and divorce?  
  - Data not available

- Allow the removal of violent spouses?  
  - Data not available

### Other laws

Are there laws that:

- Make sexuality education mandatory?  
  - Yes: to save a woman's life; to preserve a woman's physical health; because of foetal impairment

- Allow legal abortion?  
  - Yes

- Prohibit female genital mutilation?  
  - No

### Age of Consent

- What is the minimum legal age for marriage without parental consent?  
  - 18 years

- What is the legal age for HIV testing without parental consent?  
  - No law or policy

- What is the legal age for accessing contraceptives?  
  - 14 years

- What is the legal age for consent to sexual intercourse?  
  - 14 years
Enabling environment (policy and legal)

People living with HIV often face stigma and discrimination. A non-supportive environment can drive people living with HIV away from SRHR and HIV prevention, treatment, care and support services, hindering the AIDS response.

### Key findings from the Stigma Index

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denied sexual and reproductive health (SRH) services</td>
<td>3.7%</td>
</tr>
<tr>
<td>Denied family planning services</td>
<td>4%</td>
</tr>
<tr>
<td>Experienced forced or coerced sterilization by healthcare provider on the basis of HIV</td>
<td>3%</td>
</tr>
<tr>
<td>Ever counselled about reproductive options since being diagnosed HIV-positive</td>
<td>56.9%</td>
</tr>
<tr>
<td>Could access ART (among people yet to commence)</td>
<td></td>
</tr>
<tr>
<td>Had a constructive discussion on HIV treatment options</td>
<td>56%</td>
</tr>
<tr>
<td>Reported experience of stigma and discrimination that hinder access to HIV and SRH services</td>
<td></td>
</tr>
<tr>
<td>Sought redress if rights violated</td>
<td></td>
</tr>
</tbody>
</table>

#### Women’s empowerment

Achieving gender equality and empowering women (Sustainable Development Goal 5) is essential in its own right and also affects health status. It is a broad agenda that includes: ending stigma and discrimination, violence, and harmful practices; ensuring autonomy in health decisions; and accessing SRHR and equal rights to economic resources.

#### Gender-based violence

Intimate partner violence has been shown to increase the risk of HIV infection by around 50%. Violence, and the fear of violence, may deter women and girls from seeking HIV testing, disclosing HIV-positive status, and seeking other services for their HIV and SRHR needs. Visit [http://bit.ly/1PIpTip](http://bit.ly/1PIpTip)

#### Children and Social Protection

Orphanhood is frequently accompanied by prejudice and increased poverty, factors that can jeopardize children’s chances of completing school education and may lead to increased vulnerability to HIV and poor SRHR outcomes. As such, economic support (with a focus on social assistance and livelihoods assistance) to poor and HIV-affected households remains a high priority in many comprehensive care and support programmes.

---

### Stigma faced by people living with HIV

<table>
<thead>
<tr>
<th>Percentage of general population reporting discriminatory attitudes to HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>56.2%</td>
</tr>
</tbody>
</table>

Has the Stigma Index been conducted?

#### Ability to participate in decisions regarding their own health

Girls married before 18

<table>
<thead>
<tr>
<th>Girls married before 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>68%</td>
</tr>
</tbody>
</table>

Women who agree husband is justified in hitting or beating his wife:

<table>
<thead>
<tr>
<th>Women who believe wife is justified in refusing sex with husband</th>
</tr>
</thead>
<tbody>
<tr>
<td>72%</td>
</tr>
</tbody>
</table>

Orphanhood is frequently accompanied by prejudice and increased poverty, factors that can jeopardize children’s chances of completing school education and may lead to increased vulnerability to HIV and poor SRHR outcomes. As such, economic support (with a focus on social assistance and livelihoods assistance) to poor and HIV-affected households remains a high priority in many comprehensive care and support programmes.
Integrating SRHR and HIV services requires addressing components of health systems. These include coordination, joint partnerships, planning and budgeting, human resources, procurement and supply chain management, and monitoring and evaluation.

**Human resources**

*Doctors per 1,000*[^59]

*Nurses and midwives per 1,000*[^60]

*Community and traditional health workers per 1,000*[^51]

**Training and supervision**

- Are there SRHR training materials and curricular that include HIV?[^62] Yes
- Are there HIV training materials and curricula that include SRHR?[^53] No
- To what extent is supportive supervision for SRHR and HIV integrated at the health service-delivery level?[^64] S/D N/A
- Is there a tool for integrated supervision available?[^65] S/D N/A

**Logistics and supplies**

**HIV and SRHR commodities**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there integrated supply systems?[^66]</td>
<td>Partially integrated</td>
</tr>
<tr>
<td>Are there integrated ordering systems?[^67]</td>
<td>No</td>
</tr>
<tr>
<td>Are there integrated monitoring systems?[^68]</td>
<td>No</td>
</tr>
</tbody>
</table>

**Commodity stockouts**

- Contraceptives[^69]: 80.4%
- Antiretrovirals for HIV[^70]: S/D N/A
- STI drugs[^71]: S/D N/A

**Coordination, planning and budgeting**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there joint planning of HIV and SRHR programmes?[^72]</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there any collaboration between SRHR and HIV for programme management/implementation?[^73]</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Health information systems[^74]**

<table>
<thead>
<tr>
<th>Component</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>National surveys</td>
<td>1.5/2</td>
</tr>
<tr>
<td>Facility-based data collection</td>
<td>1.67/3</td>
</tr>
</tbody>
</table>

**SRHR and HIV service coverage**

- HIV testing and counselling facilities per 100,000 adult population[^75]: 1
- Primary level service delivery points offering at least three modern methods of contraception[^76]: 100%

**Rapid Assessment of SRH and HIV linkages[^77]**

Has the Rapid Assessment for Sexual and Reproductive Health and HIV Linkages been conducted?[^78] NO

A rapid assessment of SRH and HIV linkages is a useful tool for countries to assess existing bi-directional linkages at the policy, systems and service-delivery levels.
Integrated service delivery

Providing integrated services enables clients to receive as many quality services as possible at the same time and in the same place, especially at the primary healthcare level. This can happen through government, civil society, and private providers.

Integrated service provision

Health facilities provide HIV services integrated with other health services

HIV counselling and testing with SRH
Many

EMTCT with antenatal care/maternal and child health
Many

Elimination of mother-to-child transmission of HIV (EMTCT)

Eliminating new HIV infections among children and keeping their mothers alive is based on a four-pronged strategy.81

Women living with HIV delivering
10,000

New child HIV infections
2,000

Indicators for elimination of mother-to-child transmission of HIV

Prong 1: new HIV infections among women 15-4987
3,600

Prong 2: unmet need for family planning for women of reproductive age88
23%

Prong 3: final mother-to-child HIV transmission rate89
34.0%

Prong 3: women receiving antiretrovirals (ARVs – excluding single dose nevirapine) to prevent new infections among children90
46%

Prong 3: women or infants receiving ARVs during breastfeeding91
15%

Prong 4: ART coverage among children under 15 years92
22%

Demand for family planning satisfied with a modern method of contraception for women living with HIV (15-49)95

Dual elimination of mother-to-child transmission of HIV and syphilis

In 2007 WHO launched an initiative for the global elimination of congenital syphilis, outlined in the global elimination of congenital syphilis: rationale and strategy for action.96 Initiatives are now ongoing for dual elimination of mother-to-child transmission of HIV and syphilis as an integrated process, including data validation.97

http://bit.ly/1JGx7sf
Focus on adolescents and youth
Young people need access to a range of SRHR and HIV information and services on a broad range of topics related to their physical, social, emotional, and sexual development.

Sexual behaviour

Median age at first sex among young people aged 20-24

Adolescents aged 15-19 who had:

- Had multiple sexual partners in the last 12 months
- Had multiple partners and used a condom at last sex
- Had sex before age 15

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of adolescents (15–19 years-old)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had multiple sexual partners in the last 12 months</td>
<td>1%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Had multiple partners and used a condom at last sex</td>
<td>20%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Had sex before age 15</td>
<td>28%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Unmet need for family planning, among young women aged 15-19

- Young women aged 15-19 who have ever had a child
- Recent births to mothers under 20 that were unplanned
- Young women aged 15-19 able to participate in decisions about their healthcare

Youth unemployment

HIV

Estimated number of adolescents living with HIV aged 10-19

- Young people living with HIV aged 15-24

Adolescents aged 15-19 who were ever tested for HIV and received the results

- New HIV infections among adolescents aged 15-19
- AIDS deaths among adolescents aged 10-19

Knowledge and comprehensive sexuality education

- Young people aged 15-19 who have heard of family planning on any of the three sources (radio, TV or newspapers)
- Adolescents aged 15-19 who have comprehensive knowledge of HIV
- Schools that provided skills-based HIV and sexuality education in the previous academic year
Focus on key populations

Key populations, including men who have sex with men, people who use drugs, sex workers and transgender people typically have higher HIV prevalence than the general population.

The criminalization of key populations drives people away from health services, increasing vulnerability to negative SRHR and HIV outcomes, as well as to stigma, discrimination, and violence.

*Key populations are often not reached with health services, including for SRHR and HIV, and frequently experience violation of their human rights.*

<table>
<thead>
<tr>
<th>Population size estimate</th>
<th>2,300</th>
<th>1,200</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence</td>
<td>&lt;200</td>
<td>38%</td>
</tr>
<tr>
<td>HIV testing</td>
<td>38%</td>
<td>38%</td>
</tr>
<tr>
<td>Condom use</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Useful programme implementation tools* and guidelines

http://bit.ly/1HSZWVz

http://bit.ly/1hLtqZ

UNFPA et al. (2015) Implementing comprehensive HIV and STI programmes with men who have sex with men.
http://bit.ly/1LWyfQ6

*Similar implementation tools for HIV/STI programming with other key populations are currently under development.*
Additional regional and national data

This infographic snapshot builds on an overarching framework defining HIV and SRHR linkages/integration and provides related national data. Specific aspects of HIV and SRHR linkages/integration vary by region and country due to different types of HIV epidemics and structural drivers of HIV and SRHR. Therefore, a differentiated approach to investment and programming is required.

The suggested way forward

1. **Disseminate the snapshot broadly** to key decision-makers in the government (e.g. Ministry of Health and National AIDS Commission), programme managers, donors, UN agencies, civil society organisations and community-based organisations, and use for advocacy at key events.

2. **Review the data** presented in the snapshot with key HIV and SRHR stakeholders to identify and discuss areas where further work is particularly needed.

3. **Convene a technical working group** with HIV and SRHR stakeholders to jointly plan, coordinate activities and monitor progress on HIV and SRHR linkages/integration.

4. **Work with the Ministries of Justice, Education and Health, and other appropriate sectors** to eliminate human rights violations, such as gender-based violence, early and forced marriage and stigma and discrimination.

5. **Use the snapshot** when developing and evaluating strategies, operational plans and funding proposals.

6. **Collaborate with relevant data collection entities** to fill gaps where data are not available.
Endnotes


3a. Data used in the HIV and SRHR Linkages Infographic Snapshot is the most recent data available.


7. 2015. UNAIDS 2015 estimates

8. 2015. UNAIDS 2015 estimates


9a. 2015. UNAIDS 2015 estimates

10. 2015. UNAIDS 2015 estimates


15. UN Commission on Status of Women (2013). Agreed conclusions on the elimination and prevention of all forms of violence against women and girls. New York, UN CSW.


18. 2014. UNAIDS 2014 estimates


21. Indicator: Percentage of total demand for family planning among married or in-union women living with HIV aged 15 to 49 that is satisfied with modern methods (modern contraceptive prevalence divided by total demand for family planning).


23. 2014. Annuaire des statistiques sanitaires TOME A 28ème ÉDITION


26a. 2015. IPPF and UNFPA coding (2015)

27. 2015. There is no current national SRH and HIV integration policy or strategy

28. 2015. GNP+ Global Criminalisation Scan: http://criminalisation.gnpplus.net/alphabetical


30. 2015. GNP+ Global Criminalisation Scan: http://criminalisation.gnpplus.net/alphabetical


32. 2014. UNAIDS GARPR


34. 2014. UNAIDS GARPR


35. 2014. UNAIDS GARPR

82. 2015. UNAIDS 2015 estimates
83. 2015. UNAIDS 2015 estimates
86. Indicator: Percentage of pregnant women attending antenatal care (ANC) whose male partner was tested for HIV in the last 12 months. WHO Universal Access Indicator 3.5
87. 2015. UNAIDS 2015 estimates
89. 2014. UNAIDS 2014 estimates
90. 2014. UNAIDS 2014 estimates
91. 2015. UNAIDS 2015 estimates
95. Indicator: Percentage of total demand for family planning among married or in-union women living with HIV aged 15 to 49 that is satisfied with modern methods (modern contraceptive prevalence divided by total demand for family planning)
98. Indicator: Congenital syphilis rate per 100,000 live births. WHO Global Health Observatory data repository. Congenital syphilis. http://apps.who.int/gho/data/view.main.CONGENITALSYPFSTv
100. 2013. Les données de surveillance sentinelle 2013
101. 2013. Les données de surveillance sentinelle 2013
108. Indicator: Percent of recent births to mothers <20 that were unplanned
110. 2014. UNAIDS 2014 estimates
111. 2014. UNAIDS 2014 estimates
113. 2014. UNAIDS 2014 estimates
114. 2014. UNAIDS 2014 estimates
117. Indicator: Percentage of schools that provided life skills-based HIV and sexuality education in the previous academic year.
118. Indicator: Men who have sex with men population size estimate. UNAIDS GARPR
119. 2014. UNAIDS GARPR
120. 2011. UNAIDS GARPR
121. Indicator: Transgender people population size estimate
122. Indicator: Percentage of men who have sex with men who are living with HIV. UNAIDS GARPR
123. Indicator: Percentage of people who inject drugs who are living with HIV. UNAIDS GARPR
124. 2013. UNAIDS GARPR
125. Indicator: Percentage of transgender people who are living with HIV.
126. Indicator: Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results. UNAIDS GARPR
127. Indicator: Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results. UNAIDS GARPR
128. 2009. UNAIDS GARPR
129. Indicator: Percentage of transgender people who received an HIV test in the past 12 months and know their results.
130. Indicator: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner. UNAIDS GARPR
131. Indicator: Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse. UNAIDS GARPR
132. 2009. UNAIDS GARPR
133. Indicator: Percentage of transgender people reporting the use of a condom the last time they had sexual intercourse
Inter-Agency Working Group on SRH and HIV Linkages

The Inter-agency Working Group on Sexual and Reproductive Health (SRH) and HIV Linkages is convened by UNFPA, WHO, and IPPF and works with more than 20 organizations to:

- advocate for political commitment to a linked SRH and HIV agenda;
- support national action to strengthen SRH and HIV linkages at the policy, systems, and service delivery levels; and
- create a shared understanding of SRH and HIV linkages by building the evidence base and sharing research, good practice, and lessons learnt.

Key achievements since 2004

2004: The Gion Call to Action and the New York Call to Commitment

2005: A Framework for Priority Linkages

2007: Linkages: Evidence Review and Recommendations

2008 onwards: Rapid Assessment Tool for SRH and HIV Linkages

2008 onwards: Gateways to Integration Case Studies

2010: SRH and HIV linkages resource pack

2011: SRH Services and HIV Interventions in Practice

2012: What Works? SRH and HIV Linkages for Key Populations

2013: EMTCT Job Aid

2014: SRH and HIV Linkages Compendium: Indicators and Tools

2014: Navigating the Work in Progress

To find out more

Visit http://srhhivlinkages.org - a collection of SRHR and HIV linkages resources. For a list of current members of the IAWG on SRH and HIV Linkages visit http://bit.ly/1kzQDWB

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