This country snapshot provides an overview of national level data for the full scope of HIV and sexual & reproductive health and rights (SRHR) linkages/integration at three levels:\(^1\)

- enabling environment (policy and legal)
- health systems
- integrated service delivery

By highlighting results, areas that need strengthening, and data gaps, this snapshot can be used for determining priorities, programme planning, and resource mobilization.


\(^1\)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
Visit http://bit.ly/1KVaET1

To find out more about linkages/integration
Visit http://srhhivlinkages.org
- a collection of SRHR and HIV linkages resources.
Key HIV and SRHR intersections: Swaziland data

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

<table>
<thead>
<tr>
<th>Population size</th>
<th>1.27 million(^6^)</th>
<th>Life expectancy at birth</th>
<th>48.9(^4)</th>
<th>Fertility rate</th>
<th>3.3(^4)</th>
</tr>
</thead>
</table>

**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>4,800</th>
<th>3,900</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>3,000</td>
<td>1,800</td>
</tr>
<tr>
<td>Men</td>
<td>1,800</td>
<td>2,100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIV prevalence (ages 15-49)(^8)</th>
<th>27.7%</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV(^9)</td>
<td></td>
</tr>
<tr>
<td>120,000</td>
<td>80,000</td>
</tr>
<tr>
<td>19,000</td>
<td></td>
</tr>
</tbody>
</table>

| People living with HIV\(^9\)      |       |
| 15 years+                         | 66%   |
| 0-14 years                        | 52%   |
| Children                          | 43%   |

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

<table>
<thead>
<tr>
<th>Women</th>
<th>1,300</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>1,600</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Maternal mortality ratio(^13)</th>
<th>389 per 100,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal deaths attributed to HIV(^14)</td>
<td>18.6%</td>
</tr>
</tbody>
</table>

**Gender-based violence is a cause and consequence of HIV\(^15\)**

| Prevalence of recent intimate partner violence\(^16\) | 7.7% |

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

<table>
<thead>
<tr>
<th>Mother-to-child HIV transmission rate (after breastfeeding)(^18)</th>
<th>8.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women who know their HIV status(^19)</td>
<td>97%</td>
</tr>
<tr>
<td>Demand for family planning satisfied with a modern method of contraception (15-49)(^20)</td>
<td>76.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certain sexually transmitted infections (STIs) significantly increase the risk of acquiring and transmitting HIV(^22)</th>
<th>also p.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male and female condoms provide triple protection from unintended pregnancies, HIV, and other STIs</td>
<td></td>
</tr>
<tr>
<td>Number of adults reported with syphilis(^23)</td>
<td>699</td>
</tr>
<tr>
<td>Condom use at last sex(^24)</td>
<td>71.5%</td>
</tr>
</tbody>
</table>

Demand for family planning satisfied with a modern method of contraception for women living with HIV (15–49)\(^21\)
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?\(^{25}\)

If yes, have the following SRHR components been included as a measurable target:\(^{25a}\)

- Condoms (with reference to STI prevention / contraceptive method)? No
- Prevention / elimination of mother-to-child transmission of HIV? Yes
- SRHR of people living with HIV? Mentioned
- Sexually transmitted infections? Yes
- Gender based violence? Yes

Is there a national SRHR strategy?\(^{26}\)

If yes, have the following HIV components been included as a measurable target:\(^{26a}\)

- Condoms (with reference to HIV prevention)? Yes
- Prevention / elimination of mother to child transmission of HIV? Yes
- SRHR of people living with HIV? Yes
- Sexually transmitted infections? Yes
- HIV counselling and testing? Yes

Is there a national SRHR and HIV integration policy or strategy?\(^{27}\)

Laws

People living with HIV

Are there laws that:\(^{27a}\)

- criminalise HIV transmission or exposure?\(^{28}\) No
- impose HIV specific restrictions on entry, stay or residence?\(^{29}\) No
- address HIV-related discrimination and protect people living with HIV?\(^{30}\) No

Key populations

Are there laws that:\(^{30b}\)

- criminalise same-sex sexual activities?\(^{31}\) Yes
- deem sex work as illegal?\(^{32}\) Yes
- mandate the death penalty for drug offences?\(^{33}\) No
- demand compulsory detention for people who use drugs?\(^{34}\) No
- recognise a third, neutral and non-specific gender besides male and female?\(^{35}\) No

Gender-based violence

Are there laws that:

- address gender-based violence? Yes
- penalise rape in marriage? No
- allow free entry into marriage and divorce? Yes
- allow the removal of violent spouses? Yes

Other laws

Are there laws that:

- make sexuality education mandatory?\(^{36}\) No
- allow legal abortion?\(^{37}\) Yes: to save a woman's life; to preserve a woman's physical health; to preserve a woman's mental health; because of foetal impairment
- prohibit female genital mutilation?\(^{38}\) No

Support to SRHR and HIV linkages:

Inhibitive
Partial
Conducive

Age of Consent

- What is the minimum legal age for marriage without parental consent?\(^{39}\) 21 years
- What is the legal age for HIV testing without parental consent?\(^{40}\) 16 years
- What is the legal age for accessing contraceptives?\(^{41}\) 12 years
- What is the legal age for consent to sexual intercourse?\(^{42}\) 18 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

- Denied sexual and reproductive health (SRH) services: 3.7% (n=46)
- Denied family planning services: 1.1% (n=13)
- Experienced forced or coerced sterilization by healthcare provider on the basis of HIV: 3% (n=55)
- Ever counselled about reproductive options since being diagnosed HIV-positive: 52.2%
- Could access ART (among people yet to commence): 92.5%
- Had a constructive discussion on HIV treatment options: 59.3%
- Reported experience of stigma and discrimination that hinder access to HIV and SRH services: 3.7% (n=37)
- Sought redress if rights violated: 3.9% (n=42)

### 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.

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

- Women: 89%
- Girls: 68%

#### Women who believe wife is justified in refusing sex with husband

- 38%

#### Girls married before 18

- 7%

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

- For at least one specified reason: 38%
- If she refuses sex with him: 3%

### 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/1P1pTip](http://bit.ly/1P1pTip)

#### Prevalence of recent intimate partner violence

- 7.7%

### 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.

#### Children whose households received external support

- 41.2%

#### Ratio of school attendance of orphans to non-orphans (aged 10–14 years)

- Orphans: 100
- Non-orphans: 100

#### Children who have lost one or both parents due to AIDS

- 56,000
Health systems

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

Nurses and midwives per 1,000

Community and traditional health workers per 1,000

Training and supervision

- Are there SRHR training materials and curricula that include HIV? Yes (comprehensive)
- Are there HIV training materials and curricula that include SRHR? Yes (partial)
- To what extent is supportive supervision for SRHR and HIV integrated at the health service delivery level? Partially integrated
- Is there a tool for integrated supervision available? Yes

Logistics and supplies

HIV and SRHR commodities

- Are there integrated supply systems? Yes
- Are there integrated ordering systems? Yes
- Are there integrated monitoring systems? Yes

Commodity stockouts

- Contraceptives
- Antiretrovirals for HIV
- STI drugs

Coordination, planning and budgeting

- Is there joint planning of HIV and SRHR programmes? Yes
- Is there any collaboration between SRHR and HIV for programme management/implementation? Yes

Health information systems

- Health system statistical capacity
  - National surveys: 1.5/2
  - Facility-based data collection: 2/3

SRHR and HIV service coverage

- HIV testing and counselling facilities per 100,000 adult population: 36
- Primary level service delivery points offering at least three modern methods of contraception

Rapid Assessment of SRH and HIV linkages

- Has the Rapid Assessment for Sexual and Reproductive Health and HIV Linkages been conducted? Yes 2010

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

EMTCT with antenatal care/maternal and child health

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\(^{82}\)

11,000

\(<1,000\)

New child HIV infections\(^{83}\)

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

<table>
<thead>
<tr>
<th>Prong 1: new HIV infections among women 15-49(^{87})</th>
<th>4,600</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prong 2: unmet need for family planning for women of reproductive age(^{88})</td>
<td>15.2%</td>
</tr>
<tr>
<td>Prong 3: final mother-to-child HIV transmission rate(^{89})</td>
<td>8.3%</td>
</tr>
<tr>
<td>Prong 3: women receiving antiretrovirals (ARVs – excluding single dose nevirapine) to prevent new infections among children(^{90})</td>
<td>&gt;95%</td>
</tr>
<tr>
<td>Prong 3: women or infants receiving ARVs during breastfeeding(^{91})</td>
<td>66%</td>
</tr>
<tr>
<td>Prong 4: ART coverage among children under 15 years(^{92})</td>
<td>43%</td>
</tr>
</tbody>
</table>

Demands 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/1jCx7sf

Elimination of mother-to-child transmission of syphilis

| Antenatal care attendees tested for syphilis at first antenatal care visit\(^{99}\) | 58.3% |
| Antenatal care attendees who test positive for syphilis\(^{100}\) | 3.3% |
| Antenatal care attendees positive for syphilis who are treated appropriately\(^{101}\) | 93.3% |

Initiatives are now ongoing for dual elimination of mother-to-child transmission of HIV and syphilis as an integrated process, including data validation.\(^{97}\)
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: 1% (Female), 3% (Male)
- Had multiple partners and used a condom at last sex: 92% (Female), 3% (Male)
- Had sex before age 15: 1% (Female), 3% (Male)

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

- Young women aged 15-19 who have ever had a child: 24.6%

HIV

Estimated number of adolescents living with HIV aged 10-19

- Young people living with HIV aged 15-24: 21,000 (Female), 9,600 (Male)

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

- 23% of adolescents tested for HIV

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): 55%
- Adolescents aged 15-19 who have comprehensive knowledge of HIV: 56%
- Schools that provided skills-based HIV and sexuality education in the previous academic year: 52%
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>Men who have sex with men</th>
<th>People who inject drugs</th>
<th>Sex workers</th>
<th>Transgender people</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence</td>
<td>16.7%</td>
<td>69.7%</td>
<td>54.3%</td>
<td>87%</td>
</tr>
<tr>
<td>HIV testing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Useful programme implementation tools* and guidelines


*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.

Select national/regional documents on SRHR and HIV linkages/integration

Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region
Southern African Development Community, 2015
bit.ly/1WyqT3Z

The Swaziland Linking HIV and SRH Programme Best Practice Series. Integrating Family Planning into ART Services: The Case of Siphofaneni Clinic
UNFPA and UNAIDS, 2013

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

4a. Data used in the HIV and SRHR Linkages Infographic Snapshot is the most recent data available.
6. 2014. UNAIDS 2014 estimates
7. 2014. UNAIDS 2014 estimates
8. 2014. UNAIDS 2014 estimates
9. 2014. UNAIDS 2014 estimates
10. 2014. UNAIDS 2014 estimates
11. 2011. UNAIDS QPR
13. 2014. UNAIDS GARPR
16. 2014. Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence by a male intimate partner in the past 12 months. UNAIDS GARPR
18. 2014. UNAIDS 2014 estimates
21. Indicators: 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)
24. 2013. UNAIDS GARPR
26a. 2015. IPPF and UNFPA coding (2015)
27. 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
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

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

Disclaimer: All reasonable precautions have been taken by the publisher to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the IAWG on SRH and HIV Linkages or any organization whose logo appears on this document be liable for damages arising from use of this publication. This publication does not necessarily represent the views of the IAWG on SRH and HIV Linkages or any organization whose logo appears on this document.