

Recommendations on Integration of Reproductive Health & HIV/AIDS UNFPA, April 2004

- **Rationale:** Over 75% of HIV infections are sexually transmitted, and many of the same means used to address sexual and reproductive health needs can also respond to the HIV prevention, treatment and care continuum, such as information on sexual and reproductive health, behaviour change communication to support safer sexual behaviour, provision of condoms for dual protection of STIs/HIV/AIDS and unintended pregnancies, safer delivery practices to reduce maternal and infant mortality and morbidity, diagnosis and treatment of STIs etc.

Recommendation: Seize the opportunities to integrate HIV/AIDS and reproductive health programmes thereby reducing costs, increasing effectiveness, and better serving clients needs. Reproductive health services, including family planning, STI management, and maternal care, are effective entry points for addressing HIV/AIDS prevention, treatment and care including voluntary counselling and testing – the reverse is also true. Examples of potential areas for integration include:

- Incorporating routine HIV prevention services into maternal health services (counseling on safer sexual behaviour, provision of condoms, HIV voluntary counseling and testing (VCT), information on mother-to-child transmission of HIV, STI management, infant feeding counseling in the context of HIV/AIDS, safer delivery practices, antiretroviral provision)
 - Integrate VCT into reproductive health services including family planning, STI and ANC. Some clients are more apt to utilize VCT services when they are integrated, as issues of stigma and discrimination can be more blatant in free-standing VCT clinics.
 - Utilizing antiretroviral treatment programmes to make referrals to RH services for HIV positive clients, and the reverse.
- **Rationale:** There is no single model of integration of HIV/AIDS and reproductive health.

Recommendation: Maintain flexibility in integrating RH and HIV/AIDS programming, as there is not one overarching model that is applicable under often complex and evolving circumstances. For example, it would not be necessary to programme all components of VCT into every type of RH service and site. Considerations to achieve optimal programming to integrate VCT include available resources, including human resource capacity, community needs, HIV prevalence, target groups, and existing services within the community. Not every provider need be expected to provide the full range of VCT services, such as prevention counseling, community education and mobilization, pre-test and post-test counseling, HIV testing, and medical and social care and support.

- **Rationale:** Condoms are recognized as a critical component of HIV prevention for sexually active individuals. Consistent and correct use of condoms is an important adjunct to such preventive behaviours as abstinence, delayed age at sexual debut, decreasing the number of sexual partners and fidelity. Condoms are the only method of disease prevention and protection from unintended pregnancies available currently, however, condom use is low compared to the need engendered by the epidemic.

Recommendation: The continued rapid spread of HIV/AIDS highlights the urgent need to ramp up our condom programming efforts to address supply, demand and the supportive environment. We need to galvanize support for condom programming to provide an adequate supply of male and female condoms, and to more effectively meet the needs of clients, including for dual protection. Condom programming, whether for male or for female condoms requires a thorough assessment of user and community attitudes so that programming can address any potential attitudinal barriers to access and use. National capacities must be enhanced to design, implement, and assess condom programmes and integrate this aspect into on going reproductive health programmes particularly family planning services and National HIV/AIDS strategic and operational plans. Among the activities needed to ramp up condom use are the following:

- Conduct Needs Assessments for Demand-driven Male and Female Condom Programming.

Needs assessments help to determine user profiles, risk-taking behaviour, gender dynamics, knowledge of HIV/AIDS, perceptions of condoms, condom negotiating skills, and level of condom programming, including supply side information on logistics, distribution channels and procurement arrangements, and to clarify access issues;

- Develop and deliver information, communication, and education (IEC) messages on male and female condoms to address user needs, through various service delivery channels including facility and community based family planning service delivery channels;
- Build capacity to programme for male and female condoms. A variety of tools have already been developed to provide guidance on condom programming, including
 - ‘The Female Condom: A guide for planning and programming’.
 - Condom programming guidelines for programme managers,
 - Condom programming guidelines for providers
 - Rapid needs assessment tool for condom programming, and
 - Compendium of Approaches to Increase Condom Use by Overcoming Condom Myths, Negative Perceptions and Fears.

- Design and Implement Male and Female Condom Programming Strategies
The cultural, socio-economic, and gender environment will have to be taken into account when designing effective strategies, especially the concerns and experiences of potential users and providers, and engaging public/private sector partnerships,

social marketing, facility and community based distributors and other potential stakeholders.

- Address Male Responsibility and Involvement.

Since in many countries men still maintain the dominant role in sexual decision-making, additional time and attention needs to be committed to motivating men, particularly men who rarely practice safer sex, to learn about male and female condoms and to understand the use of condoms for dual protection, and the need for sexual communication and negotiation.

- **Rationale:** Health coverage is still abysmally low in many countries, and some populations who are most vulnerable to HIV infection are not currently availing themselves of reproductive health services, which are often running at insufficient scale to cope with demand. Some of the populations who would benefit from HIV services do not access reproductive health services, and remain outside of the reach of RH including men (often RH services cater to the needs of married women), young people, and many marginalized groups.

Recommendation: Programmes to provide HIV/AIDS services must be innovative, not necessarily relying on traditional health delivery systems to reach those in need. While integration with conventional RH services will be effective for reaching some populations, outreach activities will be critical, which may go beyond the current scope of some health service based programmes. However, models for community based outreach services used in RH programmes such as family planning may provide a solid basis for integrating some HIV prevention, treatment and care programmes. Already innovative condom distribution channels, such as in bars, and taxis, have been found to be effective, as have vocational programmes to reach out of school young people.

- **Rationale:** Reproductive health and HIV are both complex multisectoral challenges; programming must go beyond the health sector encompassing inter-related socio-economic, legal, attitudinal, cultural, educational, and gender dimensions, including stigma and discrimination. At the macro level, reproductive health-related illnesses and HIV/AIDS contribute to unacceptable levels of morbidity and mortality that are eroding socio-economic gains. The current workforce of teachers, agricultural workers, miners, mothers, and young people - the next generation - are being lost to death and illness from sexually transmitted infections (including HIV/AIDS), complications of pregnancy and delivery, opportunistic infections, and other preventable health problems. Poverty adversely affects reproductive health and HIV/AIDS. Poverty forces individuals, especially women and girls, to engage in sex for survival increasing their risk of HIV infection, other STIs, and unintended pregnancy. Poverty denies people access to health services, places unreasonable workloads upon them, creates malnutrition, and lessens the chances of getting an education. Among the disadvantageous attitudes that influence how both HIV/AIDS and RH is viewed is stigma which exacerbates reproductive health problems such as obstetric fistula, and has an adverse impact on HIV/AIDS, including the right to exercise one's sexual and reproductive rights. People living with HIV/AIDS and with

fistula can attest to stigma-related abandonment, condemnation, ridicule, which prevents them from seeking and accessing reproductive health services, let alone exercising their sexual rights.

Recommendation: Both RH and HIV/AIDS programmes have to be inextricably linked to poverty reduction strategies to have a truly significant and lasting impact. While an ambitious undertaking, recognition of the macro socio-economic constraints is essential to effective programming. Often stigma and discrimination, and unequal power relations between the sexes exacerbate the poverty and visa versa, and must be addressed for any meaningful results. Simply expecting people to change behaviour out of recognition of potential risk will not be effective if they cannot exercise their rights to act. Successful interventions in both reproductive health and HIV/AIDS respect sensitivities and cultural diversity and are adaptable to local circumstances, while simultaneously adhering to the internationally endorsed principles of human rights.

- **Rationale:** Women and girls are particularly vulnerable to HIV infection and other reproductive health ailments due to lower status in society, poverty, malnutrition, lack of education, early marriage and pregnancy, legal and policy constraints, and harmful traditional practices. Alarming, women now make up 50% of all adult HIV infections, and 58% in Sub-Saharan Africa. Violence against women - including rape, coercive or survival sex, and partner abuse - can increase the risk of HIV and other STI transmission, unwanted pregnancy, high risk behaviours such as substance use, and lead to poor diet, chronic illness, miscarriages, low birth weight, suicide and homicide.

Recommendation: By addressing gender-based inequities and violence, we can simultaneously achieve our goals in reproductive health and HIV/AIDS. Better education for women, increased access to maternal care, increased decision making power, a reduction in harmful traditional practices, and freedom from gender-based violence, including coercive sex will have an enormous impact on women. Male involvement and responsibility is critical for attainment of reproductive health and rights, and to respond to the HIV/AIDS epidemic. Men and boys have the opportunity to help foster healthy lifestyles for their partners and families, acting as role models for their sons, supporting their pregnant partners, and renouncing in words and action insensitive and inhumane treatment of women and girls. Programming needs to promote women's advancement and full enjoyment of human rights, shared responsibility and capacity of men and women to ensure safer sex, and elimination of all forms of discrimination and violence against women and girls, including harmful traditional practices (e.g., FGM), abuse, rape, battering, trafficking, and other forms of sexual violence.

- **Rationale:** An increasing proportion of women are HIV positive, leading to what has been termed the 'feminization' of the HIV/AIDS epidemic. In 1997, 41% of the adults infected with HIV were women, whereas in 2002, the proportion of women had risen to 50%. Women are disproportionately vulnerable to HIV due to physiological susceptibility compounded by social, cultural, economic and legal forms of inequity that increase their risk. Poverty, limited educational opportunities, trafficking, abuse, gender-based violence, limited power to negotiate safer sex, and

certain cultural practices, including early forced marriage, are all contributing factors that have lead to the 19.2 million women who were HIV positive as of the end of 2002.

Recommendation: Sexual and reproductive health is a right for all, regardless of HIV status. For HIV positive women, there are special reproductive and sexual concerns that need to be addressed through programming with their unique needs in mind and be supported within a human rights framework. For HIV positive pregnant women, sensitive counselling, and access to available treatment, care, and support for the women, their children, and partners is essential. The provision of effective reproductive health care among HIV positive women must be guided first and foremost by a rights-based approach. PLWAs, especially women, are often not able to exercise their reproductive rights, and are subjected to stigma and discrimination.