East and Southern Africa Region

Evidence brief

WHAT IS THE EVIDENCE OF EFFECTIVENESS OF SRH/HIV INTEGRATION?

What are the key findings?

Integration of services is effective in improving condom use, HIV testing and counselling uptake as well as contraceptive use. Other desired outcomes are decreased STI incidence, better quality of care and cost benefits.

What are the key recommendations?

Upscale integration in the region, in line with the regional frameworks and using the lessons learnt from demonstration projects.

Integrate gender-based violence services, in line the World Health Assembly recommendations and using the WHO GBV clinical and policy guidelines.

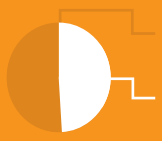
Context

TOO MANY PEOPLE DO NOT HAVE ACCESS TO QUALITY HIV AND SRH SERVICES

Sexual and reproductive health and HIV remain key public health concerns in East and Southern Africa.

ESA is the epicentre of the HIV epidemic

36.7 million people globally live with HIV
19 million of these live in East and Southern Africa.

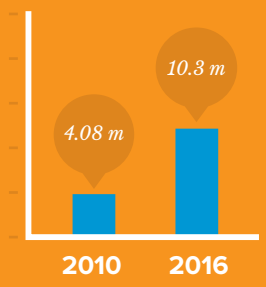


2.1 million new infections worldwide in 2015
1 million of these live in East and Southern Africa.

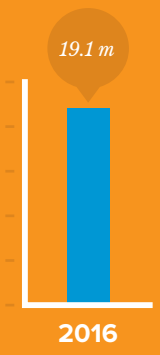
However, progress was made in the region:

- The largest reduction in new adult HIV infections occurred in East and Southern Africa: There were about 40,000 fewer new adult HIV infections in the region in 2015
- Deaths since 2010 have been reduced by 36 per cent

Number of people on treatment



Number of people living with HIV in ESA



Access to treatment has dramatically improved but half of the people in need of treatment in the region do not access it

The number of people on treatment has more than doubled since 2010

South Africa has 3.04 million people on treatment; Kenya 900,000; the rest of the countries have increased coverage by more than 25% between 2010 and 2015

However, annually, there are still more people who become newly infected than people who start a treatment

At the same time, there is an unmet need for contraception

This includes for women living with HIV; there is a heavy burden of unintended pregnancies in the region with an estimated 25 per cent of women aged 20-24 years who have given birth under 18 years of age[1]

High rates of unintended pregnancy among women living with HIV (between 53 per cent and 84 per cent) were noted in Africa[2]

With around nine million people not receiving treatment and a high unmet need for contraception, it makes sense to offer SRH and HIV services through integrated service delivery strategies. Services must be high quality, effective and accessible to children and adults, as well as key populations such as sex workers and youth.

WHY SHOULD WE INTEGRATE SEXUAL AND REPRODUCTIVE HEALTH AND HIV SERVICES?

- HIV and poor Sexual and Reproductive Health (SRH) have **shared drivers** such as gender and economic inequality, lack of access to information, gender-based violence and harmful cultural norms.[3]

- Target populations of HIV and SRH services often have the same needs for prevention and treatment of HIV and STI infections, contraception to prevent unintended pregnancies, and condoms for triple protection.

- SRH services can provide an **opportunity to reach** women and young girls with HIV prevention, treatment and care, while people living with HIV can be reached at HIV services for sexual and reproductive health care including contraception, infertility treatment, STI management, cervical cancer screening and antenatal care.

- The integration of HIV and SRH services is a health systems response with the **potential to increase access and uptake of services, improve staff satisfaction, extend coverage and reduce costs to users and services, ultimately improving joint SRHR and HIV outcomes.**

- Ultimately, integration aims to improve the dual health outcomes related to SRH and HIV, such as HIV/STI infections, AIDS-related deaths, unintended pregnancies and maternal mortality, cervical cancer and gender-based violence.

Integration has been supported at the highest policy levels such as the 2006 and 2011 Political Declarations of the United National General Assembly Special Sessions on HIV/AIDS, the SADC Protocol on Health, the SADC HIV and AIDS Strategic Plan and the Maputo Plan of Action on Sexual and Reproductive Health and Rights. This has in turn led to national commitments to strengthen linkages between SRHR and HIV strategies, laws and policies, as well as improvements in health systems and integrated services. It will support the Sustainable Development Goal 3 on health.[4]

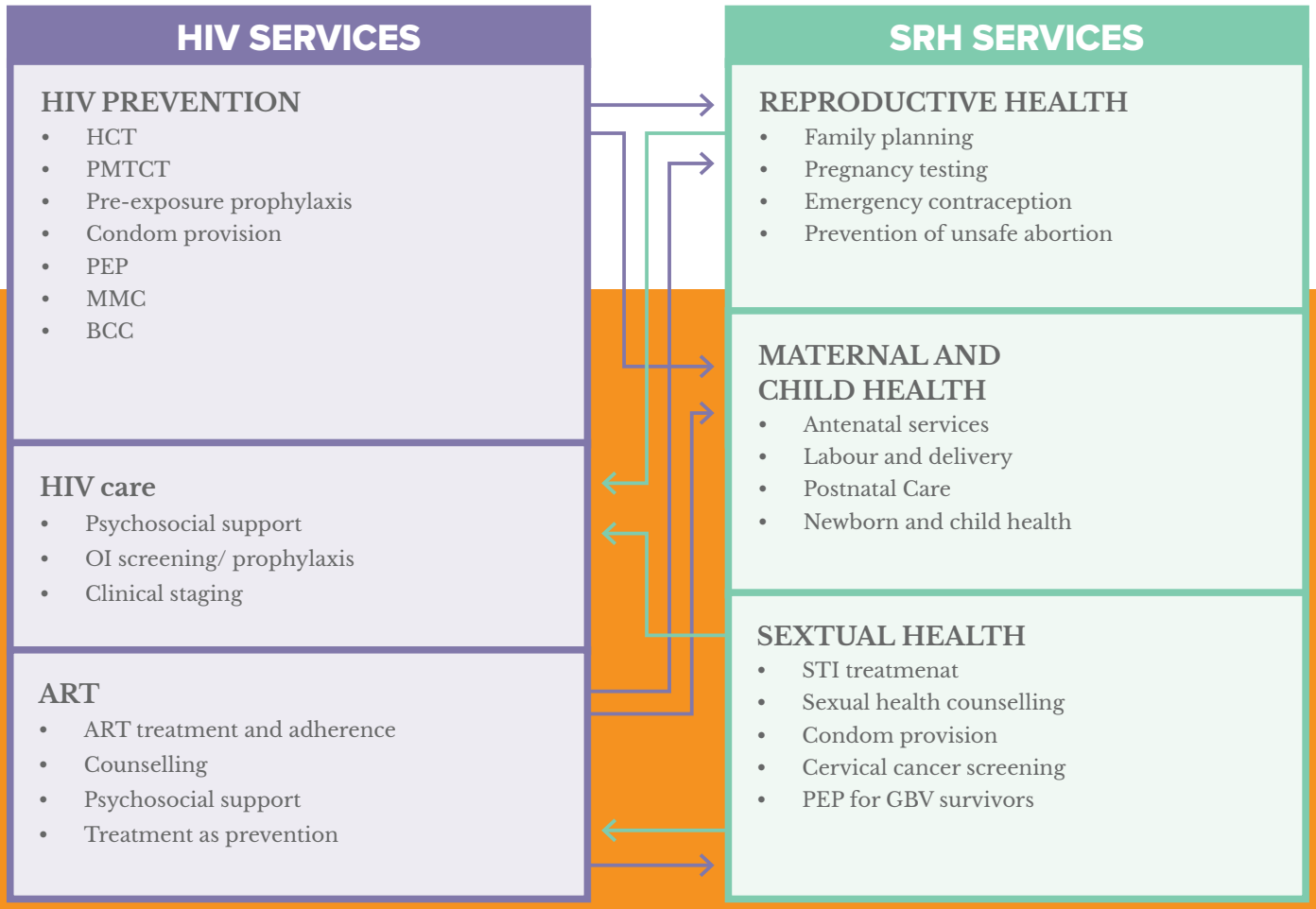
WHAT IS SRH AND HIV INTEGRATION?

'Different kinds of sexual and reproductive health and HIV services or operational programmes that can be joined together to ensure and perhaps maximize collective outcomes. This would include referrals from one service to another, for example. It is based on the need to offer comprehensive services.' [5] SRH-HIV linkages refer to the policy, programmatic and advocacy synergies between SRH and HIV. Bi-directional integration occurs when SRH service components form part of HIV services and HIV services form part of SRH services.

What are SRH and HIV integration interventions?

There are a few models for SRH and HIV integrated service delivery, such as the "one-stop-shop/ kiosk" model offering all services during the same visit by one provider in the same room, or the "supermarket" model offering all services during the same visit under the same roof. There is also a wide range of SRH and HIV integration entry points. SRH interventions can be added to HIV services, or vice versa. Integration can be viewed on a continuum with many services partially integrated.

Common approaches to integration of services



WHAT DOES THE EVIDENCE TELL US?

How was the evidence review conducted?

The literature for this review was sourced through multiple electronic databases and grey literature. It included systematic reviews, reviews of reviews, and intervention evaluations of specific SRH-HIV projects conducted in East or Southern Africa. A total of four published papers (including three systematic reviews), summarising evidence from 78 quantitative studies, were included. An annex presenting more details about the methodology and a table presenting the details of the studies included in this review is available on http://bit.ly/ESAROHIVBrief.

What were the limitations?

- **Much of the evidence is from observational studies that do not use rigorous study designs.**
- **Few studies reported on the effect of integration on HIV and STI incidence, none on maternal deaths, AIDS deaths, gender-based violence or unintended pregnancies.**
- **While the published studies had limited information on quality of services as an outcome of integration, the programme reports contained more detail on quality indicators.**
- **Review of the qualitative data was limited by the relatively few studies included.**
- **There is limited evidence on cost-effectiveness.**
- **The impact of integration on stigma and on access from key populations has not been sufficiently documented in this region.**

Examples of good practices

UNFPA-UNAIDS: SRHR and HIV linkages project

This project started in 2011 in seven Southern African countries[6] with a focus on strengthening linkages between SRHR and HIV policies, programmes and services. It aimed to contribute to Millennium Development Goals 3,4,5,6 to achieve universal access to reproductive health and HIV prevention, treatment, care and support. Project successes have been documented. For example, in Botswana integration led to an increase in female family planning clients who accessed both HIV and FP services by 89 per cent. Other findings were an increase in opportunities for continuity of care for SRH and HIV care services and decongested health facilities by reducing the number of client visits for different health care services. Strategic partnerships with NGOs strengthened provision of youth-friendly services, mobilised communities around stigma reduction and promoted male involvement and gender mainstreaming. Phase 2 of the project has started in 2016 and seeks to intensify and institutionalise integration by including a focus on TB, malaria and gender-based violence, and work in an additional three countries – Kenya, South Africa and Uganda.

Case studies of best practice: Integra initiative in East and Southern Africa

The Integra Initiative was a research project implemented between 2008 and 2013 by the International Planned Parenthood Federation, London School of Hygiene and Tropical Medicine and Population Council. It aimed to document the benefits and costs of models for delivering integrated HIV and SRH services in high and medium HIV prevalence settings to reduce HIV incidence and unintended pregnancies. Integration of facility level postnatal care and HIV services in Swaziland and Kenya used a model that encompassed comprehensive services for both mother and baby during the first few days and weeks after delivery. This included family planning, breastfeeding counselling and HIV testing for mother and infant. Service provider training used a peer-mentoring approach. Quality of care was assessed, looking at indicators related to counselling mothers (on infant feeding, fertility and sexuality, taking temperature and BP of mother, post-partum register, STI/HIV risk discussions). Study results showed that integration improved all quality indicators between 2009 and 2012 in Swaziland and Kenya. Staff reported additional benefits such as increased client satisfaction, enhanced personal skills, improved communication among staff and increased service uptake. Integration of services for postnatal mothers led to improved quality of services and health system strengthening.

Integration of SRH and HIV services has been shown to be effective in improving several health outcomes in a range of settings. These include condom use, contraception use, HIV testing and counselling uptake and reduced STI incidence. Important quality of care and cost benefits have also been documented. Although many studies have not used randomised controlled designs, the many studies and consistency of the findings in different settings supports the effectiveness of

Summary of the evidence: What works, what are the challenges to implementation and strategies to overcome barriers?

	Intervention outcome	Models of integration
EFFECTIVE	Improved condom use	Integration of HIV services into SRH services Integration of SRH services into HIV services
	Increased HIV testing uptake	Integration of HIV services into SRH services
	Decreased STI incidence	Integration of HIV services into SRH services
	Increased contraceptive uptake	Integration of SRH services into HIV services
	Cost efficient	Integration of SRH services into HIV services
PROMISING	Quality of HIV counselling	Integration of HIV services into SRH services
	Quality of care	Comprehensive delivery of integrated SRH and HIV services
	HIV incidence	Integration of HIV services into SRH services
	Earlier initiation and/or retention of ART	Integration of HIV services into SRH services Integration of HIV into ANC services
	Improved clinic attendance and/or utilisation of services	Comprehensive delivery of integrated SRH and HIV services Integration of SRH services into HIV services
CONFLICTING	Unintended pregnancy among HIV positive women	Integration of SRH services into HIV services
	Stigma	Concurrent integration of SRH and HIV services

integration. More research is required to explore the impact of integration on stigma experienced by people living with HIV, key outcomes of HIV incidence and unintended pregnancies and gender-based violence. For the latter, future integration initiatives could focus on gender-based violence services linked to the roll-out of the WHO GBV clinical and policy guidelines. Scaling up integration at facility level is feasible and will require ongoing commitment at national, regional and district levels.[7]

Evidence and examples of interventions

- HIV voluntary counselling and testing for women attending antenatal clinic and their partners in Uganda[8]
- HIV voluntary counselling and testing for male STI clinic attendees in India[8]
- SRH and HIV services for sex workers in India and the Ivory Coast[8]

- HIV testing services for pregnant women and MTCT in Swaziland[9]
- HIV testing services and short course nevirapine treatment introduced into antenatal services in the Ivory Coast[10]
- HIV voluntary counselling and testing programme integrated into an antenatal clinic for pregnant women in Scotland[8]

- Four weekly interactive sessions focusing on female empowerment, HIV risk, condom use skills and healthy relationships among women living with HIV in the US[8]
- HIV testing targeting adolescents at a public STI clinic in the US[8]

- Informational video about contraception and a facilitated discussion offered to women as part of HIV testing service in Rwanda[8]
- Family planning services integrated into HIV clinic to promote use of more effective contraception amongst women receiving care at HIV clinics, Kenya[11]

- Integration of family planning services into HIV care and treatment clinics to promote more effective contraception amongst women in Kenya[12]

- Provider training in HIV counselling and testing for pregnant women at antenatal clinics, Ukraine[10]

- Comprehensive clinic offering SRH services for women living with HIV, UK[13]

- HCT provided to women from prenatal and paediatric clinics with AIDS education video/discussion, condoms and spermicide in urban Rwanda[8]

- ARV treatment and adherence services offered at antenatal clinic for pregnant women in South Africa[10]
- Training of antenatal care staff on initiation of ART for pregnant women in Zambia[10]
- In Kenya integration led to increase in ART retention[14]

- Enhanced role of nurses through task shifting and task sharing, leading to expanded access to HIV testing, ART dispensing and initiation, dual contraception and screening for cervical cancer, Botswana[9]
- FP counselling for clients in HIV clinics, Nigeria[10]
- Integration of services for women living with HIV at an HIV outpatient clinic (separate waiting room, examination rooms were private and oriented to mothers and children, merged scheduled visits for mothers and children) US[10]

- Decrease in pregnancies in HIV-discordant couples after the introduction of integrated FP-HIV services that included staff training, couples family planning sessions and free provision of family planning on site, Kenya[10]
- Educational video on contraceptive methods and group discussion, and a range of contraception offered free of charge to women who received HIV counselling and testing led to a significant decrease in the rate of incident pregnancies (both HIV positive and HIV negative women) in Rwanda[10]
- In another research conducted in Kenya, there was no significant difference in pregnancy rates between integrated and non-integrated sites (short follow-up study not adequately powered to measure pregnancy) where clients wanting contraception were referred to a family planning clinic at the same facility[11]

- The `one-stop-shop' model led to decreases in stigma and discrimination rates for people living with HIV in Botswana[9]
- In Swaziland women preferred stand-alone facilities where there was more psychosocial support, as opposed to integrated facilities where inadvertent disclosure from the services was perceived to be more likely[15]

Barriers to implementation	Recommended strategies
Lack of clarity on content and degree of SRH-HIV integration	• Advocate and build consensus on the level and content of integration amongst policy and programme managers at regional and district levels[7] • Strengthen middle management capacity to facilitate integration • Involve providers at all stages including design
Lack of data on staffing levels and skills at facility level to facilitate integration	• Capacity assessment at facility level to assess staffing shortages or surpluses to facilitate reallocation of duties and task shifting • Training and mentorship needs to be planned to transfer new skills such as HIV counselling and testing and family planning
Facilities not equipped, organised or staffed for integration	• Introduce peer mentoring as an effective, feasible and sustainable intervention for strengthening delivery of SRH-HIV services[18] • Invest in physical infrastructure and drug availability supply • Re-organise rooms to improve client flow
Facility factors contribute to perceived stigma such as clients being identified by coloured ARV cards/non discrete ARV disbursement/provider indiscretion around family members	• Confidentiality needs to be prioritised as integration is implemented • Staff training needs to include sensitisation issues of privacy, confidentiality and stigma
Heavy staff workloads	• Introduce task shifting, task sharing, more efficient client flow • On site capacity building such as peer mentoring for health care providers so that staff are retained while being trained
A lack of community engagement with service provision	• Linkages to the community are important, not only to create demand, but also allow for adolescent and younger women to access the services • Strategic partnerships with NGOs can facilitate these linkages

CONCLUSION

The evidence clearly confirms the effectiveness, feasibility and efficiency of SRH-HIV integration. With support for integration at the highest policy levels both internationally and regionally, concerted efforts are needed within countries to strengthen integrated service provision so that optimal HIV and SRH outcomes are achieved. This in turn will contribute to the realisation of the SDG 3. Lessons learnt from carefully documented demonstration projects, such as the UNFPA-UNAIDS linkages project and the INTEGRA initiative, need to be absorbed into implementation. The SADC Minimum Standards for Integration of HIV and Sexual and Reproductive Health in the SADC Region provide a useful framework for countries to implement and monitor progress.

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Delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is realized.

Background documents and references numbered in this text are available online at: http://bit.ly/ESAROHIVBrief