Strengthening the Linkages Between Reproductive Health and HIV/AIDS Programs

By
Elizabeth Lule
Population and Reproductive Health Advisor
Human Development Network
The World Bank
ACRONYMS

AIDS   Acquired Immuno-Deficiency Syndrome
ANC   Antenatal Care
ARV   Anti-Retroviral
COPHIA Community-based HIV/AIDS Prevention, Care, and Support
DOTS  Directly Observed Treatment Short course
FP    Family Planning
HIV   Human Immuno-Deficiency Virus
ICPD  International Conference on Population and Development
ICRW  International Center for Research on Women
IEC   Information, Education, Communication
MCH   Maternal and Child Health
MDGs  Millennium Development Goals
MOH   Ministry of Health
PLWHA People living with HIV/AIDS
PMTCT Prevention of Mother-to-Child Transmission
RH    Reproductive Health
STI   Sexually Transmitted Infection
SWAp  Sector-Wide Approach
UNAIDS The Joint United Nations Program on AIDS
UNICEF United Nations Children’s Fund
USAID United States Agency for International Development
VCT   Voluntary Counseling and Testing
WHO   World Health Organization
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I. The Reproductive Health and HIV/AIDS Challenge

The 1994 ICPD Programme of Action articulated revised approaches to population issues. It reflected how population and development are inextricably linked, and emphasized that empowering women, and investing in education and health, including reproductive health, are necessary for individual welfare, protection of human rights and for development. The Programme of Action recommended a people-centered approach and called for universal access to an integrated comprehensive package of reproductive health services including HIV/AIDS through the primary health care system. The Millennium Declaration builds on the ICPD Plan of Action and reaffirms the goals of poverty reduction, universal education, gender equality, improving reproductive/maternal health, reducing child mortality, curbing the spread of HIV/AIDS and strengthened partnerships. The World Bank includes these goals in its corporate agenda.

The developing world faces an enormous task in accelerating progress to achieve the MDGs by 2015 and to address the growing unmet needs of reproductive health, and the challenges of curbing the spread of HIV/AIDS. Although some progress has been made, much remains to be done to build capacity to address these challenges more effectively and efficiently. In the face of an accelerating HIV/AIDS epidemic, population and reproductive and sexual health remain unfinished agendas for many developing countries.

Despite gains in access to contraception, over 120 million women still have an unmet need for family planning. According to WHO estimates this results in 80 million unintended pregnancies, some 45 million of which are terminated and 19 million under unsafe conditions. The number of young people aged 10-24 has increased by 50 percent in just 30 years (UNDP, 2000) We have the largest cohort of young people ever in their reproductive health ages. Between 1994 and 2015, 3 billion people will have entered their reproductive years.

Furthermore, many adolescent girls still marry and bear children too young. Addressing this unmet need could save the lives of tens of thousands of women and millions of children who are at risk because of unwanted pregnancies or of births that are not well spaced. Maternal mortality remains too high and many women do not deliver with skilled care, over 500,000 women a year die from pregnancy-related causes (WHO). For every woman who dies, 30-50 suffer injury, infection, and life long disability. Poor maternal health has a strong impact on child survival, especially the 7 million still births and neonatal deaths estimated to occur every year. Although infant and child mortality has been reduced, neonatal mortality or deaths of babies in their first week of life has not
declined in the last two decades mainly because of poor reproductive health and inadequate care during pregnancy, child birth and in the postnatal period.

HIV/AIDS is a large and growing problem in many countries. It has profound effects and impact on development, societies, communities, families and individuals. Around the world, 42 million people—95 percent of which live in developing countries—are currently infected with the HIV/AIDS virus. Sub-Saharan Africa bears the brunt of the epidemic, with 29.2 million people carrying the HIV virus. UNAIDS estimates that each day another 14,000 people worldwide, including 5,500 women, 6,000 young people aged 15-24 and 2,200 children, become infected.

The epidemic varies from region to region. There is concern about the accelerating HIV epidemic in other regions and in countries like China, India and Russia. Although 70 percent of the infections occur through heterosexual relations, a variety of economic, demographic, social, and political realities in different regions determine the different patterns of the epidemic. Poverty, conflict, gender inequalities, human rights violations as well as drug use and human trafficking contribute to the varied regional epidemics. HIV/AIDS is a chronic disease that is still unfolding and its impact will be felt for decades to come.

Women and young people are especially vulnerable to HIV/AIDS. Young people are in the precarious position of being the most vulnerable to infection and hard hit by HIV and STI. Half of all new infections occur in young people aged 15-24 -- about five young people per minute. Young girls are worst affected. Young women account for 62 percent of the 11.8 million young people living with HIV/AIDS (UNAIDS/UNICEF/WHO, 2002). In Zambia 16 times as many girls as boys were infected (Glynn et al. 2001) Young people have the least access to information and services that can prevent HIV/STIs.

Because of gender inequalities, women carry a large part of the burden of the disease. They are biologically and socially vulnerable to HIV infection. Women often cannot negotiate safe sex or condom use. Until an effective and affordable vaccine or microbicide is developed, they lack the means within their control to prevent HIV/STI infection. In 2002 alone, 2 million women around the world contracted HIV/AIDS. HIV infected women can transmit the virus to their babies in 35 percent of infants born to them. UNICEF estimates that nearly 1.8 million pregnant women living with HIV/AIDS deliver 600,000-700,000 infants with HIV/AIDS annually. When women fall ill, their families lose their primary caregiver and often the primary breadwinner. The women who die leave behind millions of orphans estimated at 13 million in 2003. Meanwhile, other sexually transmitted infections (STIs) remain both a cofactor in the spread of HIV and a major problem in their own right with an estimated 340 million new cases of STIs annually (WHO, 2003). Each year 230,000 people die from diseases such as gonorrhea and syphilis. HIV positive women carry increased disease and reproductive health morbidities.
According to WHO, all these aspects of reproductive and sexual ill health – maternal mortality and morbidity, cancers, sexually transmitted infections and HIV/AIDS account for nearly 20 percent of global burden of ill health for women and 14 percent for men. These figures likely underestimate the burden of reproductive and sexual ill health because of poor reporting on sexual violence, harmful traditional practices like female genital mutilation, menstrual abnormalities, infertility, reproductive health cancers and other gynecological morbidities. At a time when these burdens are growing, the global political economy in support of the ICPD Programme of Action is worsening.

To address the challenge of meeting increasing demand for reproductive and sexual health and HIV/AIDS, strong health systems are required. However, HIV/AIDS has overwhelmed and weakened health systems decimating health workers and managers of programs with deterioration in the quality of services provided. Migration is also a key source of workforce attrition in low-income countries. Better remuneration, career opportunities and active recruitment attract health workers with internationally accepted degrees to industrialized countries. In Zambia, out of more than 600 doctors trained since independence, only 50 remain in the country (Couper, 2002). More than 50% of physicians trained in Ghana during the 1980’s practice abroad (UNDP, 1992). The U.N. Conference on Trade and Development estimated that 56% of all migrating physicians flow from developing to industrialized countries, while only 11% flow in the opposite direction. The imbalance was even greater for nurses (Zarilli, Kennon (1998).

In the last thirty years, countries and donors have invested billions of dollars in vertical family planning and reproductive health programs and contraceptive prevalence rates have increased. Although HIV/AIDS has been around since the 1980s, political commitment by countries and donors to address the problem was slow but has recently gathered momentum. More recently more resources are becoming available to increase access to treatment and care services. Although reproductive health services are critical to prevention of HIV/AIDS, the existing infrastructure, logistics and information systems and skills in RH programs to address HIV/AIDS have not adequately been exploited. This was a missed opportunity and a costly mistake in the early 1990s. In retrospect, nobody would have known that HIV/AIDS would become the catastrophe it is today. The devastating impact of HIV/AIDS was clearly underestimated by donors and countries themselves. Many of the currently worst affected countries were initially in denial about the disease.

Even as commitment has improved and resources for HIV/AIDS have become available (see Figure 1), linkages between the two programs have weakened and coordination is lacking in the majority of countries. Because of the magnitude of the crisis and the need to accelerate progress, new parallel vertical and parallel organizational structures have been established specifically to address HIV/AIDS. There is also growing concern that with the focus on treatment, attention to prevention will diminish creating yet another missed opportunity to use treatment to strengthen prevention.

Concerned about insufficient and sluggish progress on curbing the HIV/AIDS and the challenge of meeting the growing demand for reproductive health, countries and
donors have started to think about strengthening the linkages between reproductive Health, maternal and child health services and HIV/AIDS programs.

This paper describes the challenges of HIV/AIDS and reproductive health, examines the overlapping areas between the two and examines the rational of strengthening the linkages between the two programs. It discusses the limitation of linking programs and reviews experience to date on linkages and integration and makes recommendations to address some of these challenges. The paper uses strengthening “linkages” rather than “integration”, because integration means so many different things.

II. The Components of RH/MCH and HIV/STI programs

FP/MCH and HIV/STI services are both elements of reproductive health care, as defined by the ICPD Programme of Action. Both FP/MCH and HIV/STI programs aim to improve the reproductive health of individual women and men and to improve the health of children. Although ICPD Programme of Action calls for an integrated approach within the primary health care system, current evidence shows that progress on implementation has been a challenge. In the 1990s linkages focused on adding management of STIs to FP/MCH services. However, mainstreaming the management of STIs in reproductive health and MCH services remains limited beyond a few limited cases (Askew and Berer, 2003).

<table>
<thead>
<tr>
<th>Program Components</th>
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<tr>
<td><strong>Family planning/pregnancy prevention</strong></td>
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<tr>
<td>Counseling and IEC</td>
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<tr>
<td>Provision of contraceptives and condom distribution</td>
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<tr>
<td>Basic screening of sexually transmitted infections and reproductive tract infections</td>
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<td>Infection prevention and quality of care</td>
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<td>Youth-friendly services</td>
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<td>Male involvement</td>
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<td>Community participation</td>
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<tr>
<td><strong>Maternal-child health</strong></td>
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<td>Antenatal and newborn care</td>
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<tr>
<td>Safe delivery</td>
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<td>Emergency obstetric care</td>
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<tr>
<td>Breastfeeding support</td>
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<tr>
<td>Well-baby/well-child care;</td>
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<tr>
<td>Postabortion care</td>
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<tr>
<td>Community participation</td>
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<tr>
<td><strong>HIV/STI</strong></td>
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<tr>
<td>Behavior change through IEC, counseling, and reducing stigma and discrimination</td>
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<tr>
<td>Condom promotion and distribution</td>
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<tr>
<td>Voluntary counseling and testing</td>
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<tr>
<td>Diagnosing and treating sexually transmitted infections;</td>
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<tr>
<td>Preventing mother-to-child transmission (PMTCT)</td>
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<tr>
<td>Treatment with Antiretrovirals</td>
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<tr>
<td>Male involvement and youth-targeted programs</td>
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<tr>
<td>Treatment, care and support</td>
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<tr>
<td>Community participation</td>
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<tr>
<td>Health worker safety</td>
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<td>Social Safety net.</td>
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_The Rationale for Linking_
Although the resource envelope for HIV/AIDS has recently improved, overall funding remains insufficient to address the myriad associated health problems, weak health systems and inadequate management and technical capacity. Money alone is not enough. It will depend on how the money is effectively used to build capacity, build strong health systems and how well it is coordinated. We are faced with the challenge of meeting the needs of the largest-ever generation of youth, the growing demand for family planning and other reproductive health services and combating the spread of HIV/AIDS and other sexually transmitted diseases. Countries and donors must strive to maximize the use of scarce financial and human resources and become responsive to clients needs and reducing their opportunity costs of utilizing health care. Lessons learned from Africa, India and China highlight that “business as usual” is unlikely to provide us the rapid and effective ways of meeting this challenge. Donors and countries need to think out of boxes and silos and work more across different sectors and strengthen program linkages more effectively.

III. Advantages

Linking of FP/MCH and HIV/STI programs creates a number of important synergies. When programs offer clients the chance to meet multiple needs, either within the same visit or via referral, they are more likely to achieve these important health goals. Integrated services or better linkages may promote reaching broader groups with information and services that are not typically reached in a particular vertical program.

Both FP/MCH and HIV/STI address human sexuality, serve similar target groups, promote safe responsible sexual behavior, treat sexually transmitted infections, rely on effective prevention, and promote and distribute condoms within and outside clinics and health services. In addition, both programs require and use similar medical/health skills and facilities and rely on community participation to address sensitive sexuality issues and sociocultural determinants of behavior change. Both programs have common objectives and desire common outcomes including reduction in maternal, infant and child mortality. Both programs are interested in addressing the vulnerability and high-risk behaviors of young people that fuel the epidemic in this age group, early child bearing and high maternal mortality contributing to high infant mortality. Both programs focus and rely on behavior change and often use the similar behavior change communication channels.

In Africa, countries with high rates of contraceptive prevalence such as Botswana, Zimbabwe and Kenya show some of the highest HIV prevalence rates. These countries had invested heavily in vertical family planning programs and have had functioning programs for decades, yet linkages between HIV/AIDS and FP and MCH country programs are generally inadequate (even in these countries) resulting in many missed opportunities. Zimbabwe has started using its community based workers to also address HIV/AIDS. If linked RH/FP/MCH programs are linked with HIV/AIDS, each program can contribute significantly to the other, reaching more people. Existing FP/MCH programs can play a vanguard role in the prevention of HIV/AIDS transmission and provide a sound basis and experience upon which intervention to curb the HIV/AIDS
epidemic can be built. Addressing HIV/AIDS in family planning and maternal-child health services and vice versa can provide a broader outreach to underserved groups and a broader range of preventive and clinical services at one site during one visit, thus better meeting the needs of clients. For example, RH/FP/MCH programs can integrate VCT and prevention of mother to child transmission (PMTCT) interventions in maternal health care programs so that clients can obtain HIV/AIDS education and services.

On the other hand, HIV/AIDS programs can integrate family planning and maternal health services to address the unmet RH needs including sexuality counseling and enhance reaching other high risk groups who do not typically use FP/MCH services such as high transmitters (including sex-workers and their clients), adolescents, men and HIV positive women. Most importantly, integration of services will help reach the majority of women accessing MCH services that are living with HIV/AIDS or STIs but are asymptomatic and provide informed choice for HIV infected women.

If one considers the continuum of care required for HIV/AIDS and also the growing demand for reproductive health services, strengthening the linkages between reproductive health and HIV programs is likely to promote client satisfaction, efficiency, and effectiveness by reducing duplication of services; reducing administrative and overhead costs, maximizing the utilization of scarce human and financial resources by sharing facilities and rationalizing staff responsibilities; and minimize missed opportunities. Greater efficiency may be achieved through better coordination, using the same infrastructure and sharing facilities, minimizing administrative duplicated tasks, and training workers to perform multiple tasks. From a client perspective, integrated or linked services may reduce out of pocket payments and other costs for transport and other opportunity costs.

IV. Limitations

Concerns remain on reaching high-risk groups that do not utilize reproductive health services that are heavily focused on maternal and child health and reaching young people who typically are reluctant to use the formal health structures, men and other high risk groups. While more work has been done on expanding youth friendly services, there has been insufficient attention to male reproductive and sexual health. Special targeted services may, therefore, be more relevant to reach high risk groups but even these will require strong referral linkages. In countries where there is high contraceptive prevalence and sterilization is the main method, these women may not frequent FP/MCH services. The challenge remains on how to reach who have achieved their desired family size with HIV/AIDS information.

Focusing on health facilities is not sufficient. Community based services were instrumental in increasing contraceptive use and community participation is critical to changing behavior required for safe sexual behavior and protection against unwanted pregnancy and infection. Community participation is particularly important for reducing stigma. The demand for counseling services for linked services VCT and family planning, or for PMTCT services and managing HIV syndromes cannot be met through
health facilities. To provide the continuum of care and support, home based care will increasingly become a critical intervention to provide follow up support of HIV infected women participating in and their family members. The Directly Observed Treatment (DOTS) approach is also relevant for compliance on ARV treatment and monitoring resistance issues. The COPHIA project in Kenya has pioneered this approach in the slums of Nairobi and added community based family planning to home based care. Family planning and other reproductive health services were also added to home-based interventions.

Other limitations to integration and strengthened linkages between HIV/AIDS and RH/FP/MCH that are often cited include:

- Reproductive and sexual health may not be a priority in every country and RH is still seen as a service for married women and may not necessarily be the best entry point for HIV/AIDS services.
- RH/MCH programs are perceived as very weak with serious systemic problems, (few trained staff, insufficient equipment and often experience stock outs of commodities and supplies, lack of supervisory and monitoring and evaluation systems). In light of this, adding HIV/AIDS services would be overwhelming.
- Stigma remains a barrier to accessing care even when services are available. PLWHA may prefer HIV/AIDS services because of confidentiality and fear of stigma and associated rejection and violence.
- Reaching the poor with RH/FP/MCH and HIV services remains a challenge. Utilization of RH/MCH services show the biggest disparity between the rich and the poor. Lack of information among the poor puts them at highest risk for HIV/AIDS infection and high mortality and morbidity from poor reproductive health. HIV/AIDS has also contributed to impoverishing many families and communities. Safety nets and user fee waivers remain limited in scope to increase access to basic health services.
- While donors have introduced sector wide approaches (SWAps), introducing health reform and are increasingly working through budgetary support, HIV/AIDS programs remain vertical to these new instruments. Even with these new instruments, family planning remains a vertical program often with separate logistics and distribution systems and various aspects of RH/FP are managed by separate and poorly coordinated departments within the MOH in budgeting and planning, creating rivalry for budgetary control.

V. Experience with Linking

Major efforts to link FP/RH/MCH with HIV/STIs began in the early 1990s (see for example Hardee and Young 1995). Programs initially focused on using the existing family planning and maternal-child health infrastructure to diagnose and treat sexually transmitted infections. Early efforts of integration focused on integrating the diagnosis and management of STIs in FP/MCH services. Little attention has been paid to integrating the other way, i.e. adding RH and family planning to HIV/AIDS services even as technologies and programs for prevention of mother to child transmission of
HIV/AIDS have expanded. Results from various studies (Mwanza, Rakai etc.) have provided contradictory results (Gosskurth, 1995, Waiver, 1999).

Promotion of condoms for disease prevention was another natural entry point for linkages to explore double protection against unwanted pregnancy and prevention of HIV/STIs. More recently, efforts have expanded to include programs for adolescents and men. The advent of inexpensive strategies to prevent mother-to-child transmission of HIV has opened up another significant area for linkage. As HIV/STI programs have developed their own infrastructure over the past two decades, the opportunities for providing FP/MCH services in the HIV/STI setting have also expanded. An example of this is VCT centers offering contraceptive methods, including condoms.

While the benefits of a linked response to produce sustained impact to meet the increasing demand for RH and HIV/AIDS is well recognized, implementation and the actual level of collaboration between the two programs is far from optimal. For example, although Uganda has succeeded in reducing new HIV infections, addressing other dimensions of reproductive health has barely improved. Its maternal and infant and child mortality remain unacceptably high and contraceptive prevalence use remains low especially in the rural areas.

In 2001, USAID conducted an informal survey among the agencies it funds to ascertain the level of linked programs. Of the twenty three agencies that completed the survey, there were a total of 343 different integration activities reported globally. A majority of the integration activities were focused on training and communication interventions, such as counseling and behavior change approaches. Recent reviews of program practice (Kisubi 1995; Dehne and Snow 1999) have tried to determine the extent to which programs are already linked but such reviews are far from comprehensive. Much of the research has focused on small-scale pilot or model programs. Moreover, information on linking is changing rapidly as new program evidence emerges, as programs scale up, as the epidemic changes course, as new technologies such as prevention of mother-to-child transmission begin to have an impact and as access to ARVs begins to increase.

Operations research findings in Africa highlight the failure to address integration in totality – policies, standards, service delivery guidelines, systems such as logistics and distribution, information systems, supervision and health provider workload and provision and distribution of equipment and drugs. Drawing on literature review and other sources, the following observations are noted:

The experience with linking has outpaced rigorous evaluation efforts. Relatively few good studies have examined linking with an eye towards measuring its impact on the main reasons for linking (effectiveness, efficiency, meeting client needs). Moreover, evaluation findings have not been consistent. New and innovative approaches could benefit from better evaluation, including operations research that investigates impact on health and behavioral outcomes.
Of those linking efforts that have been well-evaluated, only one--syndromic management of STI--has proved ineffective for vaginal discharge syndromes but it is effective for genital ulcers and male discharge. The debate continues on how to effectively address treatment of STIs among women who are typically asymptomatic, particularly in high-prevalence and resource-poor settings lacking laboratory diagnostics. The success of syndromic management has received mixed reviews and has been shown to be less effective in managing vaginal discharge syndromes, failing to diagnose women with infections of gonorrhea and Chlamydia but identifying other women as infected because they had a vaginal discharge. In poor resource settings with limited laboratory services, syndromic management remains the only option and attempts are being made to improve algorithms and add other screening techniques. Rapid tests for STIs are being developed. Presumptive treatment of STIs in the general population and targeted groups is being tested in various parts of Africa (Korenromp, 2000, Waiver, 1999) Although the strengthening of HIV/AIDS infrastructure for treatment will certainly improve access to laboratory services even in poor resource settings, partner notification will remain a major challenge.

Most of the linkage has involved integrating of HIV/STI into FP/MCH programs. Although opportunities for going the other direction are expanding so far, it has happened in only a few settings. Adding family planning to VCT and PMTCT services would address the needs of clients seeking these services and the needs of HIV positive women and men. Where there is no integration, referral linkages would be necessary.

Linkage through referral seems weaker than the traditional “integration” model of having the same facility or person providing two or more services. Most health workers do not have time to do effective counseling and see linked services as additional work.

Failure of RH to incorporate condoms. RH/FP programs may fail to promote dual protection because they have traditionally focused on the efficacy of non-barrier methods for pregnancy prevention and have not promoted condoms necessary for HIV/STIs in their programs. Currently there is limited evidence on the success of dual protection.

VI. Challenge and lessons learned

Linkages often make sense but their effectiveness is dependent on a number of factors including the prevalence of the HIV/AIDS epidemic, the resources available, the health system capacity, and the level of contraceptive prevalence. When moving forward with linked programs, managers and policy makers must address these challenges at the policy, health system and community levels. The following challenges and lessons learned have been identified at various regional meetings.

At the Policy level
Policies and a conceptual framework for closer collaboration was lacking in many countries. Countries felt that there is more focus now on HIV/AIDS and little interaction with RH. Policies, strategies, and program interventions need to change as the course of the epidemic changes and new evidence and technologies emerge. The more advanced the stage of the epidemic, the more appropriate the linkage. For instance, mass treatment of STIs other than HIV at FP/MCH facilities may be most cost-effective in areas of high prevalence, whereas a focus on high risk groups may be appropriate where HIV/STI prevalence is low (Lush 2002; USAID 2002). However, it is also important to remember that many high-risk populations such as commercial sex workers and HIV positive women may also have family planning and other reproductive health needs.

Most countries lack an adequate legislative framework that makes linking feasible. Other reviews have highlighted that many countries still have regulations which allow only doctors to prescribe certain drugs used in STI treatment (Lush 2002). Furthermore, the language of many HIV/AIDS policies is inadequate to support linking efforts (POLICY Project 2003).

Donor policies have contributed to fragmentation as accountability relationships have shifted to donors supporting vertical programs. Fragmentation weakens the ability of governments to coordinate and increases the burden of government reporting to the different donors. Donor funding may encourage separation of programs. Vertical programs have focused on short term results rather than a long-term perspective to promote capacity building. Sustainability of vertical programs where there is no clear exit strategy can cause major disruptions. The reproductive health commodity security may be a result of a lack of an appropriate exit strategy by donors who have traditionally supported contraceptive donations to countries. 

Health System

Weak health systems make linking difficult. Many developing countries are characterized by weak health systems. Both programs have suffered from low levels of human and financial resources and poor program management. Human resource shortages have been exacerbated by HIV and the brain drain. Poor quality of care, lack of privacy for counseling, unmotivated providers, and inconsistent stocks of drugs, contraceptives and supplies make it difficult to respond to clients needs (Lush 2002, Lule 2002). For example the addition of PMTCT to ANC clinics has increased the responsibilities of existing staff without commensurate increases in personnel (Rutenberg et al 2003). Similarly, in areas where family planning programs are weak and unmet need is high, an integrated approach may not be cost-effective. Counseling needs are very intense and can cause burn out of health workers.

RH/FP/MCH and HIV/STI programs have traditionally served very different clientele. Married women in the former and unmarried adolescents, men, and older, high-risk individuals in the latter (Caldwell and Caldwell 2002; Lush 2002; Askew and Maggwa 2002; Foreit, Hardee, and Agarwal 2002). However, this distinction is blurring.
For instance, although the married women using FP/MCH services were previously considered as low risk for HIV/STIs, this is no longer the case in high-prevalence areas, where women are now at risk based on the sexual behaviors of their husbands (Askew and Maggwa 2002). Nonetheless, FP/MCH programs still do not easily reach men and high transmitters who often require targeted interventions.

**Operationally, the two services are not compatible in all settings.** For examples, the same worker may not have the background or skills to provide both services (Foreit, Hardee, and Agarwal 2002). RH workers may not have the empathy skills found in HIV/AIDS programs. Therefore, when moving forward with a linked service, programs must consider training needs and capacity. Linked services may, however, require less training and more emphasis on referrals. Other operational barriers to linking include the reluctance of health workers to address sexuality, bias against condoms, stigma associated with HIV/AIDS and other STIs, and health workers who regard linked services as additional work (Lule 2002).

**Administrative/Management separation.** Countries often set up FP/MCH and HIV/STI programs with separate funding, budgets, personnel, and administrative structures. Donor orientation and priorities often encourage such vertical structures, and thus discourage program managers from considering opportunities to link when it makes sense (Lule 2002; Lush 2002). However, some countries have established linkages between vertical programs through technical committees and other coordination mechanisms (Kenya).

**Community**

**Community-based services. Weak links often exist between community-based services and clinical facilities.** Community participation is necessary for changing social norms, supporting behavior change, addressing stigma and gender inequality, and providing homebased care and support. Higher quality community-based services can reach high-risk and vulnerable groups and under-served groups such as men and youth with special targeted interventions often outside the health system. The majority of men are single and in less steady relationships and may be partners of women who do not use family planning or maternal health services. Providing services to men who have sex with men has been omitted in many programs. Sexual health programs for men are generally lacking. Although some opportunities for reaching men are being explored, few of them have been monitored and evaluated. Results from operations research studies to involve men in antenatal, family planning and other maternal and child health services in South Africa, India, Zimbabwe and Nigeria will be useful to build a strong evidence base of male interventions.

**Reaching high risk groups, such as commercial sex workers, with both RH/FP/MCH services is also problematic.** Commercial sex workers do not use public health facilities (Vuylstekte, 2001), and there is limited evidence of what works well to reach this group.
Weak partnerships between the public and private sectors. Many countries have an unregulated private sector and governments suffer from inadequate capacity to regulate and accredit private sector providers. NGOs, on the other hand, have comparative advantage in dealing with sensitive issues and reaching hard to reach and vulnerable groups. However, relationships between NGOs and governments are often characterized by mistrust.

VII. The Way Forward

From this review it is apparent that several countries already have some experience in linking FP/MCH and HIV/STI programs while in other settings the extent of the integrated program’s activities, and the sustained provision of linked services is unclear or uncertain. The need to use scarce resources more efficiently has generated a range of creative and innovative responses to the urgent need for more and extensive and effective reproductive health care, including HIV prevention. From this experience has emerged a series of priorities, including:

Advocate for better policies supporting better linkages to accelerate progress on RH/FP/MCH and HIV/STI goals and drive better resource allocation. More analytical work is required to identify approaches that will improve health outcomes, and have broader health impact in addressing RH and HIV/AIDS challenges and needs. Demonstrated local and international success stories to policy makers to advocate for the development of local leadership for improved collaboration and strengthened linkages. Use available evidence from program evaluations and operations research to identify priority interventions to link and integrate. These priorities should then drive resource allocation with health budgets. Improved management and tracking (through public health expenditures) of how funds are used should be part of routine monitoring and evaluation. Programs for men and adolescents—often-neglected groups—are needed now more than ever. Appropriate policies that enable scaling up of successful approaches in reaching these groups are required.

Strengthen health systems. Supporting RH commodity security and other essential HIV/STI drugs including ARVs in countries can help with better identification of critical commodity gaps and supply management issues. An effective supply chain for RH supplies, STI drugs and HIV tests and ARVs will help promote better use of services. Logistics and distribution systems for contraceptives can also be used for ARVs although the aim should be to strengthen an integrated system for essential drugs. The issue of human resources needs to be addressed at the country and by the international community.

Develop institutional capacity and structures as the foundation for better linkages. Concentrate on improving the “how to” and not on the “what”. Linkages tend to be better at lower levels of the health systems, therefore, assess all levels of the health system: planning, manpower needs facilities, services, logistics and distribution monitoring and evaluation.
Coordinated planning and management strategies that will institutionalize the linkage of the two services. As described above, FP/MCH and HIV/STI programs both have a historical legacy of being vertically managed within the health care delivery system. Linking the services at the clinic level can best be sustained if programs are coordinated, and efficiencies of mutual operations are capitalized upon at a higher level of organization. Improved coordination and integration within MOH and between different departments would enhance coordination and strengthen linkages.

More advocacy for solutions to the structural problems that hamper effective linking. By themselves, FP/MCH and HIV/STI programs have little influence on these overarching issues. Nonetheless, by joining with other groups, and other vertical programs the reproductive health field could advocate for a more favorable policy environment, better health systems, increased funding, more flexible funding mechanisms, and better in-country coordination.

Improved community participation to strengthen links between community-level behavior change communication interventions and clinical facilities. Community participation can contribute to sustainability by building awareness of both availability and need for services. Communities are key in reducing stigma so that services can be adequately utilized.

New and improved operations research, monitoring, and evaluation. We still know relatively little about costs and effectiveness of linked strategies, particularly their impact on ultimate objectives such as pregnancy and disease prevention. Policy barriers and gaps in policy implementation need to be identified. Especially for new approaches, enhanced monitoring and evaluation, including operations research, is needed to identify good practices.

Better donor support and coordination and support for in-country collaboration are key factors in building better linkages between different programs. Coordination of activities will help promote cost-effectiveness. Donors should focus on long-term sustainability and provide predictable development assistance.

Improved partnerships. Strengthened partnerships at the international level (as some of the issues such as commodity security require a global solution), regional and country levels and between the public and private sectors.

Conclusion

In conclusion, the reproductive health needs of people and of countries are constantly changing and after two decades of implementing HIV/AIDS programs it is clear that business as usual will not curb the spread of HIV/AIDS. Both RH and HIV/AIDS need a multi-sectoral approaches. New challenges and new opportunities are arising as the HIV/AIDS epidemic evolves, as technologies change, and as individuals and societies respond to these changes. The need to focus on improvement of health
systems and remove implementation bottlenecks is more urgent. Reaching the reproductive health goals set by the international community in the ICPD program of Action, as reflected in the MDGs and other international agreements, will require scaling up of cost-effective approaches and a shift to focusing on health outcomes rather than inputs. Countries can no longer afford to pass up missed opportunities to address the range of unmet reproductive health including HIV/AIDS needs of clients. Linking FP/MCH and HIV/STI services can be an efficient way to promote wanted, healthy pregnancies, improve child health and prevent disease. A better and clearer understanding of what makes linking effective and what the associated costs are, therefore, is crucial to efforts to quickly scale up activities and serve more women and men. All this will require better donor coordination and harmonization and a commitment to make good the promises of long term commitments and for additional resources made in Cairo, Monterrey and other international declarations.
References and Bibliography


FOCUS on Young Adults. 2001. *Advancing Young Adult Reproductive Health: Actions for the Next Decade*. Washington, DC: FOCUS on Young Adults.


