Lessons learnt from sexual and reproductive health and HIV linkages for multipurpose prevention technology service delivery

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Provision of comprehensive sexual and reproductive health (SRH) services that meet the complex and diverse needs of women, in particular, within resource-constrained settings, is often exacerbated by separate and uncoordinated reproductive health (RH) and HIV policies and programmes. A Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages was developed to assess bi-directional linkages between SRH and HIV at policy, systems and service delivery levels, as well as to identify gaps and contribute to the development of country-specific action plans. Findings from the implementation of this Assessment Tool are of particular relevance to the successful delivery and uptake of multipurpose prevention technologies (MPTs), which are products in the development pipeline addressing multiple SRH needs of women, including HIV. The findings highlight the need for better coordination between SRH and HIV programmes in countries; support and training for healthcare providers on SRH, HIV and human rights; supporting SRH and HIV integration at the service delivery level through relevant policies, strategic and operational plans; and strengthening logistics and supplies systems to provide a combination approach to prevention. These lessons learnt could help programme managers and service providers to better understand the strategies for positioning multipurpose prevention products in national policy and service contexts.

Keywords  HIV, integration, service delivery, sexual and reproductive health.

Introduction

The challenges of providing sexual and reproductive health (SRH) and HIV services that meet the complex and diverse needs of women is often exacerbated by separate and uncoordinated SRH and HIV programmes despite the strong synergies that exist between them. Ongoing research focused on developing multipurpose prevention technologies (MPTs) aims to address some of the SRH needs of women worldwide, in particular preventing sexually transmitted infection (STI), including HIV, and unintended pregnancies. Although the only currently approved MPTs are male and female condoms, other approaches being explored include new delivery mechanisms such as films or nanoparticles, and products that combine multiple biomedical interventions using existing technologies such as intra-vaginal rings. While clinical development, regulatory approval and marketing of these MPTs will be complex, lessons from programmatic approaches to SRH and HIV linkages could inform how to position such products in national contexts.

Background

Acknowledging the need for health systems to meet people within the reality of their lives, SRH services provide a platform upon which interventions for HIV prevention, care and treatment can be built; similarly, HIV services can provide a platform for SRH services such as family planning or antenatal and postpartum care. Services that have explored a range of creative linkages include, promoting female and male condoms in family planning services for dual protection; delivering anti-retroviral therapy through maternal health services; offering dual testing for syphilis and HIV within antenatal care; and offering family planning services and cervical cancer management in
anti-retroviral therapy centres. In addition, scaling up and integrating comprehensive SRH and HIV services may provide an opportunity to improve coverage, quality of care and programme efficacy and effectiveness.

In May 2004, the World Health Organization (WHO) Global reproductive health strategy to accelerate progress towards the attainment of international development goals and targets was adopted by the 57th World Health Assembly. The Strategy recognises the crucial role of a comprehensive approach to SRH in social and economic development in all communities and aims to improve SRH by targeting five core elements: improving antenatal, delivery, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe termination of pregnancy (TOP); combating STIs, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health.

The most recent Joint United Nations Programme on HIV/AIDS (UNAIDS) report also highlights the need for stronger linkages between SRH and HIV programmes and policies, and the clear need for integrating HIV interventions within diverse systems and sectors. This report cites as an example that 70% of countries describe integrating services to prevent mother-to-child HIV transmission in antenatal care and two-thirds report integrated HIV and sexual and reproductive health services.2

Rapid assessment tool for sexual and reproductive health and HIV linkages

Around the same time, a number of related commitments to link SRH and HIV were launched.3,4 In order to support national efforts to strengthen SRH and HIV linkages, the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages (Assessment Tool) was developed in partnership between International Planned Parenthood Federation (IPPF), United Nations Population Fund (UNFPA), WHO, UNAIDS, Global Network of People Living with HIV/AIDS (GNP+), International Community of Women Living with HIV/AIDS (ICW) and Young Positives.5 The Assessment Tool is designed to assess bi-directional linkages between SRH and HIV at the policy, systems and service delivery levels, identify gaps, and contribute to the development of country-specific action plans. (Further technical information on topics related to SRH and HIV linkages, the international policy commitments that have been made in support of such linkages and the research that has been conducted to date —along with the Rapid Assessment Tool itself, can be accessed from the SRH & HIV Linkages Resource Pack. The resources have been developed and collated by the Inter-Agency Working Group on SRH & HIV Linkages and is accessible from www.srhhivlinkages.org.6) It is based on a set of principles that are critical to the implementation of the Assessment Tool. These include addressing structural determinants; focusing on human rights and gender; promoting a coordinated and coherent healthcare response; meaningfully involving people living with HIV; fostering community participation; reducing stigma and discrimination; and recognising the centrality of sexuality. It was designed to be adapted so that it can be used in diverse contexts, and implemented as a ‘stand-alone’ activity or as part of a broader country-level review of SRH/HIV linkages.

The Assessment Tool encompasses three related parts:

1. Policy: national laws, policies and guidelines; funding and budgetary support;
2. Systems partnerships; planning, management and administration; staffing, human resources and capacity development; logistics, supplies and laboratory support; and monitoring and evaluation; and
3. Service delivery: what and how HIV interventions are delivered through SRH services, and SRH interventions through HIV services; as well as clients’ and providers’ experiences with linked services.

The Assessment Tool focuses on questions that can be answered in desk reviews and individual or group interviews (Policy and Systems sections), and individual interviews of various service providers and clients (Service Delivery section). These approaches can be supplemented with a range of other research methodologies, including observations of services, focus group discussions among policy-makers, service providers and clients, as well as collection of data from clinic records. The methodology used is explained in detail in the Assessment Tool.7

Lessons from implementation of the Assessment Tool

Since 2008, 49 countries have either implemented or were at some stage of implementation of the Assessment Tool by the end of 2013 (Figure 1). (Individual country summaries, highlighting the experiences, results and recommended action from the implementation of the Rapid Assessment Tool in the majority of these countries are available from www.srhhivlinkages.org.)

Using the results from the first 20 countries (Bangladesh, Belize, Benin, Botswana, Burkina Faso, Central African Republic, Ivory Coast, Kyrgyzstan, Lebanon, Malawi, Morocco, Pakistan, Russian Federation, Sudan, Swaziland, Tanzania, Tunisia, Uganda, Vietnam and Zimbabwe) to implement the Assessment Tool, a study was conducted in 2011/12, to assess the country-level perspectives on SRH/HIV linkages between 2008 and 2010 and analysing factors that contribute to or hinder strengthening bi-directional
Where has the Rapid Assessment Tool been implemented?

Since 2008, the tool has been implemented in 47 countries

Figure 1. Countries that have implemented or are in the process of implementing the SRH and HIV Linkages Rapid Assessment Tool.

Lessons learnt from SRH and HIV linkages

1. Coordination between the HIV and SRH programmes in countries is important for synchronicity in strategic and operational planning and the delivery of integrated services.
2. Further capacity-building of healthcare providers in the context of SRH and HIV linkages is needed in many resource-limited settings. In particular, healthcare providers need to be supported in their working conditions and provided with information, knowledge and training about SRH, HIV and human rights. Linked and/or integrated healthcare services delivered by knowledgeable, competent providers.
and non-judgemental healthcare workers have been shown to benefit clients of both SRH and HIV services. SRH and HIV linkages at the service delivery level need relevant policies, and strategic and operational plans in place that support this and that need to be implemented. An integrated SRH and HIV service can offer women and children a ‘one-stop’ service, which enables women to save time and money, and to access comprehensive health care. However, improving acceptability and uptake of a combination of services being delivered in one clinical setting will necessarily have implications for planning, coordination and service delivery. Linking the logistics and supplies systems, which tend to be separate, is needed to provide a combination approach to preventing unintended pregnancy and HIV and STI acquisition. This could result in strengthened laboratory capacity and improvements to the systems for procuring testing kits and commodities, including preventing stock-out of reproductive health and HIV commodities.

**Discussion**

The WHO global reproductive health strategy outlines the components of a comprehensive, integrated package of essential SRH interventions and services for women. These include family planning information and services, antenatal, newborn and postnatal care, including emergency care, skilled care during childbirth at appropriate facilities, safe TOP services (where TOP is not prohibited by law), sexuality counselling, prevention and treatment of STIs, including HIV, and addressing gender-based violence. Integrated care also needs to address other health and human rights concerns, such as sanitation, safe drinking water, nutrition, preventing and treating tuberculosis and hepatitis, and eliminating stigma and discrimination.

Based on the findings and lessons from the implementation of the Assessment Tool, the optimal delivery and successful uptake of MPTs may require that a number of criteria exist at national levels at the policy, systems and service delivery levels. Given that MPTs are still at various stages of development, the lead time until these products are ready for end-users offers opportunities to ensure that some priority criteria exist or are strengthened before the introduction of these new prevention products for women at national level. These include, but are not limited to, training of healthcare workers to better understand how to deliver rights-based comprehensive SRH and HIV interventions, ensuring sufficient reproductive health commodities to prevent stock-outs, strengthening laboratory facilities as well as creating and enabling policy and legal environments.

The findings from the implementation of the Assessment Tool also mirror other research findings on models of linked or integrated SRH and HIV interventions. For example, the Integra Initiative found that integrating HIV services such as counselling and testing into family planning and postnatal care services successfully reduced the unmet need for HIV counselling and testing. In terms of the use of condoms, the Integra Initiative found that clients visiting a less integrated facility were less likely to report having used a condom at last sex than those visiting a more integrated facility. The Joint UNFPA/UNAIDS regional project on linking SRH and HIV in southern Africa has led to similar outcomes: in Swaziland, for instance, linked service delivery resulted in an increase in the percentage of pregnant women tested for HIV at first antenatal clinic visit from 87% in 2011 to 100% in 2013. Significantly, these gains were made without decreasing quality of care and were preferred by clients because integrated services saved them both time and money. A pilot study of integration of SRH/HIV services in seven sites in Namibia analysed four dimensions of integration: Who (provider) does What (service), Where (setting) and When (time) and found that organising services using the model of ‘one nurse, one patient, one room’ has the potential to improve productivity, reduce client waiting times, and reduce stigma and discrimination. A survey of integrated and comprehensive...
approach to eliminating mother to child transmission of HIV,\textsuperscript{11} which includes preventing HIV and unintended pregnancies as two of the four key strategies\textsuperscript{12} was conducted in ten countries. The purpose of the survey was to identify bottlenecks related to identifying, initiating and retaining patients in care and treatment and lay the groundwork to identify solutions for overcoming barriers to further integration of service delivery. The survey results showed many missed opportunities for integrated service delivery for HIV and SRH interventions, and underscored the need to better train healthcare providers and strengthen commodity supply and management.

Among the many MPT products being developed, is a topical microbicid that uses an anti-retroviral drug delivered in a gel (1\% tenofovir gel), which reduces the risk of two sexually transmitted infections, herpes simplex virus type 2 and HIV. The FACTS 001 trial is currently under way to confirm the results of the promising CAPRISA 004 trial. However, the VOICE (Vaginal and Oral Interventions to Control the Epidemic) trial results showed no effect of any of the oral or vaginal ARV-based products tested to reduce HIV acquisition in women.\textsuperscript{13} These results were attributed to very low adherence, especially among the group at highest risk: unmarried women between 18 and 25 years of age and with a male partner under the age of 28 years. The results of the study reflect the problems encountered in consistent and correct use of many user-initiated prevention products, including male and female condoms. It will therefore be important that the conceptualisation and introduction of MPTs be linked to clients’ needs and preferences and that these innovative products be placed within a gender and human rights framework. Identifying factors that could facilitate expansion of contraceptive choice and STI and HIV prevention options and products can also be learnt from the contraceptive field such as the CHOICE Project, which resulted in increased uptake of contraceptives, fewer unintended pregnancies and reduced TOP rates through appropriate information for providers and clients; availability of methods free of charge; and reducing delay and unnecessary procedures/barriers in delivering the method.\textsuperscript{14}

In conclusion, MPTs will most likely need to be delivered in the context of linked or integrated SRH and HIV programmes. Therefore, strengthening a comprehensive approach to SRH will need to take place hand in hand with the research and development of new MPTs so that when these products become available, they can have the greatest impact. Maximising the synergies between SRH and HIV requires strengthening and re-orienting systems such as coordination mechanisms, partnerships, capacity building and commodities security. In addition, clearer understanding of clients’ needs, ability and preferences to use contraception as well as STI and HIV prevention products will assist countries to accelerate progress towards attaining universal access to SRH and HIV interventions as well as increasing access and coverage of services to all.

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References