Policy Brief

Key Linkages & Key Populations:
Is HIV/SRHR Integration Serving the Needs of Vulnerable Communities?

Why HIV/SRHR integration matters for key populations

There is increasing evidence and recognition that the integration of HIV and sexual and reproductive health and rights (SRHR) brings multiple benefits at multiple levels. It can, for example increase and improve: an individual's access to a wider range of *both* HIV and SRHR support; a service's efficient use of human and financial resources; and a health systems' collaborative planning and management. The benefits are particularly clear in the uptake of key 'cross-over' services, such as condoms (for *dual* protection from both HIV and unwanted pregnancy).

HIV/SRHR integration has been increasingly recognised in global policy commitments, including the 2011 UN Political Declaration on HIV/AIDS. It has also been reflected in many national frameworks. The strategy is seen as critical to achieving Millennium Development Goals 4 (improve child health), 5 (improve maternal health), and 6 (combat HIV, malaria and other diseases).

HIV/SRHR integration has received particular interest within the changing – and often challenging – financial and political environment for responses to HIV: one characterised by increased attention to cost efficiency and impact ('value for money') and the integration of HIV within wider responses to health.

Within such dialogue, it is often indicated that HIV/SRHR integration particularly 'makes sense' for key populations. This is because integration has the potential to address some of the specific factors, needs and challenges that heighten such groups' SRHR vulnerability. For example, it can help to reduce stigma and discrimination and increase the quality and relevance of SRHR services for specific populations [see Box 1].

India HIV/AIDS Alliance

However, while integration of SRHR and HIV is a desirable goal in the long-run, concerns remain that the joining of programmes and systems that are not ready could, in fact, *compromise* the quality of and access to services for key populations.

An increasing number of organisations working with key populations in different settings are putting HIV/SRHR integration into practice. Based on documented experiences from around the world, there is an emerging consensus about 'what matters' and 'what works', for example in relation to HIV/SRHR integration for people living with HIV (PLHIV). However, overall, there remain many important yet unanswered questions about what constitutes good practice for integration and, in turn, what should be included in technical guidance. *For example: Exactly what types of HIV services should be integrated into exactly what types of SRHR services and for which specific key populations? What pace and scale of integration is both desirable and feasible? And what are the important issues to address to ensure integration enhances – rather than compromises – the quality of and access to services for key populations?*

This policy brief is based on the experiences and lessons from a wide range of organisations around the world. In particular, it is informed by a global review of good practice commissioned by the India HIV/AIDS Alliance and a satellite session at the International Conference on AIDS in Asia and the Pacific (ICAAP) 2011. The session was hosted by the India HIV/AIDS Alliance with input from the Family Planning Association of India (FPAI) and the Regional Offices of the United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA) and Family Health International (FHI360).

This brief asks how, within the context of a policy and donor 'push' towards integration, the strategy can not only improve the efficiency of programmes, but truly serve the needs of vulnerable communities

Terminology: HIV/SRHR integration

HIV/SRHR integration refers to one or more components of HIV programming being integrated into (or joined with) one or more components of SRHR programming; or vice versa. This includes referrals from one service to another, with the overall aim of providing more comprehensive support.

Box 1: Benefits of HIV/SRHR integration for key populations

The potential benefits include that HIV/SRHR integration can:

- **Provide a 'one stop shop' for both HIV and SRHR support** – increasing key populations' access to and uptake of comprehensive and continuous support.

- **Promote a rights-based and holistic approach** – going beyond a focus on disease control to treating someone as a 'whole person' who has the right to have satisfying sexual relations, a family, etc.

- **Reduce stigma and discrimination related to HIV and/or key populations** – increasing key populations' access to and uptake of services by 'normalising' issues and needs with subsequent impact on health status.

- **Increase the quality and appropriateness of HIV and SRHR services** – by enabling them to be 'tailor made' to the specific and sometimes complex needs of key populations.

- **Improve the efficiency of services for key populations**, for example by reducing the frequency of health-related appointments (reducing people's transport costs, time off work, etc.).

- **Make good use of scarce financial and human resources for HIV/SRHR programmes for key populations.**

What are the SRHR needs of key populations and why are they often unmet?

According to universal commitments, key populations have the same sexual and reproductive **rights** as anyone else. For example, they have the right to have sexual relations free from coercion, to have children and to protect themselves from infection.

Key populations also have many of the same **needs** for HIV and SRHR information, support, services and commodities. For example, like other community members, they might need access to HIV testing, advice about family planning and access to maternal, newborn and child health (MNCH) services.

There are also, however, a significant number and range of factors that mean that key populations often experience **heightened vulnerability** to SRH ill health (such as STIs, unintended pregnancies and maternal mortality) and **greater barriers** to the support and involvement that they need [see Box 2].

These factors are further affected by the context of, and differences between **individuals** – such as in terms of their sex, age and status. For example: a young woman who is living with HIV might have greater needs for family planning than a woman who is older; a man who has sex with men (MSM) who is married to a woman might have more complex SRHR needs than a man who is not; a sex worker who lives in a rural area might find it harder to access SRHR services than one in a city; or a woman who uses drugs and is unmarried might find it harder to access SRHR services than a woman who is married.

Box 2: Factors that affect key populations in the context of SRHR	
Factors	*For example, compared to other community members …*
Specific or more complex SRHR needs	• A female sex worker might experience higher levels of coerced and violent sex – increasing her need for emergency contraception and post-exposure prophylaxis. • A male sex worker might require larger supplies of condoms and more regular access to STI testing. • A transgender person might require specialist counseling on gender-reassignment. • A pregnant woman who uses drugs and is living with HIV might require specific advice on interactions between methadone, contraceptives and antiretroviral therapy. • A man who uses drugs might need behaviour change support to ensure safer sex while under the influence of drugs. • An MSM who is married might require support to plan a family with his female partner and prevent HIV with a male partner.
Additional or stronger barriers to accessing SRHR services	• A woman living with HIV might face stigma and discrimination by staff at mainstream antenatal services. • A female sex worker might work at night and not be able to access a family planning clinic during normal opening hours. • A transgender sex worker might not access a public SRHR service if she fears violence by the police. • A woman who uses drugs might feel unable to discuss SRHR needs in a project focused on harm reduction. • An MSM might not access a government clinic if the staff lack the equipment or expertise to carry out ano-genital examinations. • A person who uses drugs, who is criminalized, might not be allowed to register at a government STI centre.
Weaker capacity or opportunities to demand SRHR services	• A sex worker might not be included in a district consultation on women's SRHR needs. • The needs of an MSM might not be included in the assessment and planning stage of an SRHR project because he is part of a 'hidden population'. • A PLHIV might lack self-esteem or a 'safe space' to advocate for their SRHR needs to decision-makers in health services. • A transgender person might not be able to participate in SRHR decision-making because their legal status does reflect their identity. • A person who uses drugs might lack the skills to define their SRHR needs because they are left out of community capacity building projects.

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As a result of these multiple and often overlapping factors, key populations can experience **significant unmet needs for SRHR** [see Box 3]. These needs often 'fall through the net' of both SRHR (that are often designed for the general public and focus on mainstream services, such as family planning) and HIV services (that are often designed to address people's high risk behaviours, rather than looking at the 'whole person').

Box 3: Unmet SRHR needs of key populations – examples from India

A study of **women who use drugs** in Manipur found that:

- 56% of those that were married had an unmet need for contraception.
- 52% had experienced an STI-related symptom in the last 3 months.
- 15% had experienced forced sex and 17% physical violence in last 3 months.
- Many concealed their drug use from health providers.

A study of **female sex workers** in Andhra Pradesh found that:

- Although 70-75% usually used condoms with clients, few used them with their regular partners.
- Oral pills were the most popular form of contraception, but little information was given about side effects.
- 30% had experienced unintended pregnancies; most resorted to abortion (with 10% self-induced at home); and the majority had post-abortion complications.
- Government clinics were the least preferred services – due to judgemental attitudes and low confidentiality.

What lessons have been learned about HIV/SRHR integration for key populations?

Based on the practical experiences of a range of organisations – including those involved in producing this policy brief –a variety of lessons have been learned that begin to answer some of the remaining questions about HIV/SRHR integration for key populations. The lessons include that, despite the 'push' towards HIV/SRH integration for such groups, there are still a number of fundamental **challenges** [see Box 4].

However, the lessons learned of multiple organisations also include that key steps can be taken to put HIV/SRHR integration into action and maximize its effectiveness among key populations. These include that it is important to:

1. Promote good practice principles throughout HIV/SRHR integration for key populations:

- **Recognise the centrality of community organisations and systems for high quality HIV/SRHR integration.** For example, the India HIV/AIDS Alliance has seen that community groups – especially those that are *by* and *for* key populations – are in a unique position to: gather evidence of the real HIV/SRHR needs of key populations; facilitate key populations' access to services through referrals and demand generation; and address critical barriers for key populations (such as stigma and discrimination).

- **Use a rights-based approach that recognizes key populations' individual rights, including to sexuality, to have children and to make choices about their own SRHR.** For example: the Family Planning Association of Trinidad and Tobago complements the provision of clinical services with raising sex workers' awareness of their rights – leading to an increase in safer sex practices.

- **Ensure the principle of the greater involvement of PLHIV (GIPA) and other key populations at all stages of integrated programming.** For example: Family Health Options Kenya involves PLHIV throughout the cycle of its integrated programme, including as community-based volunteers and members of its Management and Advisory Boards; and PROFAMILIA, Colombia, employed men who have sex with men to design and deliver training to the staff of their SRHR clinic.

- **Take a family-centred approach that supports not only the HIV/SRHR needs of key populations, but those around them.** For example, the International HIV/AIDS Alliance has learned that this includes looking at the HIV/SRHR needs of people's partners (such as the male partners of female sex workers or the female partners of MSM) and children (who, due to the stigma associated with their parents, may also experience challenges in accessing relevant support). FPAI found it important to work with the family members of MSM and transgender people to improve family acceptance and understanding of their needs.

2. Plan and get started on HIV/SRHR integration by building on 'what's there', gathering evidence and identifying key entry points:

- **Develop integrated programmes that build on 'what's there' for HIV and SRHR, rather than starting from scratch.** For example, where possible: support a local SRHR clinic to become 'sex worker friendly' rather than set up a separate clinic; or train existing staff at a harm reduction NGO to be multi-disciplinary rather than recruit specialist SRHR staff. Only set up new services where there is a clear added value and/or a neglected area, such as MNCH for sex workers or women who use drugs.

- **Use a situational analysis (of the community and the wider environment) to understand what type of HIV/SRHR integration is effective and/or possible in a specific context.** For example, some women living with HIV may be able to access mainstream SRHR services, while others - such as those who are sex workers - may require specialised services.

- **Identify and start with the most needed and obvious 'entry points' for integrating HIV and SRHR services.** These will vary according to the context, but can be identified by understanding what services people use and how those services match their needs. For example: a study in Andhra Pradesh, India, found that sex workers' visits for post-abortion services served as an opportunity to provide support on comprehensive contraceptive options; and Bandhu Social Welfare Society, Bangladesh, found that providing general health care was a good way to start engaging MSM on issues of SRHR.

- **Identify, understand and respond to the diversity of HIV/SRHR needs within key populations.** Consider factors such as:

  Gender: For example, women who use drugs may have significantly different SRHR needs to men who use drugs.

  Age: For example Alliance Zambia found that young people living with HIV had intensive SRHR needs, but less access to services, due to their age; and a study of sex workers in Guntakal, Andhra Pradesh, found that, while the priority for 21-30 year olds was safe abortion, for 31-40 year olds it was free pregnancy testing.

  Relationship status: For example: an India HIV/AIDS Alliance study found that young married women living with HIV face pressures to become pregnant and have children; and a study among MSM in Warangal, Andhra Pradesh, found that 33% of the men were married to women.

  Other status or behaviours: For example: a sex worker might also be a migrant or use drugs; or an MSM might also be living with HIV.

3. Ensure comprehensive HIV/SRHR integrated programming for key populations:

- **Use comprehensive definitions of HIV and SRHR that go beyond the 'usual suspects' for integration.** For example, this might involve: integrating SRHR services such as safe abortion that – while still not commonly integrated with HIV for the general public can be particularly vital for key populations, such as sex workers; ensuring attention to taboo subjects, such as anal STIs for sex workers; and addressing the SRHR needs that often 'fall through the net', such as of women who use drugs who require a package combining HIV-related interventions (such as opiate substitution treatment, needle and syringe programming, education about safe injecting and overdose prevention) with key SRHR and MNCH services.

- **Within the development of integrated programmes, address how key populations' different types and levels of vulnerability inter-relate.** For example, a Population Council study among 15-34 year old women who use drugs in Manipur, India, found that many were also sex workers, only 20% used condoms with their regular boyfriends and only half of those with an SRHR problem sought support at a facility.

- **Proactively address stigma and discrimination (related to both HIV and key populations) as a fundamental barrier to integrated programmes.** For example, in India, PATH's training on stigma for health providers and sex workers led to an increase in access to integrated services.

4. Ensure effective and creative service delivery for HIV/SRHR integration for key populations:

- **Create demand as well as supply for HIV/ SRHR integrated services.** For example: PLHIV may not know that they have the right to SRH or may need active encouragement (such as accompaniment by volunteers) to access services; and sex workers may have only previously been targeted for HIV prevention and been isolated from SRHR support.

- **Offer flexible service delivery.** For example: the Institute for Students Health, Serbia, reaches sex workers through combining centre-based services, community outreach and mobile support at 'hot spots'; and, in targeted interventions for the National AIDS Control Programme-III in India, programmes for MSM to provide STI support can do so through referral to in-house services at an NGO, a Community Preferred Private Practitioner or a government clinic.

- **Recognise peer education as a critical strategy in HIV/SRHR for key populations, especially for addressing sensitive or complex issues.** For example: Mythri clinics in Andhra Pradesh, India, found that peer educators helped MSM to build self-confidence and self-esteem – leading to greater health seeking behaviour; and the staff and peer educators of Korsang, Cambodia, are all current or former drugs users, while support for women who use drugs is delivered by female workers.

- **Work in partnership both within a project and with the community and other stakeholders.** For example, in countries such as Myanmar, UNFPA has found it vital to build a partnership between sex workers and service providers, as well as with other HIV/SRHR service providers and decision-makers.

5. Ensure a strong 'chain' of HIV/ SRHR integrated services for key populations, including through high quality and systematic referrals:

- **If integration involves referrals, ensure the quality, confidentiality and 'key population-friendliness' of such services.** For example, programmes to support women who use drugs supported by the Open Society Institute, Ukraine, only provide referrals to trusted and trained services, with staff acting as a 'bridge' for clients; and the Family Planning Association of India found it necessary to offer MSM who are married different options for accessing services (to avoid 'outing' them to men who were not married).

6. Promote HIV/SRHR integration for key populations at all levels, including building an enabling internal and external environment:

- **Build a multi-level approach to HIV/SRHR integration for key populations that includes, but goes beyond, the provision of joint services.** For example, ensure that programmes include raising awareness of key populations' rights and supporting them to demand appropriate integrated services.

- **Build an organisation's knowledge of and 'friendliness' to key populations.** For example, FPAI found it vital to take proactive steps to create an enabling environment for MSM and transgender people in their SRHR clinics and treat clients with dignity and respect.

- **If necessary, reconfigure an organisation's physical space to provide integrated programmes.** For example, Puskesmas, Indonesia, needed to refurbish some facilities and provide a separate entrance for a methadone clinic within its primary health care services.

- **Ensure that training to support integrated programming for key populations is appropriately targeted, comprehensive and high quality.** This includes: targeting all staff and volunteers – including administrative, management and clinical personnel – at both the 'home' site and referral facilities; addressing technical aspects of HIV/SRHR programming and attitudes towards key populations; and being led by or, at least, actively involving members of key populations. For example, in Myanmar, TOP (supported by UNFPA) found it vital to train staff in specific clinical services for female, male and transgender sex workers.

7. Address the political, legislative and funding context of HIV/SRHR integration for key populations:

- **Complement the provision of integrated services with local/national advocacy on legislative, structural and policy barriers to HIV/SRHR for key populations.** Examples include: advocating to local health or police authorities to support integrated programmes; advocating to national policy-makers to change laws that criminalise same-sex acts between consenting adults or do not recognise the identity of transgender people; and advocating to legal authorities for recourse in instances of violence against key populations.

- **Advocating to donors about why the HIV/SRHR needs of key populations matter and how integration is a critical 'investment opportunity'.** For example, where possible, demonstrate to donors the cost-efficiency of integrated programmes – for individuals, services and health systems – including through more extensive documentation of experiences, lessons learned, benefits and impact.

Box 5: Examples of HIV/SRHR integration for key populations in practice	
People living with HIV	In 2010, **India HIV/AIDS Alliance** secured support from the European Commission to implement a state-level advocacy project to realize the SRHR of PLHIV. Across four states of India (Maharashtra, Tamil Nadu, Andhra Pradesh and Gujarat), coalitions will be advocating for improved HIV/SRHR policies and their implementation. With a total membership of 20 organisations, each coalition will mostly consist of representatives of PLHIV or other key populations. Feedback and community consultation mechanisms through district-level community groups will ensure that state-level advocacy messages and recommendations for SRHR/HIV programming and policies are informed by communities' needs and realities. Representatives from PLHIV in each of the states will work with the India HIV/AIDS Alliance to ensure that national policy processes reflect the priorities identified at the state-level.
Sex workers	**UNFPA** Asia Pacific Regional Office, together with UNFPA country offices in seven countries, are focussing on improving access to sexual and reproductive health for sex workers, which is critical to achieving universal reproductive health *and* HIV prevention outcomes that are well tailored to the largely concentrated epidemics in the Asia Pacific region. Programmes to address HIV among sex workers are too often narrowly focussed on VCT, access to condoms and diagnosis and treatment of STIs. These programmes provide critical entry points to: • provide counselling and the full range of contraceptive methods to prevent unintended pregnancies • provide and promote access to VCT as central to planning pregnancy • ensure access to antenatal, delivery and post natal care including access to the antiretroviral drugs both for the mothers' own health and to prevent infection to their child during pregnancy, delivery and breastfeeding and • ensure referral systems, improve appropriateness of mainstream SRH services and tackle stigma and discrimination that is commonly a barrier to access mainstream health care services. In **Myanmar**, UNFPA supports TOP – a community-led intervention that supports female, male and transgender sex workers. It operates in 19 cites, reaching over 75% of the estimated number of sex workers in the country through a combination of peer outreach, drop-in centres, clinical services and community outreach. TOP's HIV services include voluntary counselling and testing, Antiretroviral therapy and care and support. Its expanded SRHR services now include: oral, injectable and emergency contraceptives; pregnancy testing; antenatal services; and cervical cancer screening. Out of its 19 drop-in centres, 15 have HIV/SRHR clinics, while the other 4 provide referrals to trained clinics trained by Population Services International.

Box 5: *continued*

MSM and transgender people	The work of **FHI360** with MSM and transgender people in the Asia and the Pacific Region has identified that such community members have a wide range of HIV/SRHR needs. Key examples include STI treatment, information on male sexual health, commodities (condoms and lubricant) and support for feminisation. FHI360 supported the regional branch of the International Union Against Sexually Transmitted Infections (IUSTI) to produce Clinical Guidelines for Sexual Health Care of MSM. These focus on an integrated approach, including addressing areas such as sexuality, STIs and sexual and genital health, as well as specific issues related to transgender people (including identity, hormone care, re-assignment surgery and neo-vaginal health). In **Cambodia**, FHI360 and partners support MStyle – a peer-led social network that combines an emphasis on high quality and confidential HIV/SRHR services with music and fashion. To date, it has reached nearly 6,000 of the country's 9,900 visible MSM, on average reaching each man 7 times with HIV prevention messages, sexual health services and referrals. As many of the MSM also have female partners, MStyle works in partnership with FHI 360's SMARTgirl programme which targets female entertainment service workers and their male clients. MStyle emphasizes peer support and outreach, with sessions going beyond discussion of STIs and HIV to address other issues that MSM may face - from disclosure of their sexual practices to drug use or sexual violence. Outreach workers distribute materials along with condoms, lubricants and referral cards for HIV counselling and testing, treatment for STIs and other health services.
People who use drugs	The **International Planned Parenthood Federation (IPPF)** has documented case studies of promising models of HIV/SRHR integration for key populations, including MSM and transgender people in India (including by the Tilak Nagar Clinic of FPAI). In **Indonesia**, IPPF's case study focuses on HIV/SRHR integration for people who use drugs. The first model looks at Klinik DKI (Pisangan) – a clinic of the Planned Parenthood Association of Indonesia (PKBI), a civil society organisation. The clinic provides a package of support to people who use drugs by integrating HIV services (such as voluntary testing and counselling) and harm reduction services (such as needle and syringe exchange) into the organisation's existing SRHR services (such as family planning, antenatal care and prevention of unsafe abortion). The steps towards integration have included: adjusting each of the organisation's services to ensure they are effectively integrated; re-orienting services and staff to key populations; combining service delivery methods (clinic-based and community outreach); and developing a referral system (for example for women who use drugs who are pregnant). PKBI's lessons include that there is a need for on-going capacity building, for example to ensure that harm reduction staff have not only the skills, but the confidence to raise SRHR issues with their clients and also that they can address specific clinical issues (such as methadone services for women who use drugs who are pregnant). The second model is **Puskesmas Gambir** – a government Community Primary Health Centre that integrates the services of three clinics – MNCH/family planning, HIV/voluntary counselling and testing and harm reduction – to provide a 'one stop shop' for people who use drugs. The Centre's steps towards integration have included building the capacity of the staff in drug-related issues, working in partnership with harm reduction NGOs and creating a welcoming and supportive space for clients. Its lessons include that the organisation needs to develop stronger protocols for integrated services, improve its referral system and improve the provision of prevention of mother to child transmission for women who use drugs.

Key messages about HIV/SRHR integration for

1 HIV/SRHR presents an important opportunity to respond to the unmet needs of key populations.

2 Integration can, in particular, **decrease stigma and discrimination and increase key populations' access to a comprehensive range of both HIV and SRHR support** – moving beyond a focus on their vulnerability to a rights-based, 'whole person' approach. Such support might, otherwise, 'fall through the net' of solely HIV or SRHR services.

3 However, **HIV/SRHR integration is not a 'magic bullet'.** In practice, it can pose significant challenges to organisations working with key populations – many of which face significant existing pressures and challenges. This is exacerbated by the current lack of clear technical guidance about good practice in integration for specific groups.

4 **Comprehensive HIV/SRHR integration may be a good long-term goal for some organisations.** However, integration that is too premature, too rapid or too large-scale risks compromising – rather than enhancing – key populations' access to high quality HIV and SRHR services.

5 In the short-term, full HIV/SRHR integration is not required. Instead, **efforts should start with the integration of selected services that are priorities for the community** and relatively easy to implement (with an obvious entry point and areas of complementarity).

key populations

6 **HIV/SRHR integration shows potential to enhance cost-efficiency.** However, the specific and often complex needs of key populations mean that such programming can be challenging to take to scale and requires a realistic level of investment.

7 **Good practice principles for work with key populations are particularly critical in HIV/SRHR integration.** Examples include gender equality, a human rights-based approach and the meaningful involvement of PLHIV and other key populations.

8 **A gender and sexuality approach is essential for HIV/SRHR integration** – that recognises the issues and differences involved for women/girls and men/boys from key populations and takes a non-judgemental and empowering approach to people's sexual choice and freedom.

9 **Community systems and organisations** (particularly those that are by and for key populations themselves) **are critical to making integration happen.** Beyond the provision of HIV/SRHR services, **they are vital for mobilising demand, ensuring services are appropriate and providing a continuum of support** (for example with follow-up within communities).

10 However, community organisations cannot achieve HIV/SRHR integration on their own. Instead, **a partnership approach is needed**, for example with the 'buy-in' of other service providers, national governments and international donors and the development of an enabling environment at all levels (including organisations and nationally).

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India HIV/AIDS Alliance (Alliance India) is a diverse partnership that brings together committed organisations and communities to support sustained responses to HIV in India. Complementing the Indian national programme, we work through capacity building, knowledge sharing, technical support and advocacy. Through our network of partners, we support the delivery of effective, innovative, community-based HIV programmes to key populations affected by the epidemic.

Our Vision: A world in which people do not die of AIDS

Our Mission: To support community action to prevent HIV infection, meet the challenges of AIDS and build healthier communities

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