



HIV/SRHR Integration for Key Populations

A review of experiences and lessons
learned in India and globally

India HIV/AIDS
Alliance

India HIV/AIDS Alliance

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

Acknowledgements

Thanks are given to the many people and organisations that contributed their experiences and documentation to this publication.

This report was written by Sarah Middleton-Lee (independent consultant). Alliance India would like to acknowledge the following for their contributions to this report: Sunita Grote, James Robertson, Sonal Mehta, Sophia Lonappan, Divya Bajpai and Susie McLean. This report was produced with support from the European Union.

Published in June 2012

© India HIV/AIDS Alliance

Photography: Unless otherwise stated, the appearance of individuals in this publication gives no indication of their HIV or key population status.

Information contained in the publication may be freely reproduced, published or otherwise used for non-profit purposes without permission from India HIV/AIDS Alliance. However, India HIV/AIDS Alliance requests to be cited as the source of the information.

The contents of this publication are the sole responsibility of India HIV/AIDS Alliance and do not necessarily reflect the views of the European Commission.

Recommended Citation:

India HIV/AIDS Alliance (2012). *HIV/SRHR integration for Key Populations: A review of experiences and lessons learned in India and globally*. New Delhi: India HIV/AIDS Alliance.



This project is funded by the European Union



India HIV/AIDS Alliance
Kushal House, Third Floor
39 Nehru Place
New Delhi – 110019
+91-11-4163-3081
info@allianceindia.org
www.allianceindia.org

HIV/SRHR Integration for Key Populations

**A review of experiences and lessons
learned in India and globally**

Acronyms

ANC	Antenatal care
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
FHI	Family Health International
FP	Family planning
GIPA	Greater involvement of people living with HIV
GNP+	Global Network of People Living with HIV
IPPF	International Planned Parenthood Federation
HCT	HIV counselling and testing
HPV	Human papillomavirus
IDU	Injecting drug user
KPs	Key populations
MNCH	Maternal, newborn and child health
MSM	Men who have sex with men
OSI	Open Society Institute
OST	Opiate Substitution Therapy
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother to child transmission
PNC	Postnatal care
PUD	People who use drugs
RTI	Reproductive tract infection
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
SW	Sex worker
UNAIDS	United Nations Joint Programme on AIDS
WHO	World Health Organisation

Contents

- 1. Introduction 1**
 - 1.1. Content of report 1
 - 1.2. Rationale and context for review 1
 - 1.3. Objectives and methods of review 2

- 2. Overview of HIV/SRHR integration for key populations 3**
 - 2.1. What are the SRHR needs of key populations and why do they matter? 3
 - 2.2. What is HIV/SRHR integration? 5
 - 2.3. Why is HIV/SRHR integration a vital strategy for key populations?..... 7
 - 2.4. What strategies are being used for HIV/SRHR integration for key populations? 8
 - 2.5. What lessons have been learned about HIV/SRHR integration for key populations?..... 10
 - 1. Promote good practice principles throughout HIV/SRHR integration for key populations: 10
 - 2. Plan and get started on HIV/SRHR integration by building on ‘what’s there’, gathering evidence and identifying key entry points: 10
 - 3. Ensure comprehensive HIV/SRHR integrated programming for key populations:..... 11
 - 4. Ensure effective and creative service delivery for HIV/SRHR integration for key populations:..... 12
 - 5. Ensure a strong ‘chain’ of HIV/SRHR integrated services for key populations, including through high quality and systematic referrals: 13
 - 6. Promote HIV/SRHR integration for key populations at all levels, including building an enabling internal and external environment: 13
 - 7. Address the political, legislative and funding context of HIV/SRHR integration for key populations:..... 13
 - 2.6. How do organisations ‘get started’ with HIV/SRHR integration for key populations?..... 14

- 3. HIV/SRHR integration for people living with HIV 17**
 - 3.1. What does HIV/SRHR integration for people living with HIV involve? 17
 - 3.2. What are some common strategies for HIV/SRHR integration for people living with HIV? 18
 - 3.3. What lessons have been learned about good practice HIV/SRHR integration for people living with HIV?..... 18
 - 3.4. Case studies of HIV/SRHR integration for people living with HIV 20

4. HIV/SRHR integration for sex workers	31
4.1. What does HIV/SRHR integration for sex workers involve?	31
4.2. What are some common strategies for HIV/SRHR integration for sex workers?...32	32
4.3. What lessons have been learned about good practice HIV/SRHR integration for sex workers?	32
4.4. Case studies of HIV/SRHR integration for sex workers.....	34
5. HIV/SRHR integration for men who have sex with men	47
5.1. What does HIV/SRHR integration for men who have sex with men (MSM) and transgender people involve?	47
5.2. What are some common strategies for HIV/SRHR integration for men who have sex with men and transgender people?	48
5.3. What lessons have been learned about HIV/SRHR integration for men who have sex with men and transgender people?	49
5.4. Case studies of HIV/SRHR integration for men who have sex with men and transgender people	51
6. HIV/SRHR integration for people who use drugs	61
6.1. What does HIV/SRHR integration for people who use drugs involve?	61
6.2. What are some common strategies for HIV/SRHR integration for people who use drugs?.....	62
6.3. What lessons have been learned about HIV/SRHR integration for people who use drugs?.....	62
6.4. Case studies of HIV/SRHR integration for people who use drugs.....	64
7. Conclusions and key messages	73
HIV/SRHR Integration for KPs: Key Messages.....	75
Annex 1: List of resources for review	77
Sources of information for review	77
India:.....	77
Global:.....	77
India resources included in review	78
Resources related to HIV/SRHR integration for key populations (general).....	78
Resources related to HIV/SRHR integration for specific key populations	79
Global resources included in review.....	81
Resources related HIV/SRHR integration for key populations (general)	81
Resources related to HIV/SRHR integration for people living with HIV	83
Resources related to HIV/SRHR integration for sex workers.....	84
Resources related to HIV/SRHR integration for men who have sex with men and transgender people.....	85
Resources related to HIV/SRHR integration people who use drugs.....	86

Annex 2: Key SRHR vulnerabilities for key populations: Alliance Good Practice Guide	87
Annex 3: Gender and SRHR issues for people who use drugs: Alliance Good Practice Guide	92
Women.....	92
Lack of “women-friendly” services	92
Gender and vulnerability	92
Women and injecting – risks and vulnerabilities	93
Women, sex work and drug use.....	93
Pregnancy and motherhood.....	93
Annex 4: Ten essential steps to strengthen family planning and HIV service integration (Family Health International)	94



1. Introduction

1.1. Content of report

This report summarises the findings of a review commissioned by India HIV/AIDS Alliance of experiences and lessons from integrating HIV and sexual and reproductive health and rights (SRHR) in programmes for key populations [see Figure 1].

The report outlines definitions and benefits of HIV/SRHR integration for key populations and presents some general lessons learned about good practice. It then addresses each of the selected key populations – describing issues to consider within integrated HIV/SRHR support, sharing key strategies and providing examples of integration in action.

Figure 1: Who are key populations?

‘Key populations’ refers to groups that are particularly vulnerable to and affected by HIV. They are key to both the dynamics of and response to epidemics.

Reflecting Alliance priorities, this review focused on five such groups:

- People living with HIV
- Sex workers
- Men who have sex with men
- Transgender people
- People who use drugs

1.2. Rationale and context for review

The review was carried out within a context of growing interest in HIV/SRHR integration [as defined in Section 2]. There is a growing wealth of evidence that the strategy ‘makes good sense’ and brings concrete benefits – including to people, services and national health systems.

The review specifically responded to the ‘push’ for HIV/SRHR integration within the changing and increasingly complex environment for responses to HIV. Within this context – one characterised by constrained resources, increased demands for cost-efficiency and political re-positioning (with HIV increasingly integrated into wider frameworks for health) – integration is clearly an important strategic option. It also, however, risks being seen as a ‘magic bullet’.

In India – as well as other countries in the Asia and the Pacific Region and globally – there is increasing policy support for the concept of HIV/SRHR integration. However, there remain significant questions and uncertainties about what such programming means in practice. This is particularly the case within the context of a concentrated HIV epidemic – where little is still known about what integration should ‘look like’ (for groups such as sex workers and men who have sex with men) and what practical opportunities and challenges it involves.

However, while integration 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. This review identifies a number of challenges and recommendations for SRHR/HIV integrated programmes. These challenges need to be taken into account when national responses aim to scale up SRHR/HIV integrated programming. While this approach clearly has the potential to increase reach and improve quality of interventions, integrating services and systems that are not ready may in the short-run actually compromise outcomes for key populations.

A number of critical questions remain outstanding. These include: *Do we have strong evidence to support HIV/SRHR integration as an effective approach to improve both SRHR and HIV outcomes specifically for key populations? If so, what needs to be taken into account to ensure that integration does not compromise access to services for key populations? For example, what type, pace and scale of integration works best for specific populations in specific contexts? And what is possible in the short-term and what goals should be set for long-term?*

1.3. Objectives and methods of review

This review aims to assess how, within the context of greater political support for SRHR/HIV integration, this strategy can not only improve the efficiency of programmes but truly serve the needs of key populations.

The objectives of the review were:

1. To identify and review a **selection of existing documentation** on programming for HIV/SRHR integration for key populations in India and internationally.
2. From that documentation, to **identify and analyse successful approaches and lessons learned** from HIV/SRHR integrated programming for key populations – both overall and in relation to the five priority groups for India HIV/AIDS Alliance.
3. To inform the future development, implementation and evaluation of **HIV/SRHR integrated programmes by India HIV/AIDS Alliance** – in particular ensuring that such programmes are based on good practice and respond to the specific needs and contexts of key populations.

The review did not aim to serve as a systematic or meta-analysis of all relevant documentation. It also did not aim to provide comprehensive documentation of the SRHR needs of key populations or detailed, technical guidance on the ‘how to’ of integrated programming for such groups.

The methodology for the review focused on assessing over 160 resources available on the websites of selected national and international organisations, including NGOs, technical support agencies and UN agencies [see **Annex 1** for a list]. The resources included case studies, mappings, toolkits, policy briefings and reports. Where adequate information was available, a template was used to record the details of programmes (such as the type of population, the HIV/SRHR components integrated, lessons learned, etc.) to facilitate comparison across different contexts and models



2. Overview of HIV/ SRHR integration for key populations

2.1. What are the SRHR needs of key populations and why do they matter?

According to universal commitments, key populations have the same, universal 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 share many common *needs* for HIV and SRHR information, support, services and commodities. For example, like other community members, they might require access to HIV testing, advice about family planning and access to maternal, newborn and child health (MNCH) services.

In practice, however, there are a significant number and range of factors that mean that key populations often experience both 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 **Figure 2**¹ for a summary and **Annexes 2 and 3** for extracts from Alliance Good Practice Guides on 'Integration of HIV and Sexual and Reproductive health and Rights' and 'HIV and Drug Use: Community Responses to Injecting Drug Use and HIV'].

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

¹ Adapted from: Integration of HIV and Sexual and Reproductive Health and Rights: Good Practice Guide, International HIV/AIDS Alliance, 2010; and Who Are We Failing? How Marginalisation and Vulnerability Affect Adolescents' Needs for and Access to SRHR, Interact Worldwide, 2011.

Figure 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • A woman living with HIV might face stigma and discrimination by staff at mainstream antenatal services. • A female sex worker might work at nights and not be able to access a family planning clinic in normal opening hours. • A transgender sex worker might not access a public SRHR service if they face threats 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 might not be allowed to register at a government STI centre if they are criminalized.
Weaker capacity or opportunities to demand SRHR services	<ul style="list-style-type: none"> • Sex workers might not be included in provincial consultations on women's SRHR needs. • MSM might not be included in the monitoring and evaluation of SRHR projects because they are a 'hidden population'. • People living with HIV might lack self-esteem or 'safe spaces' to advocate for their SRHR needs to decision-makers in health services. • Transgender people might not be able to participate in SRHR decision-making because they lack legal status. • People who use drugs might lack the skills to define their SRHR needs because they are left out of community capacity building projects.

As a result of these multiple and often overlapping factors, key populations can experience **significant unmet needs for SRHR** [see **Figure 3**²]. These needs often ‘fall through the net’ of SRHR services (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’).

Figure 3: Examples of key populations’ unmet SRHR needs, 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% regularly 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 type of services – due to judgemental attitudes and low confidentiality.

2.2. What is HIV/SRHR integration?

In this review, integration refers to **one or more components of SRHR programming being integrated into (or ‘joined with’) one or more components of HIV programming; or vice versa. This includes referrals from one service to another, with the overall aim of providing more comprehensive support**³ [see **Figure 4**].

This review was based on the understanding of HIV/SRHR integration promoted by the Good Practice Guide⁴ and Programming Standards⁵ of the International HIV/AIDS Alliance. [See **Figure 5** for the 11 good practice standards]. The review was also informed by key normative documents on integration produced by the International Planned Parenthood Federation (IPPF) and partner UN agencies (UNFPA, UNAIDS and WHO)⁶, as well as leaders in the field of integration in India, notably PATH India.

There is increasing evidence and recognition that HIV/SRHR integration brings multiple benefits at multiple levels⁷. It can, for example increase and improve: an **individual’s** access to a wider

Figure 4: How HIV/SRHR integration strengthens programming

“Linkages and integration enable programmes to reach more people, especially key populations, to respond more fully to their needs and to reach both HIV and SRH goals more effectively. Linkages strengthen programmes to address the root causes of SRH ill-health, including HIV. Linkages between SRH and HIV also address the social and structural issues that make people vulnerable to SRH ill-health and HIV – gender inequality, poverty, stigma and discrimination, rights violations and legal issues.”

Good Practice HIV Programming Standards, International HIV/AIDS Alliance

2 India HIV/AIDS Alliance and SASO (2011). In the Shadows: The Chanura Koi baseline study on Women who inject drugs in Manipur, India. New Delhi. India HIV/AIDS Alliance (150 women who use drugs, aged 18-49 years in 3 sites in Manipur) India HIV/AIDS Alliance. Understanding Barriers to Sexual Reproductive Health for FSW. Hyderabad, India HIV/AIDS Alliance Andhra Pradesh. (146 female sex workers in 5 districts in Andhra Pradesh).

3 Based on description of Standard 4.1 in *Good Practice HIV Programming Standards*, International HIV/AIDS Alliance, June 2010.

4 *Good Practice Guide: Integration of HIV and Sexual and Reproductive Health and Rights*, International HIV/AIDS Alliance, 2010.

5 Standards to guide the design, implementation and evaluation of Alliance programmes in seven areas, with each including a number of agreed standards (measurable and evidence-based benchmarks of quality). *Good Practice HIV Programming Standards*, International HIV/AIDS Alliance, June 2010.

6 For example: *A Framework for Priority Linkages*, IPPF, UNFPA, UNAIDS and WHO, 2005; and *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide*, IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives, 2009.

7 For example: *Sexual and Reproductive Health and HIV Linkages: Evidence Review and Recommendations*, UCSF, WHO, UNAIDS, UNFPA and IPPF, 2009; and *Good Practice Guide: Integration of HIV and Sexual and Reproductive Health and Rights*, International HIV/AIDS Alliance, 2010.

range of *both* HIV and SRHR support; a **service**'s efficient use of human and financial resources; and a health **system**'s collaborative planning and management⁸. The benefits are particularly evident in the uptake of key 'cross-over' services, such as condoms (for dual protection from *both* HIV and unwanted pregnancy)⁹.

HIV/SRHR integration has been increasingly recognized in key global policy commitments – including the 2011 UN Political Declaration on HIV/AIDS¹⁰ – and national frameworks. It is seen as critical to achieving *both* Millennium Development Goals 5 (improve maternal health) and 6 (combat HIV, malaria and other diseases).

Figure 5: Good practice programming standards for HIV/SRHR integration, International HIV/AIDS Alliance

1	Our organisation promotes the linking and integration of SRH and HIV in policies, programmes and services.
2	In collaboration with others, our organisation promotes the SRH needs and rights of all people.
3	The people most affected by HIV and SRH problems are meaningfully and consistently involved at all stages of the project cycle.
4	Our organisation promotes and/or delivers sexuality education that is comprehensive, increases knowledge, self-esteem and skills and is socially and culturally context-specific and tailored to people's needs.
5	Our organisation promotes and/or provides information, education and counseling on HIV that is integrated with reproductive concerns and options.
6	Our organisation promotes and increases uptake of the essential elements of PPTCT.
7	Our organisation promotes and/or provides STI education, diagnosis, treatment and condoms.
8	Our organisation promotes and refers users to quality, user-friendly services whenever feasible rather than setting up parallel services. We collaborate with and build the capacity of service providers to better meet the needs of our beneficiaries.
9	Our organisation works with others to promote and/or implement programmes that address gender and sexuality as an integral component of the SRH and HIV response.
10	In collaboration with others, our organisation promotes and/or provides interventions to address gender-based and sexual violence and abuse in its HIV and SRH response.
11	Our organisation has a policy and programme to address stigma and discrimination, which undermine protective behaviours and act as barriers to accessing SRH and HIV services and support.

8 A Framework for Priority Linkages, WHO, UNFPA, UNAIDS and IPPF, 2005.

9 Sexual and Reproductive Health and HIV Linkages: Evidence Review and Recommendations, UCSF, WHO, UNAIDS, UNFPA and IPPF, 2009.

10 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, UN General Assembly, June 2011.

2.3. Why is HIV/SRHR integration a vital strategy for key populations?

Within dialogue on HIV/SRHR integration, it is often indicated that the strategy particularly ‘makes sense’ for key populations¹¹. This is because – beyond the generic benefits to all community members – 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 [see **Figure 6**¹²].

In response, an increasing number of organisations working with key populations in a variety of different settings are putting HIV/SRHR integration into practice. This involves a broad spectrum of approaches – from the joining of small, specific components to full-scale comprehensive integrated programming.

Figure 6: Potential benefits of HIV/SRHR integration for key populations

- **Provides a ‘one stop shop’ for both HIV and SRHR support** – increasing key populations’ access to and uptake of comprehensive and continuous support.
- **Promotes a rights-based and ‘whole person’ 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.
- **Reduces stigma and discrimination related to HIV and/or key populations** – increasing key populations’ access to services by ‘normalising’ issues and needs.
- **Increases 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.
- **Improves 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.).
- **Makes good use of scarce financial and human resources for HIV/SRHR programmes for key populations.**

Based on these experiences, there is some emerging consensus about ‘what matters’ and ‘what works’, for example in HIV/SRHR integration for PLHIV¹³. However, on the whole, and especially for the other populations – sex workers, people who use drugs, MSM and transgender people – there remain important questions about what constitutes good practice for integration, and what opportunities and challenges are involved in putting the strategy into practice.

11 For example: *A Framework for Priority Linkages*, IPPF, UNFPA, UNAIDS and WHO, 2005.

12 Adapted from: *Thematic Segment: Sexual and Reproductive Health Services with HIV Interventions in Practice: Background Paper*, 26th Meeting of the UNAIDS Programme Coordinating Board, June 2010; and *Sexual and Reproductive Health and HIV Linkages: Evidence Review and Recommendations*, WHO, UNFPA, IPPF, UNAIDS and UCSF, 2008

13 *Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A Guidance Package*, GNP+, ICW, Young Positives, EngenderHealth, IPPF and UNAIDS, 2009.

2.4. What strategies are being used for HIV/SRHR integration for key populations?

The review identified that there are a range of examples of interesting and/or successful strategies for HIV/SRHR integration for key populations:

Figure 7: Examples of strategies for HIV/SRHR integration for key populations

HIV programme	Integration	SRHR programme	Case studies in this report
People living with HIV			
ART (also often care and support)	←	FP (also often STIs and/or broad SRHR)	<ul style="list-style-type: none"> • TASO, Uganda • Ministry of Health, Kenya
HCT (also often PMTCT or care and support)	←	FP (also often broad SRHR)	<ul style="list-style-type: none"> • POZ, Haiti • HCT Centres, Kenya • HCT Centres, Ethiopia • PSI, Zimbabwe
General services for PLHIV	←	Selected components of SRHR (e.g. support related to STIs or gender-based violence)	<ul style="list-style-type: none"> • MAMTA, India • Gheskio, Haiti • International HIV/AIDS Alliance in Uganda, Uganda
HCT (often followed by other services, e.g. PMTCT and ART)	→	FP (also often broad SRHR)	<ul style="list-style-type: none"> • ABEF, Rwanda • PROFAMILIA, Dominican Republic • FHOK, Kenya
Advocacy on HIV	↔	Advocacy on SRHR	<ul style="list-style-type: none"> • SAATHII, India
Sex workers			
HCT (and broader HIV)	←	FP (and broader SRHR, especially STIs and condoms)	<ul style="list-style-type: none"> • Aastha Project, India • KANCO, Kenya
HIV prevention	←	Female condoms for dual protection	<ul style="list-style-type: none"> • EC-CAP, Caribbean
HCT or other specific, key services for SWs	→	Broad SRHR (especially STIs and condoms)	<ul style="list-style-type: none"> • FPAM, Malawi • CEMOPLAF, Ecuador
HIV prevention (plus wider HIV)	↔	STI prevention (plus wider SRHR)	<ul style="list-style-type: none"> • Avahan programme, India
Comprehensive or selected HIV components (especially HCT)	↔	Comprehensive or selected SRHR components (especially STIs and condoms)	<ul style="list-style-type: none"> • PATH India, India • CSI, India • YPSA, Bangladesh • ISH, Serbia • Community Support Concern/HMAP, Pakistan • TOP, Myanmar

Men who have sex with men/transgender people			
HCT (and other HIV services)	→	FP (and broader SRHR, especially STIs)	<ul style="list-style-type: none"> • FPA India, India • PROFAMILIA, Colombia
HCT (and other HIV services)	→	SRHR, especially STIs	<ul style="list-style-type: none"> • RHAC, Cambodia • Mythi clinics (Avahan Programme), India
General HIV services	←	STIs	<ul style="list-style-type: none"> • Tamil Nadu State AIDS Control Society, APAC and TAI, India
Selected components of HIV	↔	Selected components of SRHR	<ul style="list-style-type: none"> • Bandhu Social Welfare Society, Bangladesh • PAVNHA and Pakistan Society, Pakistan • Blue Diamond Society, Nepal • North Africa Regional Programme, International HIV/AIDS Alliance • Espace Confiance, Cote D'Ivoire • Humsafar Trust, India
Advocacy on HIV	↔	Advocacy on SRHR	<ul style="list-style-type: none"> • SAATHII, India
People who use drugs			
HIV and harm reduction	←	SRHR (especially condoms and STIs and often specifically including women's health)	<ul style="list-style-type: none"> • DICP, Malaysia • Korsang, Cambodia • OSI, Ukraine • SASO, India • Five Hearts Service Centre, China
HIV and harm reduction	→	Broad SRHR or primary health care	<ul style="list-style-type: none"> • PKBI, Indonesia • Puskesmas, Indonesia

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

Based on the case studies described in the following sections, the review identified many important lessons about HIV/SRHR programming for all key populations. While some are specific to integration, many serve as a reminder of good practice for *any* type of work with communities that are marginalised and vulnerable in the context of HIV/SRHR. The review's findings highlight 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; and address critical barriers for key populations (such as stigma and discrimination)¹⁴.
- **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 awareness of sex workers' rights – leading to an increase in safer sex practices¹⁵.
- **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 Boards¹⁶; and PROFAMILIA, Colombia, employed men who have sex with men to design and deliver training to the staff of their SRHR clinic¹⁷.
- **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)¹⁸. FPAI found it important to work with the family members of MSM and transgender people to improve family acceptance and understanding of their needs¹⁹.

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

14 *SRHR/HIV Integration: Alliance India Experiences and Review*, (powerpoint presentation at ICAAP 2011), India HIV/AIDS Alliance, 2011.

15 *Exploring Integrated SRH and HIV Models and Programming Examples from a Variety of Settings in Countries/Areas with Concentrated HIV Epidemics*, Amitrajit Saha, Anna Zakowicz, Dawn Averitt Bridge, Jill Gay, Robert Carr, (Presentation at International AIDS Conference), July 2010.

16 *Models of Care Project: Linking HIV/AIDS Treatment, Care and Support in Sexual and Reproductive Health Care Settings: Examples in Action*, International Planned Parenthood Federation, 2005.

17 *Models of Care Project: Linking HIV/AIDS Treatment, Care and Support in Sexual and Reproductive Health Care Settings: Examples in Action*, International Planned Parenthood Federation, 2005.

18 *Positively Caring* (powerpoint presentation), International HIV/AIDS Alliance, March 2011.

19 *Linking SRH And HIV To Meet The Needs Of MSM & Transgender People: Experiences from India*, (powerpoint presentation), Family Planning Association of India, August 2011.

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 drugs²⁰.

- **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 services²¹.
- **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 family planning²²; and Bandhu Social Welfare Society, Bangladesh, found that providing general health care was a good way to start engaging MSM on issues of SRHR²³.
- **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 age²⁴; 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 testing²⁵.
 - **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 children²⁶; 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 integration²⁷.** 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 workers²⁸; 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 services²⁹.

20 *Integration of HIV and Sexual and Reproductive Health & Rights (SRHR): Report on Existing Alliance Programmes and Policy Work and Potential Strategic Partnerships*, International HIV/AIDS Alliance.

21 *Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A Guidance Package*, GNP+, ICW, Young Positives, EngenderHealth, IPPF and UNAIDS, 2009.

22 *Sexual and Reproductive Health Needs of FSWs, MSMs and TGs: Research Report on Quantitative Findings from Warangal, Guntakal and Piler Sites of Alliance in Andhra Pradesh*, SWASTI Health Resource Centre, December 2008.

23 *Summary Report of Key Findings and Programme Recommendations: From FHI MSM Programme Evaluations (Bangladesh, Indonesia and Nepal)*, Family Health International.

24 *Needs, Challenges and Opportunities: Adolescents and Young People Living with HIV in Zambia: Briefing Paper*, International HIV/AIDS Alliance, 2011.

25 *Sexual and Reproductive Health Needs of FSWs, MSMs and TGs: Research Report on Quantitative Findings from Warangal, Guntakal and Piler Sites of Alliance in Andhra Pradesh*, SWASTI Health Resource Centre, December 2008.

26 *Issue Brief: Sexual and Reproductive Health and Rights – Key Issues for Adolescents Affected by and Living with HIV*, International HIV/AIDS Alliance in India.

27 *Integration of HIV and Sexual and Reproductive Health & Rights (SRHR): Report on Existing Alliance Programmes and Policy Work and Potential Strategic Partnerships*, International HIV/AIDS Alliance.

28 *Integration of HIV and Sexual and Reproductive Health & Rights (SRHR): Report on Existing Alliance Programmes and Policy Work and Potential Strategic Partnerships*, International HIV/AIDS Alliance.

29 *HIV and Drug Use: Good Practice Guide*, International HIV/AIDS Alliance, 2010.

- **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 facility³⁰.
- **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 services³¹.

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'³²; 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 clinic³³.
- **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 behaviour³⁴; and the staff and peer educators of Korsang, Cambodia, are all current or former drugs users, while support for women who use drugs is always delivered by female workers³⁵.
- **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-makers³⁶.

³⁰ *Exploring the Links between Drug Use and Sexual Vulnerability among Young Female Injecting Drug Users in Manipur*, Population Council, 2008.

³¹ *PATH, India: HIV-SRH Convergence, Policy and Practice Update 4*, HIV-SRH Convergence Project, PATH, December 2009; and *Exploring Integrated SRH and HIV Models and Programming Examples from a Variety of Settings in Countries/Areas with Concentrated HIV Epidemics*, Amritrajit Saha, Anna Zakowicz, Dawn Averitt Bridge, Jill Gay, Robert Carr, (Presentation at International AIDS Conference), July 2010.

³² *Gateways to Integration: A Case Study from Serbia*, WHO, UNFPA, UNAIDS and IPPF, 2009.

³³ *Advocacy Brief: Integration of Sexual and Reproductive Health and HIV-Related Services for Men Who Have Sex with Men (MSM) and Transgender People in India*, (draft), Family Planning Association of India, 2010.

³⁴ *Integration of HIV and Sexual and Reproductive Health and Rights: Good Practice Guide*, International HIV/AIDS Alliance, December 2010.

³⁵ *HIV and Drug Use: Community Responses to Injecting Drug Use and HIV: Good Practice Guide*, International HIV/AIDS Alliance, 2010.

³⁶ *Advancing Sexual and Reproductive Health and Rights for Sex Workers*, (powerpoint presentation at ICAAP 2011), UNFPA Asia Pacific Regional Office, August 2011.

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 referral systems and 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 clients³⁷; 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)³⁸.

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 respect³⁹.
- **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 services⁴⁰.
- **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 workers⁴¹.

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 policie 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.

37 *Making Harm Reduction Work for Women: The Ukrainian Experience*, Open Society Institute, 2010.

38 *Advocacy Brief: Integration of Sexual and Reproductive Health and HIV-Related Services for Men Who Have Sex with Men (MSM) and Transgender People in India*, (draft), Family Planning Association of India, 2010.

39 *Linking SRH And HIV To Meet The Needs Of MSM & Transgender People: Experiences from India*, (powerpoint presentation at ICAAP 2011), Family Planning Association of India, August 2011.

40 *Linking Sexual and Reproductive Health and HIV: Advocacy Brief on People Who Use Drugs*, Indonesia, IPPF East and South Asia and Oceania Region, 2011.

41 *Advancing Sexual and Reproductive Health and Rights for Sex Workers*, (powerpoint presentation at ICAAP 2011), UNFPA Asia Pacific Regional Office, August 2011.

2.6. How do organisations ‘get started’ with HIV/SRHR integration for key populations?

The review particularly highlighted lessons learned about good practice in initiating HIV/SRHR integration for key populations. These include that it is vital to take a steady, step-by-step approach [see **Figure 8**, informed by a range of publications, for example including Ten Essential Steps to Strengthen Family Planning and HIV Service Integration by Family Health International (FHI) – see **Annex 4**]. The lessons also include that it is important to avoid organisational ‘pitfalls’, such as⁴²:

- Doing integration because it’s ‘the right thing to do’ rather than something the organisation *wants* to do.
- Simply ‘doing more’ without considering the most effective ways to do integration.
- Having HIV and SRHR components that just ‘co-exist’ rather than are complementary.
- Lacking sustainable funding to support increased integration for key populations.
- Starting too big – and risking over-load of staff/services and building false expectations.
- Failing to back up integrated programming with appropriate policies and procedures.
- Expecting staff to provide broader services, but not supporting them through training, etc.
- Lacking appropriate/adequate infrastructure, equipment or commodities for integration.
- Having ‘weak links in the chain’, such as unsupportive referral services or little community support (with loss to follow-up).

⁴² Informed by multiple documents and adapted from the generic ‘helps’ and ‘hindrances’ identified in *Linkages: Evidence Review and Recommendations*, IPPF, UCSF, UNAIDS, UNFPA and WHO, 2008.

Figure 8: Ten key steps to developing an HIV/SRHR integrated programme for key populations

1. Mobilise the key population community to create demand for HIV/SRHR integrated services.
2. Secure the ‘buy-in’ for the *concept* of integration among all key stakeholders both:
 - Internally – particularly among the organisation’s management and governance.
 - Externally – including among the wider health community and leaders of key populations.
3. Start with steps to gather evidence and assess needs, such as combining:
 - A **participatory community assessment** to identify the key population’s specific needs and desires in relation to HIV and SRHR and explore issues such as barriers to services.
 - An **environment mapping** to identify ‘what’s already there’ for HIV and SRHR in terms of existing data, services, infrastructure, funding, types of providers, accessibility, cost, etc.
4. Based on the assessment and technical guidance (such as National AIDS Programme guidelines), identify an essential package of HIV and SRHR information, services and commodities to meet the specific needs of the key population.
5. Based on the essential package and environment mapping, develop an organisational strategy for HIV/SRHR integration. Consider issues such as:
 - What HIV or SRHR components are already available and accessible to community members.
 - What areas would be easiest, cheapest and/or most effective to integrate with each other – with particular attention to ‘overlapping’ areas (such as condoms for dual protection).
 - Which direction integration works best (e.g. integrating SRHR into an HIV programme or vice versa).
 - The extent to which integration will involve *provision* of services or *referral* to other facilities.
6. When the type of integration has been agreed, plan and implement a series of key steps to ‘make integration happen’. These might include:
 - **Securing resources** for integrated programming and/or renegotiating funding with existing donors.
 - **Providing training** to all staff involved in the programme, as well as referral sites.
 - **Developing specific strategies to respond to barriers to services** identified in the needs assessment, such as stigma and discrimination.
 - **Preparing/re-organising space and infrastructure within health facilities.** For example, creating shared reception areas or increasing the number of confidential counselling spaces.
 - **Re-organising/managing commodities.** For example, integrating supply management systems.
 - **Developing protocols and guidelines for integrated programming.**
 - **Strengthening project management** to deal with additional challenges or processes related to integrated programming.
 - **As necessary, building a strong referral system,** including ensuring that referral facilities are ‘key population friendly’ and have relevant technical expertise.
 - **Strengthening systems for patient monitoring,** including to track clients ‘journey’ within the integrated programme, including referrals to other organisations.
 - **Strengthening the monitoring and evaluation system,** with indicators for integrated programming.
7. Build a ‘key population-friendly’ and ‘HIV/SRHR-friendly’ environment throughout integrated programming. For example, ensure that: an HIV organisation understands/addresses the changes needed to provide SRHR services; or an SRHR organisation understands/addresses the changes needed to provide safe and non-stigmatising services to key populations.

8. Start with a pilot project (perhaps focusing on some 'easy wins' for integration), then improve the model before scaling up.
9. Integrate HIV or SRHR components over time, building up to a fuller range of integrated. For example, an SRHR programme might start with 'easy fit' options (such as HCT and PMTCT) before integrating more complex options (such as ART).
10. Plan on-going opportunities for dialogue to enhance knowledge and respect, for example between service providers and community members and between an NGO and health authorities.

3. HIV/SRHR integration for people living with HIV

3.1. What does HIV/SRHR integration for people living with HIV involve?

The review indicated that – building on a generic essential package for HIV/SRHR – there are a number of components that may need specific attention within integrated programming for people living with HIV. These include information, support and services related to⁴³:

- **Psycho-social support, including focused on sexuality and sexual health (e.g. sexual desires, safer sex) for both men and women.**
- **FP (e.g. counselling on safe ways to become pregnant and access to a full range of contraceptive options, including long-lasting ones).**
- **Interactions between different drugs, such as ART, hormonal contraceptives and methadone.**
- **Pregnancy and birth, including PMTCT, ANC, delivery and PNC.**
- **MNCH, including infant feeding and treatment.**
- **Positive health, dignity and prevention (e.g. information on ‘positive prevention’, support for voluntary disclosure).**
- **Empowerment on sexual and reproductive health rights.**
- **Full range of treatment, including second/third line ARVs and for opportunistic infections.**
- **Full range of STIs (e.g. rapid testing, treatment).**
- **Male and female condoms (e.g. supplies, support for negotiation skills) for dual protection.**
- **Sexual dysfunction (e.g. low libido related to ART).**
- **(Where legal) safe and confidential abortion and (in all contexts) post-abortion care.**
- **Sexual and intimate partner violence (e.g. support after rape or gender-based violence following disclosure of HIV status), including PEP.**
- **Sero-discordant couples (e.g. information on safer sex, counselling on disclosure, biomedical prevention services).**
- **HPV, cervical and anal cancer (e.g. vaccination, regular screening).**

⁴³ Referenced from case studies and literature review, in particular: *Convergence of HIV and SRH Services in India: Impacts on and Implications for Key Populations: A Literature Review*, HIV-SRH Convergence Project (India), PATH, January 2007; *Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls: Manual for Trainers and Programme Managers*, ENGENDERHEALTH and International Community of Women Living with HIV, 2006; *Sexual and Reproductive Health of Women Living with HIV: A Flipbook*, India HIV/AIDS Alliance; *Sexual and Reproductive Health of Women Living with HIV/AIDS: Guidelines on Care, Treatment and Support for Women Living with HIV/AIDS and Their Children in Resource-Constrained Settings*, WHO, 2006; *Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A Guidance Package*, GNP+, ICW, Young Positives, EngenderHealth, IPPF and UNAIDS, 2009; and *Case Study: Zimbabwe, Integration of Family Planning and HIV Services in Zimbabwe: Hormonal Implants and Dual Protection Messages*, PSI Zimbabwe.

3.2. What are some common strategies for HIV/SRHR integration for people living with HIV?

The review identified that, compared to other key populations, there is emerging consensus on some of the most effective strategies for HIV/SRHR integration for people living with HIV. As seen in the literature and demonstrated in the case studies below, examples include:

Figure 9: Examples of strategies for HIV/SRHR integration for people living with HIV

HIV programme	Integration	SRHR programme	Examples in case studies
ART (also often care and support)	←	FP (also often STIs and/or broad SRHR)	<ul style="list-style-type: none"> • TASO, Uganda • Ministry of Health, Keny
HCT (also often PMTCT or care and support)	←	FP (also often broad SRHR)	<ul style="list-style-type: none"> • POZ, Haiti • HCT Centres, Kenya • HCT Centres, Ethiopia • PSI, Zimbabwe
General services for PLHIV	←	Selected components of SRHR (e.g. support related to STIs or gender-based violence)	<ul style="list-style-type: none"> • MAMTA, India • Gheskio, Haiti • International HIV/AIDS Alliance in Uganda, Uganda
HCT (often followed by other services, e.g. PMTCT and ART)	→	FP (also often broad SRHR)	<ul style="list-style-type: none"> • ABEF, Rwanda • PROFAMILIA, Dominican Republic • FHOK, Kenya
Advocacy on HIV	↔	Advocacy on SRHR	<ul style="list-style-type: none"> • SAATHII, India [see Section 5 on MSM and transgender people)

3.3. What lessons have been learned about good practice HIV/SRHR integration for people living with HIV?

The generic lessons learned for HIV/SRHR integrated programming for key populations [see section 2.5] apply to people living with HIV. In addition, some specific lessons include that it is important to:

- **Not make presumptions about the SRHR needs or desires of PLHIV.** For example, although a study by FHI in five countries found little unmet need for FP, this was because many women living with HIV were actually not sexually active (due to issues such as self-stigma)⁴⁴. Meanwhile, an Alliance India study in Maharashtra, Manipur, Tamil Nadu and Andhra Pradesh found that widows living with HIV *are* sexually active, experience heightened risk (such as related to violence and sex work) and have unmet needs for SRHR services⁴⁵.
- **Address the gender dimensions of HIV/SRHR and the implications for integrated programmes.** For example, an IPPF study of stigma in Bangladesh, the Dominican Republic and Ethiopia found that women living with HIV were more likely than men to have:

44 A Five-Country Study of Family Planning and HIV Integrated Services, Family Health International, 2010.

45 Issue Brief: Sexual and Reproductive Health and Rights – Key Issues for HIV-Affected Widows, International HIV AID Alliance in India.

decided not to have sex; decided not to have children; and chosen, or been coerced into, sterilisation⁴⁶. A report by the International Community of Women Living with HIV found that women who are living with HIV and pregnant faced increased gender-based violence. Meanwhile, an India HIV/AIDS Alliance study found that men living with HIV can also lack knowledge of FP and have many unmet needs, such as education on condom use and access to emergency contraception⁴⁷.

- **Pay particular attention to the HIV/SRHR needs of sero-discordant couples.** For example, a GNP+ study in Nigeria found that 58% of such couples said that their sexual intimacy had been negatively affected by learning of their different HIV status. It also found that 40% had never used condoms and most had not received SRHR counselling from health facilities⁴⁸.

Recognise the centrality of sexual rights for people living with HIV [see **Figure 10**⁴⁹]. This includes ensuring that positive health dignity and prevention ('positive prevention') programmes respect *both* the rights and responsibilities of people living with HIV, including to confidentiality, informed consent and voluntary disclosure⁵⁰.

- **Use integrated programme as a means to look at the full, holistic needs of people living with HIV, rather than the needs confined to their HIV status** [see **Figure 11**].
- **Build on the safe and supportive services developed for HIV to, in particular, address the full range of pregnancy-related needs of women living with HIV.** Such approaches involve integrating services such as FP, pregnancy counselling/testing/screening, ANC, PNC and, if required, safe abortion and post-abortion care.

Figure 10: Amsterdam Statement on SRHR for people living with HIV

- People living with HIV have the freedom of choice regarding consensual and pleasurable sexual expression.
- People living with HIV have the freedom of choice regarding reproduction, marriage and family planning.
- People living with HIV have the fundamental right to access sexual health information and comprehensive sexual health services.

Figure 11: How integration avoids 'missed opportunities' to address critical needs of PLHIV

"Clients typically seek SRH services for one particular need or problem – e.g. FP, an STI, abortion (where legal) and post-abortion care, or some aspect of maternal health care – and health workers typically respond to that one particular need or problem. However, people living with HIV may have other needs or concerns that contribute to their primary problem, but that are never identified or addressed by a service provider. By not addressing those needs, health workers may miss key opportunities to improve clients' overall health status. This problem of missed opportunities is particularly serious in SRH services, given the potentially life-threatening consequences of pregnancies, STIs and AIDS, and both the social stigma associated with HIV and AIDS and the discomfort that many clients and health workers feel about discussing these issues."

Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls: Manual for Trainers and Programme Managers, Engenderhealth and ICW

46 *Piecing It Together for Women and Girls: The Gender Dimensions of HIV-Related Stigma: Evidence from Bangladesh, Dominican Republic and Ethiopia*, IPPF, 2011

47 *Sexual and Reproductive Health of Males-at-Risk in India: Service Needs, Gaps and Barriers*, International HIV AID Alliance in India, May 2008.

48 *HIV Discordant Couples – An Exploratory Study: Insights from South Africa, Tanzania and the Ukraine*, GNP+, HRSC and University of Witwatersr, 2009.

49 *Amsterdam Statement on Sexual and Reproductive Health and Rights for People Living with HIV*, GNP+, December 2007.

50 *Positive Health, Dignity and Prevention: Technical Consultation Report*, GNP+ and UNAIDS, April 2009.

3.4. Case studies of HIV/SRHR integration for people living with HIV

Organisation: The AIDS Support Organisation (TASO)⁵¹ (supported by FHI)			
Country	Uganda (Mbale)	HIV epidemic	Generalised
Provider type	Civil society	Donor	USAID
Programme type	HIV	Intervention type	Facility-based; community outreach
Key population	PLHIV (individuals and couples)		
HIV/SRHR integration	<ul style="list-style-type: none"> • Centre providing comprehensive HIV services (including ART) integrating FP services (including condoms for dual protection and oral/injectable/emergency contraceptives). Referrals to regional hospital for long-acting and permanent FP methods. Complemented by community awareness-raising on FP (e.g. radio shows). • Previously only provided condoms, but saw massive unmet need for FP among PLHIV. • Start-up for integration involved: <ul style="list-style-type: none"> • Using a framework (developed by ACQUIRE) to assess organization's capacity (human, physical, financial, technical) for adding services. • Doing a participatory needs assessment of clients' FP knowledge, practices and needs – to understand the context and build ownership. • These steps showed that: TASO had good infrastructure and could refer to the regional hospital for supplementary services; staff needed training; and clients would prefer to receive FP services from their existing HIV provider. • Critical steps to implement integration included: staff training; building partnerships with referral sites; and monitoring performance. After a start-up phase, TASO then strengthened its work by: formalizing the referral system; improving its data collection; and using Ministry of Health commodity supply processes. • TASO also updated its protocols, adapted FP materials for its clients, developed a training curriculum and trained trainers in FP. Community nurses and volunteers were trained to provide support services (e.g. triage, counselling, information). • Service provision complemented by community advocacy to stimulate demand. 		
Lessons learned	<ul style="list-style-type: none"> • HIV and FP services have mutual benefits (e.g. follow-up for FP provides an opportunity to support adherence to ART). • To avoid stock-outs, an HIV NGO must familiarise itself with supply systems for FP and advocate/work with government to ensure regular supplies of condoms and other FP commodities. • It is critical to invest in people – delineating FP tasks for <i>everyone</i> in the organization, training <i>all</i> levels of staff, building the skills of supervisors and mobilizing volunteers. • Demand has to be built for services (e.g. by involving the community in project design, developing materials in local languages, providing services for couples, etc.). 		

51 Integrating Family Planning and Antiretroviral Therapy Services in Uganda, Family Health International, 2010.

Organisation: Population Services International (PSI)/Zimbabwe⁵²			
Country	Zimbabwe	HIV epidemic	Generalised
Provider type	Civil society	Donor	Government of the Netherlands
Programme type	HIV	Intervention type	Facility-based; mobile
Key population	PLHIV (particularly women) and sero discordant couples		
HIV/SRHR integration	<ul style="list-style-type: none"> • Programme focused on dual protection (from unintended pregnancy and HIV) and targeting PLHIV, sero discordant couples and young women (aged 15-29 years). • Programme combines: <ul style="list-style-type: none"> • ‘New Start’ network of 19 static and 23 mobile HCT units integrating FP (for people testing positive <i>or</i> negative) and reaching over 35,000 clients per month. Referrals to FP service providers (with follow-up to ensure success). • ‘New Life’ network of 15 centres (12 managed by local NGOs) and mobile units (including at hospitals and ANC sites) providing psycho-social support to PLHIV and integrating FP. In October 2008 – January 2010, reached 104,000 women living with HIV and couples. • Programme emphasises: <ul style="list-style-type: none"> • Inter-personal communication – in one-to-one or couple sessions and including tailor-made information materials, counselling and demonstrations of male and female condoms. • Awareness and demand creation for dual protection, including through radio and TV programmes and campaigns. • Marketing and distribution of contraceptives, including implants, injectables and emergency contraceptive pills. • To avoid loss of clients within referrals, pilot carried out in 5 ‘New Start’ centres to train nurse counsellors to provide hormonal contraceptive implants on-site. In collaboration with Ministry of Health, PSI built capacity of public health workers. In the first 7 months, 16,502 implants were provided and demand increased. • Key steps towards integration included training 250 ‘New Start’ and 100 ‘New Life’ counsellors in FP service delivery, counselling and referrals. 		
Lessons learned	<ul style="list-style-type: none"> • Inter-personal communication is vital for enabling individual PLHIV and couples to understand the benefits of dual protection and make informed decisions about the best contraceptive methods for them. • Hormonal implants provide an important option for women, including those living with HIV – as they both provide longer-term contraception and avoid recurrent costs for accessing services (such as transport). There is also, however, a need to be mindful of interactions between some hormonal contraceptives and ART. 		

52 Case Study: Zimbabwe, Integration of Family Planning and HIV Services in Zimbabwe: Hormonal Implants and Dual Protection Messages, PSI Zimbabwe.

Organisation: Groupe Haïtien d'Étude du Sarcome de Kaposi et des Infections Opportunistes (GHESKIO)⁵³			
Country	Haiti (two neighbourhoods of Cite de Dieu)	HIV epidemic	Generalised
Provider type	Civil society	Donor	
Programme type	HIV	Intervention type	Facility-based
Key population	PLHIV (including sero-discordant couples)		
HIV/SRHR integration	<ul style="list-style-type: none"> • Clinics providing HIV services (including HCT, ART, PMTCT and condom promotion/provision for HIV prevention) and integrating SRH (including services related to FP, STIs, MCH and gender-based violence). • Rationale for integration was that many PLHIV were denied SRHR care in other facilities and experienced unwanted pregnancies. • Started with a pilot integrating FP into HCT, then added components such as PMTCT. • Emphasis is placed on male and female condoms – which are provided free of charge. • 90% of clients initially visit for HCT and 16% are PLHIV. Now HCT provides an entry point to a full range of services for HIV and SRHR, as well as TB and malaria. • Counselling for PLHIV includes: information about reproductive rights and options (including for discordant couples); dual protection (using condoms alone or with other contraceptives); PMTCT; and prevention of HIV transmission to partners. Emphasis is placed on exploring feelings and enabling people to make their own decisions. • PMTCT includes provision of ART, education sessions and infant formula. ART is provided to women attending MCH (as well as to their partners and children if needed). PMTCT programme has experienced a significant increase in uptake. • Took a multi-skilled approach – with all medical staff trained to work in any of the clinics (so they can stand in for each other and have understanding of each other's work). Training and on-going education is provided, not only in HIV and SRHR, but issues such as stigma and discrimination, including using methods such as role plays. • Provision of support for survivors of sexual violence (including fast-track HCT). • Clinics were re-arranged to provide integrated services, including providing confidential counseling rooms. • Model has been scaled up and has influenced national practice – being adapted to 22 public and private health centres. • Results include that contraceptive prevalence increased from 6% to 24% in the catchment population. 		

53 Gateways to Integration: A Case Study from Haiti, WHO, UNFPA, UNAIDS and IPPF, 2008.

Lessons learned	<ul style="list-style-type: none"> • Partnerships – with government, donors and research institutions – are critical to integrated approaches. • Multi-skilled staff are essential to providing fully integrated and comprehensive support and services. • Stigma and discrimination – not just in relation to HIV, but issues such as sexual and gender-based violence – remain a significant barrier to integrated services. • Uptake of HCT increases if people can access other services at the same time. Pre and post-test counseling provide good opportunities to counsel people on SRH. • A Gheskio report stated that: <i>“Women, if they are HIV-positive, may be deterred by their status and fear of discrimination from seeking sexual and reproductive health services directly. If there is advocacy for, and automatic access to, family planning and other sexual and reproductive health services on the same site as VCT and other HIV prevention, treatment and care services, many of the practical and psychological barriers to access are removed.”</i>
------------------------	---

Organisation: Ministry of Health, Government of Kenya⁵⁴ (supported by FHI)			
Country	Kenya (Coast and Rift Valley Provinces)	HIV epidemic	Generalised
Type of provider	Government	Donor	USAID
Main programme type	HIV	Intervention location	Facility-based
Key population	PLHIV		
HIV/SRHR integration	<ul style="list-style-type: none"> • Comprehensive Care Centres providing HIV care, support and treatment and integrating FP (including condoms for dual protection). • Steps towards integration included: <ul style="list-style-type: none"> • Holding sensitization meetings with health officers and supervisors. • Training staff of Comprehensive Care Centres in FP. • Providing FP aids (e.g. an FHI tool on FP for PLHIV) to support women/couples. • Ministry of Health and FHI carrying out supportive supervision visits. • Each Comprehensive Care Centre developing its own plan for integration. • Results included a significant increase in the use of modern contraceptives by PLHIV. 		
Lessons learned	<ul style="list-style-type: none"> • Men are influential in their partners’ decisions about contraception. But opportunities to promote FP to male clients of HIV care, support and treatment are often missed. 		

54 Integrating Family Planning into HIV Care and Treatment Services in Kenya, Family Health International, 2010.

Organisation: Association pour le Bien-Etre Familial (ABEF)⁵⁵ (supported by IPPF)			
Country	Rwanda (Kigali and Butare)	HIV epidemic	Generalised
Provider type	Civil society	Donor	
Programme type	SRHR	Intervention type	Facility-based; community outreach
Key population	PLHIV		
HIV/SRHR integration	<ul style="list-style-type: none"> • SRHR clinics (providing FP, etc.) integrating HCT and HIV-related care and support. If clients test HIV positive, they are referred to government hospital for CD4 tests and ART, with ARBEF then providing follow-up for adherence and monitoring. • Work in partnership with PLHIV groups. PLHIV volunteers do community follow-up to support clinic staff (ART adherence, treatment of opportunistic infections, etc.). • Developed a holistic 'patient tracking system' – addressing the SRHR, HIV and other needs of PLHIV. • In partnership with community groups, PLHIV supported with income generating activities (e.g. related to nutrition and shelter), combined with home based care. • Started integration with a site assessment. As a result, steps included: <ul style="list-style-type: none"> • Improving clinic reception areas. • Adding counselling rooms. • Buying laboratory equipment. • Recruiting more medical and laboratory staff. • Results include significant increase in uptake of services by PLHIV and reduced number of hospital admissions. 		
Lessons learned	<ul style="list-style-type: none"> • Involving PLHIV and the wider community is critical to reducing stigma – a major barrier to integrated programmes. • As well as training, staff need hands-on opportunities to build skills in new areas. • Referrals systems need clear processes to ensure consistent feedback and efficient follow up between organisations. • Integrated programming has been beneficial to the creation and development of PLHIV support groups. 		

55 *Models of Care Project: Linking HIV/AIDS Treatment, Care and Support in Sexual and Reproductive Health Care Settings: Examples in Action*, International Planned Parenthood Federation, 2005.

Organisation: Asociación Dominicana Pro-Bienestar de la Familia (PROFAMILIA)⁵⁶ (supported by IPPF)			
Country	Dominican Republic (Santo Domingo and Santiago)	HIV epidemic	
Provider type	Civil society	Donor	GTZ
Programme type	SRHR	Intervention type	Facility-based; community outreach
Key population	PLHIV		
HIV/SRHR integration	<ul style="list-style-type: none"> • SRHR clinics (providing FP, etc.) integrating HIV services (focused on HCT, ART and care and support). • Developed a Model Care Team – providing clinical care, adherence to ART, emotional support, safer sex counselling, family/partner education, etc. • Started with a pilot project in one clinic (Santo Domingo), aiming to increase access to care and treatment for PLHIV. Then adapted model to a second clinic. • Integrated programme involves seven key elements: training of health care workers; laboratory tests; pre-test counselling; post-test counselling; support groups; multi-disciplinary support team; and monitoring ART adherence. • Clinics provide ART adherence support. Once clients are stable on ART, they have a monthly session with a nurse and 3-monthly session with a doctor. • PLHIV clients are treated like all other clients. As a PLHIV at Santiago clinic said: <i>“I feel like any other person in the waiting room. We sit in the same seats and share the same room as everyone else, and thus, I do not feel pinpointed. No one knows in the waiting room that I am HIV positive”</i>. • Results include impressive levels of adherence to ART (largely due to treatment counselling) and establishment of monthly PLHIV support groups (addressing issues such as self-esteem, nutrition, legal issues and gender-based violence). 		
Lessons learned	<ul style="list-style-type: none"> • It is important to promote HIV services as part of a ‘package’ of support and not become an ‘HIV centre’. HIV services require confidentiality, but not separate clinics. Treating PLHIV like everyone else both reduces their isolation and minimizes disruption to the organization. • Reducing stigma and discrimination has many benefits. For example, PROFAMILIA staff now bring their own relatives to access HIV services. • It is effective to choose a proven model, develop it and then scale-up. The model needs to be supported by the development of institutional protocols. • The ‘buy in’ of the executive of organisations is critical to integrated programming. • Integrated services must address gender dimensions, such as the implications of HCT for women (e.g. violent reactions from partners if they are found to be HIV positive). • While referral is a practical strategy, there are risks involved (such as PLHIV clients being stigmatized by other health providers). As such, before putting referrals into action, it is critical to mobilise key decision-makers in the wider health sector. 		

56 Models of Care Project: Linking HIV/AIDS Treatment, Care and Support in Sexual and Reproductive Health Care Settings: Examples in Action, International Planned Parenthood Federation, 2005.

Organisation MAMTA Health Institute for Mother and Child ⁵⁷			
Country	India (districts of Delhi)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	Abbott Fund USA
Main programme type	Child health	Intervention location	Facility-based; community outreach
Key population	PLHIV (including children)		
HIV/SRHR integration	<ul style="list-style-type: none"> • Health and development programme supporting children and adults (particularly women) living with and affected by HIV. Integrating HIV services (such as behavior change communication, information materials, condom promotion and safer sex promotion) and SRHR services (such as early diagnosis and treatment of STIs). Referrals to government hospitals for HCT and care, support and treatment. • Programme implemented by 6 NGOs: Child Survival India; Salaam Baalak Trust; Asha Deep Foundation; Bhartiya Association for Rural Development; ANCHAL Charitable Trust; and Sahara. Some focus on key populations (such as Sahara working with PUD). • Emphasis on: peer education; involvement of PLHIV; and empowering communities to address stigma and discrimination. • Capacity building provided to peer educators, health service providers and PLHIV – covering issues such as STIs, safer sex and home based care. • Programme started with Rapid Situation Analysis, followed by strategic planning among partners, including NGOs focused on children and key populations. This was followed by Participatory Community Assessments in 9 sites in 3 districts. • Service provision complemented by networking and linkages with other organisations. Also supported by advocacy on areas such as PMTCT. 		
Lessons learned	<ul style="list-style-type: none"> • Continuous community involvement, combined with capacity building of key stakeholders, is vital for integrated programmes. • (According to a programme evaluation), greater links are needed between HIV and MCH services to ensure support for women living with HIV who are pregnant. • Executive Director of MAMTA says: <i>“Child health is just not about ART and follow up. It is about breastfeeding, immunisation, nutrition and various other aspects. This comprehension of child health and development was a great learning for the organisation.”</i> 		

57 Community-Based Care and Support Programme: 2000-2010, MAMTA Health Institute for Mother and Child, 2011.

Organisation Family Health Options Kenya (FHOK) ⁵⁸ (supported by IPPF)			
Country	Kenya	HIV epidemic	Generalised
Provider type	Civil society	Donor	GTZ
Programme type	SRHR	Intervention type	Facility-based; community outreach
Key population	PLHIV and truckers (clients of SWs)		
HIV/SRHR integration	<ul style="list-style-type: none"> • SRHR clinics (providing FP, etc.) integrating HIV services (such as HCT, PMTCT, ART, care and support, HIV prevention and PLHIV support groups). Complemented by community volunteers providing home based care, counselling and HIV prevention. Referral of complicated cases to the provincial hospital. • Integration involved attention to four key components: <ul style="list-style-type: none"> • Building FPAK's capacity. • Delivering integrated services. • Creating demand for services and involving PLHIV. • Carrying out research and monitoring and evaluation. • Started the integration process through: carrying out a site preparedness assessment; and training a core team of staff. • HIV services added over time. For example, used existing HCT and PMTCT programmes as an entry point to then integrate ART. Adaptions were necessary to become an accredited ART site. These included: providing more integrated counselling and psycho-social support; doing more sophisticated client monitoring; establishing systems for buying/managing ARVs; and buying equipment (fridges and computers). • ART is not free, but is subsidized by the government. Treatment for STIs and opportunistic infections is integrated into regular medical care, with minimal fees. Laboratory fees were reduced, but could still present a barrier. • To support integration, developed a core service delivery team who were trained in intensive HIV clinical management and then designed/delivered training to other staff. As a member of clinic staff said: <i>"HIV affects almost every area of sexual and reproductive health work, so you can't avoid dealing with it."</i> • Community volunteers (including PLHIV) are central to the programme, providing psycho-social support, adherence to ART and discussing prevention strategies with PLHIV. They also: deliver ARVs, contraceptives, condoms and medicines for home-based care; and 'recruit' people for ART (referring them to the clinic). • Some SRHR initiatives have specifically targeted men living with HIV. 		
Lessons learned	<ul style="list-style-type: none"> • Key staff need to be open to adapting both their services and working practices. • Within an integrated approach, the provision of treatment services must go beyond ART to also include psycho-social support, FP, etc. • Providing HIV-related services brings benefits to SRHR services (particularly in a generalised epidemic) by reaching new service users. • Putting the GIPA (greater involvement of people living with HIV) principles into practice, from having PLHIV as volunteers to on the Management and Advisory Boards of FHOK, adds credibility to an SRHR organization among PLHIV and HIV NGOs. • It is necessary to take specific steps to engage and address the SRHR needs of men, including those living with HIV. • The 'package' involved in providing ART is costly (with laboratory tests, drugs, etc.) and requires SRHR organisations to have sustainable resources. 		

58 Models of Care Project: Linking HIV/AIDS Treatment, Care and Support in Sexual and Reproductive Health Care Settings: Examples in Action, International Planned Parenthood Federation, 2005.

Organisation: Promoteurs d'Objectif Zerosida (POZ)⁵⁹ (supported by International HIV/AIDS Alliance)

Country	Haiti	HIV epidemic	Generalised
Type of provider	Civil Society	Donor	
Main programme type	HIV	Intervention location	Facility-based
Key population	PLHIV		
HIV/SRHR integration	<ul style="list-style-type: none"> • Centre Espoir (HIV organization providing services such as HCT, PLHIV support groups, nutritional support) integrating components of SRHR (e.g. support related to sexual violence and STI treatment). Also providing economic support and referrals for services not provided. • Programme addresses the HIV/SRHR needs of PLHIV, their families and friends. • Note: Project has continued since earthquake in Haiti and adapted to changes, such as the increased number of young women, including those living with HIV, turning to sex work. 		
Lessons learned	<ul style="list-style-type: none"> • Support groups (facilitated by PLHIV) are an important for integrated programming – providing an opportunity to build self-esteem and address stigma and discrimination. 		

Organisation: HIV Counselling and Testing Centres⁶⁰ (supported by FHI)

Country	Kenya	HIV epidemic	Generalised
Provider type		Donor	
Programme type	HIV	Intervention type	Facility-based
Key population			
HIV/SRHR integration	<ul style="list-style-type: none"> • HCT Centres integrating FP. Each Centre offers one of four levels of integration: <ul style="list-style-type: none"> • Risk assessment of pregnancy, STIs and HIV; counselling and information on FP, STIs and HIV; and provision of pills and condoms. • As in '1', plus injectable contraceptives. • As in '2', plus intrauterine contraceptive devices. • Provision of full range of FP methods. • Training given to service providers on integration. 		
Lessons learned	<ul style="list-style-type: none"> • There is a need to monitor the performance of staff in delivering integrated programming. For example research found that providers predominantly spoke to clients about condoms preventing HIV, less so STIs and even less so pregnancy. • Record keeping and commodity supply are critical for effective scale-up of integrated programmes. 		

59 *Good Practice Guide: Integration of HIV and Sexual and Reproductive Health and Rights*, International HIV/AIDS Alliance, 2010; and website of International HIV/AIDS Alliance (accessed 13.4.11); <http://www.aidsalliance.org/linkingorganisationdetails.aspx?id=31>

60 *Integrating Family Planning Services into Voluntary Counseling and Testing Centers in Kenya: Operations Research Results*, Family Health International, 2006.

Organisation: International HIV/AIDS Alliance in Uganda (supported by International HIV/AIDS Alliance)⁶¹

Country	Uganda	HIV epidemic	Generalised
Type of provider	Civil society	Donor	
Main type of programme	HIV	Intervention location	Community-based
Key population	PLHIV		
HIV/SRHR integration	<ul style="list-style-type: none"> • Community-based HIV outreach integrating SRHR through referral. Project aimed to expand role of PLHIV networks to improve access to/use of services. • Steps towards integration combined: training of PLHIV to offer community-based palliative care, ART adherence counselling, HIV prevention and material support for OVC; and training of some PLHIV to be Network Support Agents to mobilize PLHIV to use existing services and refer them to services such as FP, PMTCT and STI diagnosis and treatment. • Results included increased access to health services, referrals to health facilities and involvement of PLHIV in service delivery. 		
Lessons learned	<ul style="list-style-type: none"> • To support integration, it is important to maintain partnership with district health mechanisms (e.g. by attending district health team meetings and sharing reports). • Integrated approaches benefit from starting in some districts and then scaling up to a larger number. 		

Organisation: HIV Counselling and Treatment Centres (supported by Pathfinder International)

Country	Ethiopia (4 focus regions)	HIV epidemic	Generalised
Type of provider	Civil society and government	Donor	
Main type of programme	HIV	Intervention location	Facility-based
Key population	PLHIV		
HIV/SRHR integration	<ul style="list-style-type: none"> • Eight HCT centres integrating FP services. • Start-up for integration included: <ul style="list-style-type: none"> • Sensitization of all administrative and health service staff. • Then, HCT counsellors trained on FP and the provision of condoms and contraceptives. Nurse counsellors also trained in injectable contraceptives. • Developed protocols for specific HCT clients, including those testing HIV positive, and modified counsellors' logbooks to include information relating to FP. • Results included dramatic increase in the discussion of SRHR issues (such as contraception, fertility options and condoms) in HCT sessions. 		
Lessons learned	<ul style="list-style-type: none"> • It is important to train all staff in what integration is and why it matters, not just those that provide clinical services. 		

⁶¹ *Integration of HIV and Sexual and Reproductive Health and Rights: Good Practice Guide*, International HIV/AIDS Alliance, December 2010; and *Good Practice Update: Linkages and Integration of Sexual and Reproductive Health, Rights and HIV: The Alliance Approach*, International HIV/AIDS Alliance, March 2009.

Organisation: Reproductive Health Association of Cambodia (RHAC)⁶² (supported by IPPF)			
Country	Cambodia (Kurn Potproh)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	
Main type of programme	SRHR	Intervention location	Facility-based; community outreach
Key population	PLHIV (including sero-discordant couples)		
HIV/SRHR integration	<ul style="list-style-type: none"> • SRHR clinics integrating HIV services (e.g. ART, treatment for opportunistic infections, condoms for dual protection). Referral to other providers for services not available (e.g. referral to hospital for complicated opportunistic infections). Complemented by community programme, with volunteers referring clients to clinics and providing home care kits (with basic medicines and condoms) and food supplements. • Provision of loans for income generating activities. • Programme provides tailor-made support for sero-discordant couples. As a client living with HIV said: <i>“I am HIV-positive, but my wife isn’t. I always use condom when I have sex with her. My wife and I were taught how to use a condom properly. The home-based care team offer condoms and we can also get them from the health centre where monthly meetings are held. There are two reasons why I always use a condom: to prevent pregnancy and to prevent the transmission of HIV to my wife.”</i> 		
Lessons learned	<ul style="list-style-type: none"> • It is vital to back-up clinical services with community outreach to ensure on-going support for HIV/SRHR. 		

62 In a Life: Linking HIV Treatment, Care and Support in Sexual and Reproductive Health Care Settings, IPPF, 2006; In a Life: Linking HIV and Sexual and Reproductive Health in People’s Lives, IPPF, 2008; and In a Life: Linking HIV and Sexual and Reproductive Health in People’s Lives, IPPF, July 2010.

4. HIV/SRHR integration for sex workers

4.1. What does HIV/SRHR integration for sex workers involve?

The review indicated that – building on a generic essential package for HIV/SRHR – there are a number of components that may need specific attention within integrated programming for sex workers. These vary according to issues such as whether sex workers are male, female or transgender. They can include information, support and services related to⁶³:

- ‘Tailor made’ HIV prevention and behaviour change communication.
- Male and female condoms and lubricant (e.g. negotiation skills, regular supplies for dual protection).
- Safer sex negotiation skills, counselling and risk-reduction (including for anal sex).
- Full range of FP support and contraceptive options (to, for example, prevent pregnancy from clients and plan a family with a partner).
- Sexual violence (e.g. prevention strategies, counselling).
- Emergency PEP for rape or sexual assault.
- Full range of STIs, including attention to anal infections and re-occurring infections.
- Pregnancy and birth, including supportive and non-judgemental ANC, PMTCT, delivery, PNC and MNCH.
- Empowerment on sexual and health rights.
- Negotiation skills to deal with stigma and criminalised status (e.g. sexual harassment by police).
- (Where legal) safe and confidential abortion and (in all contexts) post-abortion care.

63 Referenced from case studies and literature review, in particular: *Advancing the Sexual and Reproductive Health and Human Rights of Sex Workers Living with HIV*: Policy Briefing, GNP+ and NSWP, May 2010; *Convergence of HIV and SRH Services in India: Impacts on and Implications for Key Populations: A Literature Review*, HIV-SRH Convergence Project (India), PATH, January 2007; *Exploring Integrated SRH and HIV Models and Programming Examples from a Variety of Settings in Countries/Areas with Concentrated HIV Epidemics*, Amitrajit Saha, Anna Zakowicz, Dawn Averitt Bridge, Jill Gay, Robert Carr, (Presentation at International AIDS Conference), July 2010; *Sex Work, Violence and HIV*, International HIV/AIDS Alliance, 2008; and *Integrating HIV Prevention and Family Planning Services: The Aastha Project in Mumbai, India*, Family Health International, 2010.

4.2. What are some common strategies for HIV/SRHR integration for sex workers?

The review indicated that, as yet, there appears to be little clear consensus on the most effective HIV/SRHR integration strategies specifically for sex workers. However, as seen in the literature and demonstrated in the case studies below, examples include:

Figure 12: Examples of strategies for HIV/SRHR integration for sex workers

HIV programme	Integration	SRHR programme	Examples in case studies
HCT (and broader HIV)	←	FP (and broader SRHR, especially STIs and condoms)	<ul style="list-style-type: none"> • Aastha Project, India • KANCO, Kenya
HIV prevention	←	Female condoms for dual protection	<ul style="list-style-type: none"> • EC-CAP, Caribbean
HCT or other specific, key services for SWs	→	Broad SRHR (especially STIs and condoms)	<ul style="list-style-type: none"> • FPAM, Malawi • CEMOPLAF, Ecuador
HIV prevention (plus wider HIV)	↔	STI prevention (plus wider SRHR)	<ul style="list-style-type: none"> • Avahan programme, India
Comprehensive or selected HIV components (especially HCT)	↔	Comprehensive or selected SRHR components (especially STIs and condoms)	<ul style="list-style-type: none"> • PATH India, India • CSI, India • YPSA, Bangladesh • ISH, Serbia • Community Support Concern/HMAP, Pakistan • TOP, Myanmar

4.3. What lessons have been learned about good practice HIV/SRHR integration for sex workers?

The generic lessons learned for HIV/SRHR integrated programming for key populations [see section 2.5] apply to sex workers. In addition, some specific lessons include that it is important to:

- **Identify, understand and respond to the different SRHR/HIV needs of different types of sex workers.** For example, a study among sex workers in Gutakal, Andhra Pradesh found that 35% were street-based, 27% home-based, 26% based in secret, 7% in lodges and 6% in brothels – affecting both their needs and access to services⁶⁴. Also, sex workers experience different levels of vulnerability and needs according to whether they are female, male or transgender⁶⁵, as well as other factors such as their age and income level.

⁶⁴ Sexual and Reproductive Health Needs of FSWs, MSMs and TGs: Research Report on Quantitative Findings from Warangal, Guntakal and Piler Sites of Alliance in Andhra Pradesh, SWASTI Health Resource Centre, December 2008.

⁶⁵ *Good Practice Guide: Integration of HIV and Sexual and Reproductive Health and Rights*, International HIV/AIDS Alliance, 2010.

- **Provide comprehensive integrated services that address the holistic needs of sex workers**, rather than treating them as ‘transmitters’ of infection to clients. For example, a PATH study in four states in India found that sex workers wanted a full range of SRHR services, including FP, abortion, ANC and delivery⁶⁶. Meanwhile, a study in Cambodia found that under 5% of sex workers used a modern contraceptive method (other than condoms) with their partner⁶⁷.
- **Pay specific attention to the SRHR needs of sex workers who are living with HIV**, including providing access to a non-discriminatory contraception, PMTCT, MNCH services and abortion [see Figure 13].
- **Address the cross-cutting issue of violence**. For example, Alliance partners in different countries have found that violence against sex work is common and affects their vulnerability, yet is rarely taken into account in the development of programmes⁶⁸. In response to such challenges, the Avahan Programme, India, combined advocacy to the police with capacity building of sex workers to protect themselves/hold perpetrators to account⁶⁹.
- **Advocate on the benefits of integration to gatekeepers within sex workers’ communities**. For example, Community Support Concern and HMAP in Pakistan found that it was critical to engage pimps in the development of integrated programming⁷⁰.
- **Not make assumptions about sexual ‘norms’ and needs of sex workers**. For example, within integrated programmes, sex workers may need diagnosis and treatment services for anal STIs or support during pregnancy.
- **Address the wider socio-political context for sex workers**. For example, in Nepal, the Family Planning Association partnered with the Durbar Mahila Samanwaya Committee (a sex workers’ cooperative in Sonagachi district, Kolkata, India) to design integrated SRHR/HIV services for young girls and women being trafficked for sex work⁷¹. Meanwhile, a study in Guntakal, Andhra Pradesh, found that some sex workers were forced to have abortions by their caretakers/family members, with the procedure sometimes taking place in their own homes⁷².

Figure 13: SRHR needs of sex workers living with HIV

“Sex workers living with HIV who become pregnant need to be given a full range of options and not coerced to have terminations. Many sex workers report that it is assumed that any pregnancy they have must be unwanted. Pressure on HIV-positive sex workers to have terminations is reported in most countries. Due to this focus, most HIV-positive pregnant women do not get the full range of options explained to them and, if they decide to continue with the pregnancy, often receive sub-optimal care.”

Advancing the Sexual and Reproductive Health and Human Rights of Sex Workers Living with HIV: Policy Briefing, GNP+ and NSWP

66 *Options and Challenges for Converging HIV and Sexual and Reproductive Health Services in India: Findings from an Assessment in Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh*, PATH, June 2007.

67 *Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A Guidance Package*, GNP+, ICW, Young Positives, EngenderHealth, IPPF and UNAIDS, 2009.

68 *Sex Work, Violence and HIV*, International HIV/AIDS Alliance, 2008.

69 *Violence and Sex Work: Learning from the Results of Monitoring and Evaluating Community-Led Violence Responses among Female Sex Workers in India: Think Piece*, India HIV/AIDS Alliance.

70 *Who Are We Failing? How Marginalisation and Vulnerability Affect Adolescents’ Needs for and Access to SRHR*, Interact Worldwide, 2011.

71 *In a Life: Linking HIV Treatment, Care and Support in Sexual and Reproductive Health Care Settings*, IPPF, 2006.

72 *Sexual and Reproductive Health Needs of FSWs, MSMs and TGs: Research Report on Quantitative Findings from Warangal, Guntakal and Piler Sites of Alliance in Andhra Pradesh*, SWASTI Health Resource Centre, December 2008.

4.4. Case studies of HIV/SRHR integration for sex workers

Organisation: Avahan, India⁷³			
Country	India (Rayaleema and Telengana Districts, Andhra Pradesh)	HIV epidemic	Concentrated
Type of provider	Civil society; government	Donor	Bill & Melinda Gates Foundation, then Government of India
Main programme type	HIV/STI prevention	Intervention location	Facility-based; community outreach
Key population	SWs (and their clients), MSM, transgender people, PLHIV, people who use drugs		
HIV/SRHR integration	<ul style="list-style-type: none"> • HIV/STI prevention programme with Mythri clinics combining HIV/STI components (such as behaviour change communication, male/female condom promotion/ provision and STI prevention/screening/testing) and wider SRHR components (such as pregnancy testing/care/safe delivery, FP, menstrual hygiene, cervical cancer screening, safe abortion and MCH). Own laboratories at 16 sites with facilities such as syphilis screening and urine pregnancy testing. Referrals for HCT, ART, PMTCT and other support (such as PLHIV networks). • Programme started in 2004. Originally aimed to reduce STIs, including HIV, through behaviour change communication, promoting safer sex and providing treatment. Expanded, including in response to unmet SRHR needs of clients, such as sex workers. • Phase 2 (2009-13) involves transition to government and community and specifically focuses on STI treatment, with referrals to other services. • Facility services complemented by outreach work, including at 'hotspots'. Outreach was by SWs and other key population peers. In Phase 2, is by outreach workers from outside of community (focusing on monitoring role, in accordance with NACO guidelines). Support will involve one-to-one services, HCT (by referral) and STI testing/treatment on site. • Key integration strategies have included: <ul style="list-style-type: none"> • Training outreach workers, medical officers and counsellors, covering issues such as ANC, PNC, FP, PAP smears and menstrual hygiene. • Building a community-driven approach [see above], combining one-to-one support, group sessions and mobilisation to access the Mythri clinics. • At the Mythri clinics, providing a range of appropriate services for SWs and other key populations. STI services include management, presumptive treatment, monthly check-ups, counselling and partner management. • Having an emphasis on dual protection and women-centric FP methods. • Results include increases in: uptake of dual protection against STIs and unwanted pregnancy; acceptability of STI services and, in turn, uptake by SWs; capacity of outreach staff to communicate on SRHR; sensitivity to key population issues among doctors (as a result of training); and access to SRHR services for SWs living with HIV. 		

⁷³ *Integration of HIV and Sexual and Reproductive Health and Rights: Good Practice Guide*, International HIV/AIDS Alliance, December 2010; and *Mapping Questionnaire – Scaling up SRHR/HIV Integration: Avahan Programme*, India HIV/AIDS Alliance; *Integration of SRH Communication and Family Planning with STI/HIV Services among Female Sex Workers*, (poster presentation), India HIV/AIDS Alliance, Avahan Initiative and Mythri; and *Focused STI Prevention and Treatment Services for Key Population*, (poster presentation), India HIV/AIDS Alliance, Avahan Initiative and Mythri.

Lessons learned

- It may be better to mainstream services into government initiatives from the start of a programme, rather than set up specific service points and raise expectations among community members.
- It is important to conduct a baseline situation analysis to support on-going assessment of an integrated programme.
- Community ownership is critical to ensuring programmes are good quality and 'key population friendly'. The programme originally had quarterly service review committees involving representatives from each clinic site and raising issues (including identified through regular exit interviews with clients) with the project coordinator.
- Promoting services as 'women's health' (and using issues such as menstrual hygiene as an entry point) provides a means to discuss the sensitive subject of STIs.
- Referral systems need to include follow-up. Simple systems can help (such as slips that are taken to the referral point and then collected to assess success), but can be difficult to enforce.
- Challenges include limited access to some government services for some populations, such as for women living with HIV needing support for delivery or abortion.

Organisation: Child Survival India (CSI)⁷⁴ (supported by India HIV/AIDS Alliance)			
Country	India (Holumi Kalan Phase 1, North West Delhi)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	Hewlett Foundation
Main type of programme	SRHR and HIV	Intervention location	
Key population	SWs and PLHIV		
HIV/SRHR integration	<ul style="list-style-type: none"> • Integrated programme among relocated slum community, using a comprehensive understanding of SRHR, including MCH, STIs, menstrual hygiene, gender dynamics and violations of rights. Aim to provide a 'one stop shop' or formal, timely referrals (with referral mechanism to providers such as ANC clinics and government dispensary). • Group sessions organized at government ANC clinics – increasing the number of referrals to PMTCT and HCT services. • Programme aimed to address social and health issues, such as: women's access to services being controlled by their families; and commodities being unaffordable. • Steps for integrated programming included: <ul style="list-style-type: none"> • Support groups and counselling (including for SWs and PLHIV) – leading to increased awareness about SRHR, power dynamics, etc. • Community sensitization and mobilization. • Engagement with men (e.g. to discuss FP decisions). • Sensitisation of community gatekeepers and mahila panchaya (community-based informal legal redress system for women). • Sessions with family members and sexual partners of PLHIV. • Strengthened community systems by training peer educators and fostering economic enterprise, such as the production of low cost sanitary pads (to provide a source of income) and community-based outlets for commodities. • Results included: increased uptake of PMTCT, condom use and sense of support (among PLHIV) and better coordination of services and access to commodities. 		
Lessons learned	<ul style="list-style-type: none"> • Health system benefits need to be brought closer to the community (e.g. through suraksha haats – community-based outlets for condoms, contraceptives, etc. supported by local shop owners who are trained in the use of the commodities). • It is important to invest in existing systems, rather than develop parallel structures, and actively engage the community in project design, as peer educators, etc. 		

74 Linking SRHR and HIV – A Community-Centred Approach to Achieving Universal Access, (draft), India HIV/AIDS Alliance.

Organisation: Kenya AIDS NGO Consortium (KANCO)⁷⁵ (supported by International HIV/AIDS Alliance)			
Country	Kenya	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	
Main programme type	HIV	Intervention location	Facility-based; community outreach
Key population	SWs and their clients		
HIV/SRHR integration	<ul style="list-style-type: none"> • HIV centre (providing services such as HIV information and education, HCT, behaviour change communication and opportunistic infection management) and integrating SRHR (such as FP, condom education and provision, STI screening and management, PAP smears for cervical cancer, screening for breast cancer). Also build understanding and skills related to sexuality/ safer sex and offer support for income generation. Referral for ART and TB services • Centre aims to reduce levels of unprotected sex, reduce risk of HIV infection and increase SWs' access to services. • Staff received appropriate training. • SWs trained as peer educators who reach out to SWs where they work and socialize. • SWs refer their clients to STI and HIV services. • Opening hours of centre are flexible – to respond to SWs' needs. • Results include: up to 300 SWs accessing services per day; establishment of support group for SWs living with HIV; increased uptake of HCT and health services among SWs; and reports of behaviour change among SWs and their clients. 		
Lessons learned	<ul style="list-style-type: none"> • Service delivery for integrated programming needs to be flexible (as SWs are very mobile and have unpredictable working hours). • Integrated programmes must have non-judgmental staff and include medical, psychological and behavioural components. 		

⁷⁵ Good Practice Guide: Integration of HIV and Sexual and Reproductive Health and Rights, International HIV/AIDS Alliance, 2010.

Organisation: Eastern Caribbean Community Action Project (ECCAP)⁷⁶ (supported by International HIV/AIDS Alliance)			
Country	Caribbean (Antigua and Barbuda, St Kitts and Nevis)	HIV epidemic	
Type of provider	Civil society	Donor	
Main programme type	HIV	Intervention location	Community outreach
Key population	SWs		
HIV/SRHR integration	<ul style="list-style-type: none"> • HIV programme integrating SRHR through focus on female condoms for dual protection. Community animators (including SWs) reach SWs with integrated information and condoms in venues where they work and socialize. Referrals for HCT and other services. • As many SWs are migrants, SRHR/HIV materials and outreach work carried out in home languages. Also programme collaborates with NGO from home island. • Programme uses innovative communication tools, including comic addressing situations such as negotiating condom use with a drunk male client. 		
Lessons learned	<ul style="list-style-type: none"> • When providing referrals, it is important that SWs feel secure about accessing services. For example, community animators accompany SWs to facilities. 		

⁷⁶ Caribbean: Country Study, Alliance Country Studies: A Global Summary of Achievements, Progress and Challenges under IMPACT 2010, International HIV/AIDS Alliance.

Organisation: PATH India⁷⁷			
Country	India (Srikakulan, Andhra Pradesh and Patna and Muzaffarpur, Bihar)	HIV epidemic	Concentrated
Type of provider	Government and private sector	Donor	DfID; Hewlett and Packard Foundations
Main type of programme	HIV and SRHR	Intervention location	Facility-based; community outreach
Key population	SWs and PLHIV		
HIV/SRHR integration	<ul style="list-style-type: none"> • SRH facilities (run by government in Andhra Pradesh and government/private sector in Bihar) integrating HIV-related support. • Research before project showed SWs and PLHIV needed more SRHR services, especially FP and abortion. The main barrier to services was stigma by providers. • Government, private sector and civil society (including SW and PLHIV groups) were involved from the design stage of the project. • PATH pilot project focused on: <ul style="list-style-type: none"> • Creating demand (by raising awareness and creating interest in SRHR services among SWs and PLHIV, including through outreach workers). • Ensuring supply (by building the capacity of SRHR service providers to respond to the needs of SWs and PLHIV). • Worked with groups of key populations and PLHIV to train SWs and PLHIV in problem solving interpersonal communication (IPC), with a focus on SRHR. Also developed a mechanism for referral for services not provided. • In Andhra Pradesh, used face-to-face interaction sessions between service providers and SWs and PLHIV to discuss issues about their health care and access to service. These were facilitated by PLHIV networks and NGOs and reduced prejudices. • PATH provided training to government and private sector service providers (including doctors, nurses, counsellors and laboratory staff). • Results included decreased stigma and increased access to SRHR services (including abortion) by SWs and women PLHIV. A SW in Muzaffarpur said: <i>“The women who have never visited a hospital before have started going now.”</i> • Service provision complemented by national advocacy and stakeholder meetings. 		
Lessons learned	<ul style="list-style-type: none"> • In Bihar, assessment of IPC showed that: uptake of services by SWs and PLHIV increased; HIV was becoming ‘normalised’ and PLHIV were more aware of discrimination; and programme’s communication methods were good for increasing information about services. • SWs particularly welcome sessions where they can discuss SRHR and HIV as a group and benefit from increased knowledge about using condoms for dual protection. 		

⁷⁷ PATH, India: HIV-SRH Convergence, Policy and Practice Update 4, HIV-SRH Convergence Project, PATH, December 2009; and *Exploring Integrated SRH and HIV Models and Programming Examples from a Variety of Settings in Countries/Areas with Concentrated HIV Epidemics*, Amitrajit Saha, Anna Zakowicz, Dawn Averitt Bridge, Jill Gay, Robert Carr, (Presentation at International AIDS Conference), July 2010.

Organisation: Family Planning Association of Malawi (FPAM)⁷⁸ (supported by IPPF)			
Country	Malawi	HIV epidemic	Generalised
Type of provider	Civil society	Donor	
Main programme type	SRHR	Intervention location	Facility-based; community outreach
Key population	SWs		
HIV/SRHR integration	<ul style="list-style-type: none"> • SRHR clinics (e.g. providing pregnancy testing, STI treatment and free condoms for SWs) integrating HIV services (e.g. HCT). Also provide income generation training for SWs (e.g. in catering and hairdressing). • Community-based peer educators refer SWs to the clinic's services. 		
Lessons learned	<ul style="list-style-type: none"> • Within integration strategies for sex workers, it is important to promote empowerment, for example – alongside SRH/HIV services – providing opportunities for women to learn skills for sustainable livelihoods to address income insecurity • It is vital that integrated services for sex workers are provided in a non-judgemental way, for example by peer educators who are themselves current or former sex workers. • Initiatives for sex workers work well if they combine the provision of a range of services (pregnancy testing, STI information, VCT, free condoms, etc) with providing sex workers with the information and confidence to look after their own sexual health. 		

78 *In a Life: Linking HIV and Sexual and Reproductive Health in People's Lives*, IPPF, July 2010.

Organisation: Community Support Concern and HMAP⁷⁹ (supported by Interact Worldwide)			
Country	Pakistan (Punjab)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	
Main type of programme	SRHR and HIV	Intervention location	Facility-based; community outreach
Key population	(Adolescent) SWs, MSM and transgender people		
HIV/SRHR integration	<ul style="list-style-type: none"> • Programme providing integrated HIV/SRHR support to highly marginalised adolescents through Drop-In Centre and community outreach. • SWs are highly vulnerable – some starting at 12 years, many having experienced sexual abuse and often exploited by law enforcement officials. They have high levels of STIs, such as gonorrhoea, but experience stigma at mainstream SRHR services – not able to access clinics alongside other service users. • Approach builds up incrementally, starting by addressing issues of general health (e.g. personal hygiene, contraception) before moving on to more specific issues (e.g. HIV, abortion) and rights. 		
Lessons learned	<ul style="list-style-type: none"> • It is critical to acknowledge and work through local gatekeepers, such as pimps, to address HIV/SRHR issues among marginalised key populations such as SWs. 		

79 Who Are We Failing? How Marginalisation and Vulnerability Affect Adolescents' Needs for and Access to SRHR, Interact Worldwide, 2011.

Organisation: Institute for Students' Health (ISH)⁸⁰			
Country	Serbia (Belgrade)	HIV epidemic	Concentrated
Provider type	Civil society	Donor	
Programme type	HIV and SRHR	Intervention type	Facility-based; community outreach; mobile
Key population	SWs, MSM and PUD		
HIV/SRHR integration	<ul style="list-style-type: none"> • Centre originally focused on students and then expanded to key populations. Provides integrated services related to SRHR (including STI treatment, FP and SRH counselling) and HIV (including HCT and Hepatitis B and C care). Centre is complemented by 'Power of Prevention' outreach project with SWs addressing SRHR and HIV, including distribution of condoms, counselling and mobilisation to seek services. Also mobile van provides outreach at SW hotspots. • Steps involved in integration included: <ul style="list-style-type: none"> • Upgrading the skills of staff. • Securing funding for integrating programming. • Expanding the provision of services. • Providing mentoring and support to PLHIV, their partners, family and friends. • Reaching key populations, including SWs, through collaboration with NGOs. • Building partnerships with other organisations. 		
Lessons learned	<ul style="list-style-type: none"> • It is important to have a flexible approach to service provision for key populations, for example providing HCT clinics in the evening. • Staff training is critical to responding to prejudices about key populations. • It is important to respond to a challenging environment (e.g. by training the police who often harass SWs due to their illegal status). 		

80 *Gateways to Integration: A Case Study from Serbia*, WHO, UNFPA, UNAIDS and IPPF, 2009.

Organisation: Young Power in Social Action (YPSA)⁸¹			
Country	Bangladesh (Chittagong)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	
Main programme type	SRHR and HIV	Intervention location	Facility-based; community outreach
Key population	SW and PUD		
HIV/SRHR integration	<ul style="list-style-type: none"> • Integrated Health Centre (IHC) providing integrated services for SRHR (e.g. condom promotion, STI diagnosis, treatment and counselling) and HIV (e.g. 'one stop shop' HCT, needle and syringe exchange, information materials). Centre complemented by peer education and outreach. Referral system for services not available. • Condom promotion focuses on dual protection and targets SWs and their clients. Condoms and lubricants are provided at night spots through outreach work. • Street-based SWs are trained as peer educators. • Needles and syringes are provided to PUD at the IHC and through outreach. • Services are supported by advocacy to religious leaders, landlords and authorities. 		
Lessons learned	<ul style="list-style-type: none"> • Challenges to integrated programmes include: illegal status of services; lack of capacity; stigma and discrimination; and poor national policies on integration; and fragmented donor policies on integration. • Integration provides an opportunity to meet the multiple needs of SWs. • Condom promotion provides a natural entry point to explore issues of dual protection and contraception with SWs. • Incentives (such as day care for children provided to women accessing HCT and STI diagnosis and treatment) can help to create demand for services. • Community involvement is key to ownership and sustainability of integrated efforts. 		

81 *Linking Reproductive Health to HIV & AIDS Prevention Projects: Case of Integrated Health Centers (IHCs) in Chittagong, Bangladesh*, Young Power in Social Action, 2008.

Organisation: Frontiers Prevention Programme, CEMOPLAF⁸² (supported by Kimirina – Linking Organisation of International HIV/AIDS Alliance)			
Country	Ecuador	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	
Main programme type	SRHR	Intervention location	Facility-based
Key population	Key populations, including SWs		
HIV/SRHR integration	<ul style="list-style-type: none"> • Large SRHR organisation (with 5 clinics in the Programme site) offering comprehensive SRHR services and integrating HIV components of particular relevance to SWs. • Strategies include social marketing of condoms and providing discounted/subsidised services to key populations. • Key populations are involved in the clinics and services, including as advisors and staff. • Service provision complemented by support to local groups of key populations and their involvement in advocacy. Also CEMOPLAF itself became an HIV advocate and policy-maker at the national level. This included supporting a national maternity programme for SWs – ensuring their access to free STI and SRHR services. • Challenges include how to reach SWs who are 'hidden'. • Results include SWs gaining better access to services – due to CEMOPLAF having a network of clinics. 		
Lessons learned	<ul style="list-style-type: none"> • Integrated efforts can affect the profile of an SRHR organisation. CEMOPLAF experienced a changed image (for example, having SWs in the waiting rooms) and tensions between working with key populations and 'the rest of the population'. • M&E is critical to ensure constant feedback on the quality of integrated services. 		

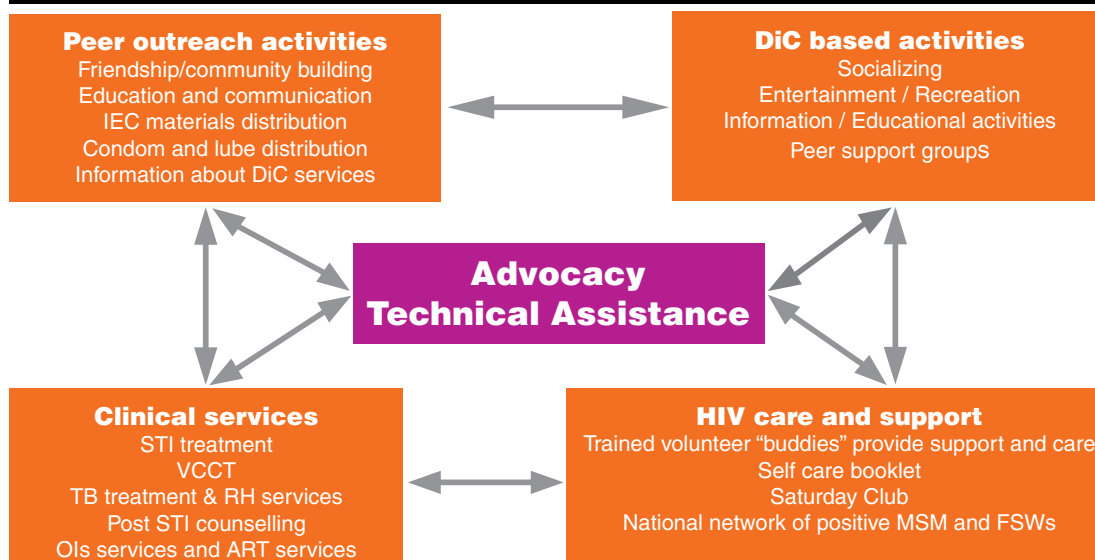
⁸² *Integration of HIV and Sexual and Reproductive Health & Rights (SRHR): Report on Existing Alliance Programmes and Policy Work and Potential Strategic Partnerships*, International HIV/AIDS Alliance; and *Working Together SRH & HIV/AIDS NGOs and CBOS in Ecuador: The Experience of Frontiers Prevention Programme*, Javier Hourcade Bellocq, LAC Team, (powerpoint presentation), International HIV/AIDS Alliance.

Organisation: Aastha ('To Care About') Project⁸³ (supported by FHI)			
Country	India	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	Bill and Melinda Gates Foundation
Main programme type	HIV	Intervention location	Facility-based; community outreach
Key population	SWs (female, MSM and transgender)		
HIV/SRHR integration	<ul style="list-style-type: none"> • Clinic and outreach work providing HIV and STI services and integrating FP for SWs in brothels, on the street, in bars and at home. Services include: FP information and counselling (including of male partners); oral contraceptives; condoms for dual protection and risk reduction; information on sexuality (especially for young clients); client assessment (covering fertility desires, risk of unintended pregnancy, etc.); strategic behaviour communication (for informed decision-making about contraceptive choices); and counselling on negotiation skills (e.g. to persuade male partners to use condoms). Referrals for other contraceptive methods. • In 4 years, services provided to 67,500 SWs in 16 clinics, 36 satellite clinics and 380 monthly health camps. • Integration started with providing HCT (through referral) and ART and then added FP. • First steps for integration were: <ul style="list-style-type: none"> • Assessment involving SWs, brothel owners and bar managers. • Review of systems and resources (such as clinic infrastructure, staff and management information system). • Steps for integrated programming included: <ul style="list-style-type: none"> • Revising counselling and training modules to include FP. • Training health care providers to offer FP during HIV counselling and STI management sessions. • Upgrading and expanding services availability at clinics to include tests for pregnancy or gynaecological problems. • Establishing a strong referral network of local providers of FP services. • Conducting community outreach activities. • Peer educators raise awareness about STIs and HIV, provide counselling on FP and advocate for community members to use the services. • Health care providers and peer educators trained in integrating FP into HIV services. • Project also supported development of first SW federation in India. • Results included reaching a much larger proportion of SWs and significantly increasing uptake of services. As a female SW said: <i>"The concerns of a sex worker go beyond HIV. We need a lot of advice on family planning, pregnancy and other basic needs of a woman. At Aastha, we get all the answers to our problems, and we would wish that none of the Aastha clinic services should ever be withdrawn."</i> 		
Lessons learned	<ul style="list-style-type: none"> • Within integrated programmes, referrals can be an important mechanism to give SWs access to a wider range of contraceptive options. • However, referrals also require support, for example with Aastha peer educators accompanying clients to other facilities. 		

83. Integrating HIV Prevention and Family Planning Services: The Aastha Project in Mumbai, India, Family Health International, 2010.

Organisation: TOP⁸⁴ (supported by UNFPA)			
Country	Myanmar	HIV epidemic	Concentrated
Type of provider		Donor	
Main programme type	SRHR and HIV	Intervention location	Facility-based; community outreach; drop-in centres
Key population	SWs (female, male and transgender)		
HIV/SRHR integration	<ul style="list-style-type: none"> • Community-led intervention, combining HIV services (such as VCT, ART and community care and support) with expanded SRHR services (including oral/ injectable/emergency contraception, pregnancy testing, antenatal services and cervical cancer screening). • Combines peer outreach, drop-in centres, clinical services and community outreach. • Programmes in 19 cities, reaching over 75% of the estimated number of sex workers in the country. • Out of the 19 drop-in centres, 15 have clinics, while the other 4 provide referrals to trained PSI clinics. • PSI provides training to private institutions and peer outreach workers. 		
Lessons learned	<ul style="list-style-type: none"> • It is important for integration to be community-led, combining clinical services with community outreach and support. 		

Figure 14: Integrated approach to HIV prevention and SRHR, TOP (Myanmar)



5. HIV/SRHR integration for men who have sex with men

5.1. What does HIV/SRHR integration for men who have sex with men (MSM) and transgender people involve?

The review indicated that, building on a generic essential package for HIV/SRHR, there are a number of components that may need specific attention in integrated programming for men who have sex with men and transgender people⁸⁵. These include information, support and services related to⁸⁶:

- 'Tailor made' HIV prevention and behaviour change communication.
- Sexuality and sexual health (e.g. counselling on sexual identity, risk-reduction strategies).
- Support for transgender people on gender reassignment (e.g. surgery and post-operative care for complications) and feminising procedures (e.g. clean needles for injecting hormones, information of interactions between hormones and ART, advice on increased risk of breast cancer due to prolonged oestrogen use).
- STIs (including diagnosis and treatment for anal and oral STIs for male and female partners).
- Negotiation within sexual relationships (e.g. between kothi and panthis in India).
- Hepatitis information and vaccination.
- Sexual violence, including PEP after rape/assault.
- Screening, vaccination and support in relation to HPV and anal cancer (at high levels among MSM, especially those living with HIV).
- Sexual dysfunction (e.g. related to ART).
- Condoms and lubricant (access to continuous supply of free or cheap high quality commodities).

⁸⁵ Note: In this report, men who have sex with men and transgender people are combined as one group – due to the lack of specific information found about transgender people. However, it is acknowledged that these are, in reality, two diverse communities, often with different needs in relation to integrated programming.

⁸⁶ Referenced from case studies and literature review, in particular: *Advocacy Brief: Integration of Sexual and Reproductive Health and HIV-Related Services for Men Who Have Sex with Men (MSM) and Transgender People in India*, (draft), Family Planning Association of India, 2010; *Sexual and Reproductive Health of Males-at-Risk in India: Service Needs, Gaps and Barriers*, International HIV AID Alliance in India, May 2008; *HIV and Men Who Have Sex With Men in Asia and the Pacific: UNAIDS Best Practice Collection*, UNAIDS, 2006; *Advancing the Sexual and Reproductive Health and Human Rights of Men Who Have Sex with Men Living with HIV: Policy Briefing*, GNP+ and MSMGF, May 2010; and *Priority HIV and Sexual Health Interventions in the Health Sector for Men Who Have Sex With Men and Transgender People in the Asia-Pacific Region*, WHO, UNDP, UNAIDS, APCOM and Department of Health of Hong Kong (China), 2010.

- Safer sex (e.g. strategies for reducing number of partners, condom negotiation and alternatives to penetrative sex).
- Legal support (e.g. for transgender people who cannot register for services under their changed gender identity).
- Support for sexual partners (male, female, transgender). Including FP, MNCH and other SRHR services for female partners.
- Counselling and support for disclosure of sexuality and/or HIV status to spouse and family members.

5.2. What are some common strategies for HIV/SRHR integration for men who have sex with men and transgender people?

The review indicated that, as yet, there appears to be little clear consensus on the most effective HIV/SRHR integration strategies specifically for men who have sex with men and transgender people. However, as seen in the literature and demonstrated in the case studies below, examples include:

Figure 15: Examples of strategies for HIV/SRHR integration for men who have sex with men and transgender people

HIV programme	Integration	SRHR programme	Examples in case studies
HCT (and other HIV services)	→	FP (and broader SRHR, especially STIs)	<ul style="list-style-type: none"> • FPA India, India • PROFAMILIA, Colombia
HCT (and other HIV services)	→	SRHR, especially STIs	<ul style="list-style-type: none"> • RHAC, Cambodia • Mythri clinics (Avahan Programme), India [see section on sex workers]
General HIV services	←	STIs	<ul style="list-style-type: none"> • Tamil Nadu State AIDS Control Society, APAC and TAI, India
Selected components of HIV	↔	Selected components of SRHR	<ul style="list-style-type: none"> • Bandhu Social Welfare Society, Bangladesh • PAVNHA and Pakistan Society, Pakistan • Blue Diamond Society, Nepal • North Africa Regional Programme, International HIV/AIDS Alliance • Espace Confiance, Cote D'Ivoire • Humsafar Trust, India
Advocacy on HIV	↔	Advocacy on SRHR	<ul style="list-style-type: none"> • SAATHII, India

5.3. What lessons have been learned about HIV/SRHR integration for men who have sex with men and transgender people?

The generic lessons learned for HIV/SRHR integrated programming for key populations [see section 2.5] apply to men who have sex with men and transgender people. In addition, some specific lessons include that it is important to:

- **Understand the different types of men who have sex with men and transgender people and, in turn, their different HIV/SRHR needs.** For example, in India, kothis and hijras have penetrative/receptive roles within sex and each may also have different types of relationships (such as long-term male or female partners, multiple male partners or paying clients), as well as different experiences of social stigma and discrimination.
- **Recognise the specific vulnerability and needs of transgender people.** For example, in many contexts, transgender people are particularly highly marginalised from society and services, with their SRHR needs poorly understood or addressed.
- **Not make presumptions about the HIV/SRHR needs or desires of men who have sex with men and transgender people.** For example, a study by India HIV/AIDS Alliance found that men who have sex who are married may want to have children and need FP⁸⁷.
- **Emphasise the rights of sexual minorities and of men who have sex with men and transgender people who are living with HIV** [see Figure 16].
- **Provide specific support to the female partners of men who have sex with men** – who may be especially stigmatised and marginalised from services. For example, Bandhu Social Welfare Society, Bangladesh refers female partners to mainstream SRHR services⁸⁸, while the Family Planning Association of India provides services for both men who have sex with men and their female partners (either together or separately) in its SRHR clinics⁸⁹.
- **Recognise and address the fact that most SRHR services are designed for heterosexual people**, especially married couples. Responses can include providing intensive training to SRHR staff or identifying non-government (often NGO) facilities to refer men who have sex with men and transgender people.

⁸⁷ *Advocacy Brief: Integration of Sexual and Reproductive Health and HIV-Related Services for Men Who Have Sex with Men (MSM) and Transgender People in India*, (draft), Family Planning Association of India, 2010.

⁸⁸ *Summary Report of Key Findings and Programme Recommendations: From FHI MSM Programme Evaluations (Bangladesh, Indonesia and Nepal)*, Family Health International.

⁸⁹ *Advocacy Brief: Integration of Sexual and Reproductive Health and HIV-Related Services for Men Who Have Sex with Men (MSM) and Transgender People in India*, (draft), Family Planning Association of India, 2010.

Figure 16: Recommendations for programme managers and policy-makers to support the HIV/SRHR rights of MSM living with HIV

1. Voluntary and affordable STI and HIV prevention, care, treatment and support services must be expanded and tailored to meet the specific needs and priorities of MSM living with HIV – based on confidentiality, informed consent and counseling.

2. Systems for HIV prevention, care, treatment and support must be strengthened to deal with disproportionately high numbers of MSM living with HIV at the same time that HIV testing is scaled up – case finding without appropriate services constitutes substandard and unethical public health practice.

3. National laws criminalising homosexuality and HIV transmission should be overturned in favour of laws that guarantee the rights of gay men and other MSM, including MSM living with HIV.

4. All MSM living with HIV, including young MSM and their sex partners (male, female, or transgender) should have access to a full and comprehensive range of SRH services including STI screening and treatment, hepatitis immunisation, mental health and other psychosocial support services.

4. Health service providers and advocates should receive sensitivity training related to the specific needs and priorities of MSM living with HIV, including stigma reduction, confidentiality, and the specific challenges facing young MSM.

Reference: Advancing the Sexual and Reproductive Health and Human Rights of Men Who Have Sex with Men Living with HIV: Policy Briefing, GNP+ and MSMGF, May 2010.

5.4. Case studies of HIV/SRHR integration for men who have sex with men and transgender people

Organisation: Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA)⁹⁰			
Country	Colombia	HIV epidemic	Concentrated (general 0.4%; MSM 18%)
Type of provider	Civil society (IPPF affiliate)	Donor	GTZ
Main programme type	SRHR	Intervention location	Facility-based
Key population	MSM, female partners of MSM and women living with HIV		
HIV/SRHR integration	<ul style="list-style-type: none"> • SRHR clinics (providing FP, etc.) integrating HCT. • Started integration process with a 3-day sensitization workshop for over 200 service providers in 3 clinics. This was designed and facilitated by MSM groups and addressed issues such as diversity, gender, sexuality identity and relationships. • Developed a service protocol and guide, alongside specific information materials for MSM and their female partners. • Also campaigned for the rights of lesbian, gay, bisexual and transgender people. 		
Lessons learned	<ul style="list-style-type: none"> • Recognise the diversity of the MSM community and that some have female partners who may be highly marginalised. • Work in collaboration with MSM groups to gain expertise and build trust. • Develop a specific strategy to support transgender people. 		

⁹⁰ Models of Care Project: Linking HIV/AIDS Treatment, Care and Support in Sexual and Reproductive Health Care Settings: Examples in Action, International Planned Parenthood Federation, 2005.

Organisation: Bandhu Social Welfare Society⁹¹			
Country	Bangladesh (6 cities)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	Various (e.g. UNDP, MSI, DfiD, Norwegian Embassy)
Main programme type	SRHR and HIV	Intervention type	Community outreach
Key population	MSM (including those involved in sex work and with female partners)		
HIV/SRHR integration	<ul style="list-style-type: none"> • Integrated HIV and SRHR services in communities, including at over 60 MSM cruising sites. Services include those related to: HIV (such as: condom and lubricant distribution; HIV information; education on safer sex) and SRHR (such as STI information). Referral to STI clinic providing drop-in services for: syndromic management; psycho-sexual counselling; condoms and lubricant distribution; social groups; general and sexual health awareness; and HCT. Also a telephone helpline. • Female partners of MSM are referred to other services. • Training and support to peer educators and outreach workers (who are MSM). • Service provision complemented by national advocacy on issues relating to MSM. 		
Lessons learned	<ul style="list-style-type: none"> • Providing comprehensive general health care provides a good entry point for approaching SRHR for MSM. • It is critical to involve community members in strategic planning for integration, as well as to actively engage with the government. 		

Organisation: Family Planning Association (FPA) of India⁹² (supported by IPPF)			
Country	India (Mumbai, Chennai, Kolkata and Kohima)	HIV epidemic	Concentrated (MSM 7%; transgender 18-41%; general 0.7%)
Type of provider	Civil society	Donor	Japan Trust Fund (for pilot)
Main programme type	SRHR	Intervention location	Facility-based; community outreach
Key population	MSM, female partners of MSM and transgender people		

⁹¹ Summary Report of Key Findings and Programme Recommendations: From FHI MSM Programme Evaluations (Bangladesh, Indonesia and Nepal), Family Health International.

⁹² Advocacy Brief: Integration of Sexual and Reproductive Health and HIV-Related Services for Men Who Have Sex with Men (MSM) and Transgender People in India, (draft), Family Planning Association of India, 2010.

HIV/SRHR integration

- SRHR clinics integrating HIV services for MSM and female partners, supported by outreach work and drop-in. Free services include: SRH services (e.g. FP; medical termination of pregnancy; STI screening and treatment); and HIV services (HIV prevention outreach and counselling; HCT – rapid tests, pre and post-test counselling; condoms (including through outreach); social marketing of water-based lubricant; diagnosis of Hepatitis B and free HBV vaccination (for MSM and transgender people); and psycho-social support groups. Referrals for: ART (at government centres); TB (at government DOTs centres); income generation; legal issues; and surgical procedures.
- Key steps to prepare for integration included:
 - Having staff focus group discussions with MSM to understand their needs and inform a funding proposal.
 - Holding an initial meeting with stakeholders (including NGOs working with MSM and transgender people) to seek collaboration. The NGOs: suggested candidates for staff posts; trained clinic staff; referred MSM and their partners to services; and provided feedback on how to improve services.
 - Ensuring that services were appropriate, such as with: long opening hours; options to drop-in for services or make an appointment; and shared waiting areas for MSM, transgender people and the general public (to reduce stigma)
- Results include that MSM clients welcomed: non-discrimination; getting information on both SRHR and HIV; and saving time and money. However, MSM were often hesitant to bring their female partners (as it would 'out' their married status to other MSM). Also some had larger expectations for services, such as free CD4 testing.

Lessons learned

- Integration was helped by the clinics: already having good infrastructure; having external (i.e. non-government) funding; building positive attitudes among both clinical and non-clinical staff; and starting with a pilot.
- Shared waiting areas initially caused tensions (e.g. due to challenging behaviour by hijras), but they were resolved by dialogue with local MSM and transgender leaders.
- It is vital to understand differences among MSM and transgender people and dynamics within the community. For example, MSM who feared being 'outed' about having female partners were given three options to protect their confidentiality: couple to be referred to other FPA clinics; couple to make an appointment for a non-drop-in clinic day; or husband and wife to attend the clinic separately.
- It is important to 'popularise' projects, for example by providing free HBV vaccination which attracts clients. But it is also important to manage expectations and clarify what services can or cannot be provided (e.g. in relation to sex reassignment surgery).
- Both clinical and non-clinical staff require extensive technical training that goes beyond just 'sensitization' about MSM and transgender issues.

Organisation: Tamil Nadu State AIDS Control Society, APAC and TAI⁹³			
Country	India (Tamil Nadu)	HIV epidemic	Concentrated
Type of provider	Government; civil society	Donor	
Main programme type	HIV	Intervention location	Facility-based
Key population	MSM and transgender people		
HIV/SRHR integration	<ul style="list-style-type: none"> • Collaborative programme by State AIDS Control Society for government hospitals to provide free 'master health check-up' (covering major communicable and non-communicable diseases, including STIs and HIV) for MSM and transgender people. • Strategy within the targeted interventions approach of NACP-III. • Government service providers (doctors and counsellors) trained on the specific health issues of MSM and transgender people. • Government facilities upgraded to provide a welcoming and non-discriminatory environment for MSMs and transgender people. 		

Organisation: Reproductive Health Association of Cambodia (RHAC)⁹⁴			
Country	Cambodia (Siem Reap)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	
Main type of programme	SRHR and HIV	Intervention location	Facility-based; community outreach
Key population	MSM		
HIV/SRHR integration	<ul style="list-style-type: none"> • RHAC and local government SRHR clinics integrating STI and HCT services. • In Siem Reap, built partnerships with local organisations to reach MSM and entertainment workers through outreach. • Trained peer educators to disseminate STI and HIV information and refer clients to clinics for testing and treatment. 		
Lessons learned	<ul style="list-style-type: none"> • Partnership brings benefits to both MSM groups (increasing the range of services) and RHAC/government clinics (increasing reach to priority populations). 		

93 *Advocacy Brief: Integration of Sexual and Reproductive Health and HIV-Related Services for Men Who Have Sex with Men (MSM) and Transgender People in India*, (draft), Family Planning Association of India, 2010.

94 *In a Life: Linking HIV Treatment, Care and Support in Sexual and Reproductive Health Care Settings*, IPPF, 2006.

Organisation: Pakistan Voluntary Health and Nutrition Association (PAVNHA) and Pakistan Society⁹⁵ (supported by Interact Worldwide)			
Country	Pakistan (Sindh)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	European Council
Main programme type	SRHR and HIV	Intervention location	Facility-based; community outreach
Key population	MSM, SWs (and their partners), PUD and PLHIV		
HIV/SRHR integration	<ul style="list-style-type: none"> • Clinics integrating SRHR and HIV, including services for primary health care, HCT, condom and lubricant distribution, safer sex practices and harm reduction for PUD. • Clinics complemented by peer education and support groups and involvement of key populations in programmes. • Community organisers trained in rights, gender, STIs, basic health and hygiene, HCT, HIV and care and support. • Developed models for integrated HIV prevention, care and support. 		
Lessons learned	<ul style="list-style-type: none"> • Challenges include the need to develop positive relations with the gatekeepers of MSM networks (e.g. the pimps of those who sell sex). 		

Organisation: Blue Diamond Society⁹⁶			
Country	Nepal (Kathmandu)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	
Main type of programme	MSM sexual health	Intervention location	Facility-based; community outreach
Key population	MSM and (female) SWs		
HIV/SRHR integration	<ul style="list-style-type: none"> • Integrated programme providing SRHR and HIV services. Drop-In Centre ('safe house') provides one-to-one education, counselling, clinical services, group sessions on HIV and STIs, condoms and lubricant. Centre complemented by outreach workers providing information, condoms and referrals for STI services. • Centre open to MSM seven days a week from 9am-6pm and also provides videos, training and social events. • Programme is supported by social marketing of condoms. 		
Lessons learned	<ul style="list-style-type: none"> • It is critical to have strong working relationships with other organisations, especially to ensure the quality of referrals for stigmatised populations such as MSM. • As well as providing integrated services, it is important to address the environment in which MSM live and work. For example, as extortion and threat of exposure are common for MSM, programme fosters solidarity among the men using public parks to protect each other from blackmailers, thieves and the police. 		

95 Website of Interact Worldwide (accessed 12.4.11).

96 Summary Report of Key Findings and Programme Recommendations: From FHI MSM Programme Evaluations (Bangladesh, Indonesia and Nepal), Family Health International; and Between Men: HIV/STI Prevention for Men Who Have Sex With Men, International HIV/AIDS Alliance, August 2003.

Organisation: North Africa Regional Programme (supported by International HIV/AIDS Alliance)⁹⁷			
Country	Algeria, Lebanon, Morocco, Tunisia	HIV epidemic	Low/concentrated
Type of provider	Civil society	Donor	USAID
Main programme type	Health and support for MSM	Intervention location	Facility-based; community outreach
Key population	MSM		
HIV/SRHR integration	<ul style="list-style-type: none"> • Organisations provide a range of HIV and SRHR services (including HCT, condoms and lubricant and information materials). Referrals to medical and support services. • Emphasis on peer education and support. Also on involvement of MSM in all stages, including needs assessment, service delivery and advocacy. • Service provision is complemented by advocacy to combat stigma and discrimination (a strong barrier to services). Targets health professionals and high ranking law enforcement officials. 		
Lessons learned	<ul style="list-style-type: none"> • A comprehensive approach to integration is needed that includes attention to the structural barriers to SRHR and HIV. • Advocacy is a critical component of integrated programmes (including to address unsupportive national policies – a major barrier). It requires planning and budgeting. 		

Organisation: Espace Confiance (supported by Alliance Nationale contre le SIDA en Côte d'Ivoire)⁹⁸			
Country	Cote D'Ivoire	HIV epidemic	Generalised
Type of provider	Civil society	Donor	AMFAR
Main programme type	HIV and SRHR	Intervention location	
Key population	MSM		
HIV/SRHR integration	<ul style="list-style-type: none"> • Clinic providing STI screening and testing, complemented by education sessions on behaviour change communication (focusing on condom use, STIs and HIV prevention). • Key steps to develop the integrated programme included: <ul style="list-style-type: none"> • Starting with a needs assessment among MSM and community groups. • Using the findings of the needs assessment to carry out joint planning and coordination among community groups. • Training MSM peer educators. • Developing targeted information materials on STIs and HIV. 		

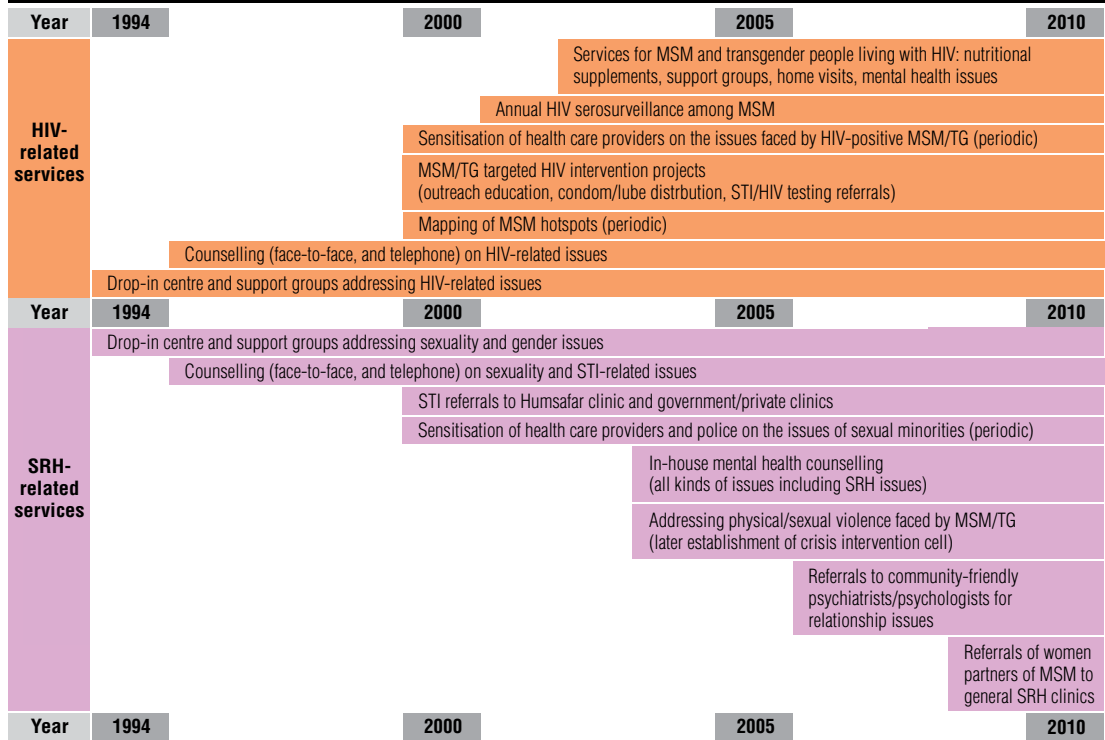
⁹⁷ Integration of HIV and Sexual and Reproductive Health & Rights (SRHR): Report on Existing Alliance Programmes and Policy Work and Potential Strategic Partnerships, International HIV/AIDS Alliance.

⁹⁸ Integration of HIV and Sexual and Reproductive Health & Rights (SRHR): Report on Existing Alliance Programmes and Policy Work and Potential Strategic Partnerships, International HIV/AIDS Alliance.

Organisation: Humsafar Trust⁹⁹			
Country	India (Mumbai)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	Various
Main type of programme	Health for sexual minorities	Intervention location	Facility-based; community outreach
Key population	MSM and transgender people		
HIV/SRHR integration	<ul style="list-style-type: none"> • NGO clinic focused on MSM/transgender health that has integrated HIV and SRHR services over time [see timeline below]. Provides comprehensive services, including: outreach on HIV and STIs; distribution of condoms and lubricant; counselling on mental health, sexuality, etc.; nutrition support; STI screening and testing; HCT (government-accredited centre); prevention and support on violence; HIV-related care and support (including at home, supported by MSM health workers); counselling for married MSM; and support relating to sexuality and disclosure. Referral to government hospitals for STI treatment and specific HIV services (e.g. CD4 count and ART) and to community-friendly psychiatrists and psychologists (e.g. for support related to gender identity and sexuality). • Female partners of MSM are referred to Mumbai branch of Family Planning Association, including for Hepatitis B screening and free Hepatitis B vaccination. • Counselling is provided face-to-face, on the phone or via e-mail. • Outreach is provided to MSM involved in sex work at a different location (Juhu). • Started with a mapping of MSM, then a pilot intervention which was scaled up. • Has built partnerships with the health sector, such as training staff at the general hospital on MSM and transgender issues and having hospital interns at its clinic. 		
Lessons learned	<ul style="list-style-type: none"> • Clients say the advantages of integration include: non-judgmental attitudes of providers; less time and money spent accessing services; and more quality time with providers. The disadvantages include fear of stigma (e.g. with MSM who are living with HIV and SWs fearing detrimental impacts on work if their HIV positive status is revealed). • MSM and transgender people are diverse groups, with different needs and, sometimes, tensions among them – which can impact on service provision. • It can be necessary to try out options to identify ‘what works’. Humsafar tried having a separate room and specific service provider for MSM living with HIV, but that system ‘identified’ those that are HIV positive. They also tried having a separate centre for such MSMs, but the clients wanted to access the organisation’s wider set of services. • For an NGO focused on MSM and transgender people, referral is a critical option to address the needs of female partners. 		

99 *Advocacy Brief: Integration of Sexual and Reproductive Health and HIV-Related Services for Men Who Have Sex with Men (MSM) and Transgender People in India*, (draft), Family Planning Association of India, 2010.

Figure 17: Timeline of integration of HIV and SRHR services into support for MSM, Humsafar Trust (India)



Organisation: Solidarity and Action Against the HIV Infection in India (SAATHII)¹⁰⁰			
Country	India (West Bengal and Orissa branch)	HIV epidemic	Concentrated (MSM 7%; transgender 18-41%; general 0.7%)
Type of provider	Civil society	Donor	
Main programme type	Support to key populations	Intervention location	(Provincial and national advocacy)
Key population	MSM and transgender organisations and PLHIV networks		
HIV/SRHR integration	<ul style="list-style-type: none"> • NGO for key populations coordinating advocacy coalitions on SRHR and HIV. • Key steps towards HIV/SRHR integration included: <ul style="list-style-type: none"> • Starting an HIV Support Centre Project focused on: building knowledge on gender, sexuality, human rights, sexual health and HIV; and providing technical support for skills related to the HIV response. Of the 9 main partners (some groups working with MSM and transgender people, others networks of PLHIV) most had experience in HIV, but not SRH. • Beginning a 5-year follow-up initiative (the Coalition-Based Advocacy Project) to strengthen the advocacy capacity of partners by assisting them to understand the specific SRHR needs of sexual minorities and PLHIV. • Having 33 (West Bengal) and 22 (Orissa) members of two state-level coalitions, with the work strengthened through training each agency and a workshop to develop on a common advocacy agenda. <p>SAATHII complements its advocacy by supporting over 40 agencies (including in West Bengal and Orissa) to integrate SRHR components into HIV targeted interventions for MSM and transgender people. Examples of SRH components include prevention and care for survivors of sexual violence, health promotion for the female partners of MSM and counselling on gender transition for transgender people.</p> <p>SAATHII's integration results include:</p> <ul style="list-style-type: none"> • Developing a common HIVF/SRHR advocacy agenda for sexual minorities and PLHIV, focused on issues such as access to services and stigma and discrimination. • Supporting policy-level advocacy. Implemented/planned activities include: policy paper on how current HIV and SRH policies (including the NACP/ NRHM convergence plan) address the specific needs of sexual minorities and PLHIV; advocacy action plan to address identified policy and programme gaps; and advocacy to articulate the specific SRH-related issues of sexual minorities and PLHIV in the next phases of the NACP and RCHP. • Supporting healthcare system-level advocacy: The coalitions' activities include sensitizing healthcare providers on issues for sexual minorities and PLHIV; and advocating for technical training for service providers. 		

100 What Works? Sexual and Reproductive Health (SRH) and HIV Linkages for MSM and Transgender People, (Draft), International Planned Parenthood Federation, 2011.

Lessons learned

- There can be tensions among different members of HIV/SRHR coalitions, such as MSM and PLHIV groups. These can be addressed by building a shared understanding of the over-lapping issues of the constituencies.
- The coalitions were challenged by the lack of a specific funding mechanism to advance the SRHR of sexual minorities and PLHIV. While HIV-related activities are funded by NACO through NACP-III, SRH activities for the general population are funded by RCHP-II/NRHM. The NRHM's plan does not mention the SRH of sexual minorities and PLHIV.
- A multi-pronged approach is needed to capacity building. SAATHII found it necessary to combine building understanding and capacity on: SRHR among agencies providing HIV services for MSM and transgender people; issues affecting MSM and transgender people among mainstream PLHIV networks; and the specific needs of MSM and transgender people among general SRH services.
- The involvement of mainstream SRH agencies is challenging. Only a limited number of such agencies have registered as members of the coalitions. However, many other SRH agencies have clarified that – even though they are not formal members – they will support advocacy actions in relation to SRHR and HIV linkages for sexual minorities and PLHIV. This will require further work, with SAATHII and the coalitions strengthening their links with other mainstream SRH and human rights agencies.
- Some agencies fear a 'backlash' of involvement in SAATHII's coalitions – such as losing funding due to criticising the government or providing support to sexual minorities and PLHIV. In response, the coalition emphasised that, while it is important to collaborate with the Government, it is also important to highlight gaps in its services and policies – to help the Government to do its job better.

6. HIV/SRHR integration for people who use drugs

6.1. What does HIV/SRHR integration for people who use drugs involve?

The review indicated that – building on a generic essential package for HIV/SRHR – there are a number of components that may need specific attention within integrated programming for people who use drugs (PUD). These vary according to factors such as people's gender, age, social status and HIV status. They can include information, support and services related to¹⁰¹:

- Full range of options to prevent HIV, STIs and unwanted pregnancy, including (but also going beyond) condoms.
- Interactions between different types of drugs (e.g. methadone, ART, contraceptives).
- Safer sex practices while under the influence of different types of drugs (e.g. risk reduction, skills to improve condom efficacy).
- Specific SRHR issues for people who use drugs (e.g. sexual dysfunction for men, impact on menstruation and fertility for women).
- Female drug users who are pregnant (e.g. information on methadone use and dosage during pregnancy), with access to full range of supportive PMTCT, ANC, delivery, PNC and MCH.
- Empowerment on sexual and health rights.
- SRHR needs of female partners of men who use drugs (e.g. family planning options). 'Drug user-friendly' SRHR options, including a full range of appropriate contraception (e.g. long-lasting contraceptives) and male and female condoms.
- Sexual violence, including PEP in relation to rape or sexual assault.
- Sexual counselling (e.g. on the relationship between sexual drive, performance and drug use).
- Family welfare services, to support people who use drugs to maintain custody of their children.
- Hepatitis B and C (e.g. information, diagnosis and treatment).

101 Referenced from case studies and literature review, in particular: *Advancing the Sexual and Reproductive Health and Human Rights of Injecting Drug Users Living with HIV: Policy Briefing*, GNP+ and INPUD, May 2010; *HIV and Drug Use: Community Responses to Injecting Drug Use and HIV: Good Practice Guide*, International HIV/AIDS Alliance, 2010; *Targeted Interventions Under NACP III: Operational Guidelines Volume 1: Core High Risk Groups*, National AIDS Control Organisation, October 2007; and *Making Harm Reduction Work for Women: The Ukrainian Experience*, OSI, 2010.

- (Where legal) access to safe and confidential abortion and (in all contexts) post-abortion care (including in cases of unsafe or illegal abortion).
- Diagnosis and treatment for TB.

6.2. What are some common strategies for HIV/SRHR integration for people who use drugs?

The review indicated that, as yet, there appears to be little clear consensus on the most effective HIV/SRHR integration strategies specifically for people who use drugs. However, as seen in the literature and demonstrated in the case studies below, examples include:

Figure 18: Examples of strategies for HIV/SRHR integration for people who use drugs

HIV programme	Integration	SRHR programme	Examples in case studies
HIV and harm reduction	←	SRHR (especially condoms and STIs and often specifically including women's health)	<ul style="list-style-type: none"> • DICP, Malaysia • Korsang, Cambodia • OSI, Ukraine • SASO, India • Five Hearts Service Centre, China
HIV and harm reduction	→	Broad SRHR or primary health care	<ul style="list-style-type: none"> • PKBI, Indonesia • Puskesmas, Indonesia

6.3. What lessons have been learned about HIV/SRHR integration for people who use drugs?

The generic lessons learned for HIV/SRHR integrated programming for key populations [see section 2.5] apply to people who use drugs. In addition, some specific lessons include that it is important to:

- **Assess, recognise and address the complex interactions between drug use/harm reduction, HIV and SRHR**, such as how drug use can affect the choices or decisions of people who use drugs in relation to sexual pleasure and risk taking and how different drugs and medicines (such as methadone, hormonal contraceptives and ART) interact with each other.
- **Not make presumptions about the HIV/SRHR behaviours or needs of people who use drugs.** For example, an India HIV/AIDS Alliance study found that male drug users may be having sexual relations with women, men and hijras – all associated with different issues and needs for support and services¹⁰².

102 Sexual and Reproductive Health of Males-at-Risk in India: Service Needs, Gaps and Barriers, India HIV/AIDS Alliance, May 2008.

- **Within integrated programming, address the cross-cutting issue of gender dynamics**
 - acknowledging that women can be affected by drug use, HIV and SRHR in different ways and that many programmes to support people who use drugs are both male-orientated and focused on drug use/HIV (making it difficult, for example, for women to discuss pregnancy). For example: programmes supported by the Open Society Institute in Ukraine found that OST programmes provided little outreach to pregnant women who use drugs and that substitution treatment was lacking in maternity settings¹⁰³; and GNP+ emphasises the need to support women who use drugs who are living with HIV [see **Figure 19**]. Meanwhile, the International HIV/AIDS Alliance recommend that attention is paid to:
 - Women who use drugs
 - Women who are partners of drug users, including wives and widows
 - Women who use drugs and sell sex
 - Pregnant women who are using drugs and mothers who are using drugs
 - Women living with HIV who are using drugs
 - Young women and girls who are using drugs¹⁰⁴.
- [See **Annex 3** for extract from *HIV and Drug Use: Community Responses to Injecting Drug Use and HIV: Good Practice Guide*, International HIV/AIDS Alliance].
- **Provide a comprehensive package of integrated HIV/SRHR support for people who use drugs.** For example, NACO in India recommends that, for Drop-In Centres, this includes: condoms and STI diagnosis and treatment in a core package; SRHR support for women who use drugs and the female partners of men who use drugs; behaviour change communication among sexual partners; and accompanied referrals to other SRHR services¹⁰⁵.

Figure 19: Supporting the SRHR needs of women who use drugs who are living with HIV

“Contraception is a very important issue for IDU women living with HIV; menstruation often ceases with regular use of opiates, which can make it difficult to detect pregnancy. It is vital that the full range of contraceptive options be made available, and that women are not forced to use a particular method in order to comply with ART contraception stipulated by service-providers. Family planning and abortion choices should be made with the same range of choices available to women who are not HIV-positive; pressured or forced sterilisation is diametrically opposed to the human rights of IDU women living with HIV and should be specifically outlawed.”

Advancing the Sexual and Reproductive Health and Human Rights of Injecting Drug Users Living with HIV, GNP+ and INPUD

103 *Making Harm Reduction Work for Women: The Ukrainian Experience*, OSI, 2010.

104 Definition from: *HIV and Drug Use: Community Responses to Injecting Drug Use and HIV: Good Practice Guide*, International HIV/AIDS Alliance, 2010.

105 *Targeted Interventions Under NACP III: Operational Guidelines Volume 1: Core High Risk Groups*, National AIDS Control Organisation, October 2007.

6.4. Case studies of HIV/SRHR integration for people who use drugs

Organisation: Perkumpulan Keluarga Berencana Indonesia (PKBI)¹⁰⁶			
Country	Indonesia (Pisangan, Jakarta)	HIV epidemic	Concentrated (general: 0.2%; PUD: 52%)
Type of provider	Civil society (IPPF affiliate)	Donor	Various (e.g. Global Fund, UNFPA)
Main programme type	SRHR	Intervention location	Facility-based; community outreach
Key population	PUD, SWs, MSM and transgender people		
HIV/SRHR integration	<ul style="list-style-type: none"> • SRHR clinic and community service delivery points integrating HIV and harm reduction services for key populations. Part of network of 26 clinics. • Integrates three packages: <ul style="list-style-type: none"> • SRHR, including FP, ANC, PNC, counselling, prevention of unsafe abortion, management of post-abortion care and cervical screening. • HIV, including HCT, PMTCT, STI and HIV prevention for key populations. • Harm reduction for PUD, including needle and syringe exchange, information, outreach and support groups. • Clinics provide simple laboratory services for STIs and rapid HIV tests, but do not provide ART or methadone. Clients are referred to main hospitals for other services (including PMTCT for pregnant women living with HIV). • Clinics work on cost-recovery basis, with charges kept minimal. • Strategy responds to NAC's recognition of HIV/SRHR integration as critical for key populations. 		
Lessons learned	<ul style="list-style-type: none"> • Combining clinic-based services and community outreach works well for integrated programmes for key populations, such as people who use drugs. • Non-judgmental attitudes are critical, for example for supporting women who are using drugs, living with HIV and pregnant. • Staff need to build specific technical expertise to deliver integrated services (e.g. in relation to contraceptive options for women living with HIV and interactions between methadone and ART). 		

¹⁰⁶ *Linking Sexual and Reproductive Health and HIV: Advocacy Brief on People Who Use Drugs, Indonesia*, IPPF East and South Asia and Oceania region, 2011.

Organisation: Drug Intervention Community Pahang (DICP)¹⁰⁷ (supported by Malaysian AIDS Council – linking organisation of International HIV/AIDS Alliance)			
Country	Malaysia (Pahang)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	Ministry of Health
Main programme type	HIV	Intervention location	Facility-based; community outreach
Key population	(Women) PUD and SWs		
HIV/SRHR integration	<ul style="list-style-type: none"> • Drop-In Centre providing HIV and harm reduction services and integrating SRHR services (including integrating information, condoms and safer sex counselling). Referrals to medical facilities. Also community outreach to PUD and SWs. • Provision of needle and syringe exchange – as part of a national programme resulting from advocacy by MAC. • Organisation set up by former PUD. 		
Lessons learned	<ul style="list-style-type: none"> • It is critical to develop specific integrated strategies for women PUD – as many harm reduction services are not women-friendly and do not address issues such as pregnancy or MCH. 		

107 *Hidden Women* (web page on women who inject drugs in Malaysia) (page of www.aidsalliance.org; accessed 5.4.11).

Organisation: Korsang¹⁰⁸ (supported by Khmer HIV/AIDS NGO Alliance)			
Country	Cambodia (Phnom Penh)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	AusAID, USAID, Global Fund, EU, World Food Programme
Main programme type	Harm reduction	Intervention location	Community outreach
Key population	PUD (including women)		
HIV/SRHR integration	<ul style="list-style-type: none"> • Harm reduction and HIV programme (with services including needles and syringes, information about HIV, information about safe injecting and blood tests) integrating SRHR (including condoms and information on women's health). Health workers attend to minor cuts, bruises or infections and help PUD to access other services, such as hospital treatment. Women offered access to SRHR advice (delivered by a woman). • Attention to human rights abuses, safe spaces and support for livelihoods. • Programme delivered through daily community outreach in vans or on motorbikes to places where PUD live or take drugs. Also through a Drop-In Centre. • Outreach delivered by four multi-disciplinary teams (each with a health worker, HIV advisor, peer educator and specialist in women's health). • Service provision complemented by advocacy with local authorities to reduce discrimination against PUD. Have also built good relationship with local communities, who appreciate efforts to reduce the numbers of discarded needles in public places. 		
Lessons learned	<ul style="list-style-type: none"> • A peer approach is critical to integrated services. Most of Korsang's staff, peer educators and volunteers are current or former drug users themselves. • Outreach is critical in a context such as Phnom Penh where many PUD are unaware of the services available to them and/or unwilling to come to the Drop-In Centre for fear of police prosecution. Korsang's approach provides support to PUD on their own grounds. The outreach team dress casually and relate to service users on equal terms, building trust and lasting relationships. • It is important to provide comprehensive and flexible integrated services. Director Korsang says: <i>"We are a 24 hour programme. A lot of our service users spend the night here. Before, they used to sleep on the streets and, in the morning, they would get beaten up, get injured and have a lot of medical issues. Since we opened, the 24 hour Drop-In Centre, they don't need as much medical attention."</i> 		

108 HIV and Drug Use: Community Responses to Injecting Drug Use and HIV: Good Practice Guide, International HIV/AIDS Alliance, 2010.

Organisation: Five Hearts Service Centre¹⁰⁹ (supported by International HIV/AIDS Alliance in China)			
Country	China (Sichuan Province)	HIV epidemic	Concentrated
Type of provider	Civil society; government	Donor	
Main programme type	HIV and harm reduction	Intervention location	Facility-based
Key population	PUD		
HIV/SRHR integration	<ul style="list-style-type: none"> • Drop-In Centre providing harm reduction and HIV services (including needle exchange) and integrating components of SRHR (including STI treatment) services to PUD, including. Referrals to methadone maintenance clinic. • Programme supported by PUD peer educators and involves PUD community. • Provides subsidised treatment for drug-related infections and STIs. • Team building carried out and methods for community involvement developed. • Service provision complemented by advocacy, including to the police. • Results include reaching an estimated 70% of PUD in the Emei area. 		
Lessons learned	<ul style="list-style-type: none"> • Subsidising treatment is critical to increasing uptake. For example, between years 1-2, the number of PUD receiving medical consultations on STIs increased by 250%. • Challenges include how to reach the partners of PUD with condoms. 		

109 *Integration of HIV and Sexual and Reproductive Health & Rights (SRHR): Report on Existing Alliance Programmes and Policy Work and Potential Strategic Partnerships*, International HIV/AIDS Alliance.

Organisation: Gender responsive harm reduction programmes (supported by Open Society Institute)¹¹⁰			
Country	Ukraine (different locations)	HIV epidemic	Concentrated
Type of provider	Various	Donor	Open Society Institute
Main type of programme	Harm reduction	Intervention location	Facility-based; community outreach; mobile
Key population	(Female) PUD		
HIV/SRHR integration	<ul style="list-style-type: none"> • Harm reduction and HIV programmes for women who use drugs integrating SRHR. • Services provided by programmes address: harm reduction; HIV (including: information on safer sex; HIV testing (including low threshold mobile services and rapid HIV testing); provision (or, if not possible, referral) of ART); and SRHR (including: free condoms; STI testing (including low threshold services); free home pregnancy tests; gender-specific information; counselling and support). Case management is used to link harm reduction, SRHR and HIV services for individuals and improve adherence to treatment. • Programmes have specific focus on OST for pregnant women, combined with support on motherhood and family issues (e.g. helping women to make informed choices about child-bearing, improve their parenting skills and maintain custody of their children). • Provision of peer and social support, including for women overcoming trauma. • Referrals are to trusted and trained services (with the programmes acting as a 'bridge' for clients). Provision of OST includes promoting the importance of an uninterrupted supply during pregnancy – enabling women to stabilize and receive support. • Complemented by strategy to identify women PUD at an early stage of pregnancy – to help them access ANC, provide home visits to support pregnancy and give support when they have their babies (monitoring the woman and child's health and, as necessary, providing ART). • Service provision complemented with legal aid and empowerment about health rights. 		
Lessons learned	<ul style="list-style-type: none"> • Beyond the provision of integrated services, there is also a need for outreach to women who use drugs and the development of women-friendly spaces. • It is important to offer options for service provision. For example, mobile vans mean that women who use drugs do not have to make appointments in advance. 		

110 Making Harm Reduction Work for Women: The Ukrainian Experience, OSI, 2010.

Organisation: Puskesmas – Pusat Kesehatan Masyarakat¹¹¹			
Country	Indonesia (Puskesmas Gambir, Central Java)	HIV epidemic	Concentrated (general: 0.2%; PUD: 52%)
Type of provider	Government	Donor	District and local municipalities
Main type of programme	Primary health care	Intervention type	Facility-based; community outreach; mobile
Key population	PUD, SWs and MSM		
HIV/SRHR integration	<ul style="list-style-type: none"> • Community Health Centres (providing 25 primary health care polyclinics in the same centre) providing services for SRHR (such as FP, STI prevention and management, ANC and MCH), HIV (such as HCT, ART and TB screening) and harm reduction for PUD (such as needle and syringe exchange, OST and Hepatitis screening). Referrals to district hospital for CD4 and viral load tests. • Male PUD given STI treatment at methadone clinic. Women referred to MCH clinic. • Staff at methadone clinic trained in PMTCT, but lack the infrastructure to address all four prongs. So women are usually referred to the hospital or NGOs. • Steps for integration included: <ul style="list-style-type: none"> • Training Centres' staff – in service delivery and supportive attitudes to PUD. • Building relationships with harm reduction NGOs and holding face-to-face meetings with PUD to discuss their needs. • Preparing the Centres' space – refurbishing facilities and providing a separate entrance for the methadone clinic. • Range of service delivery methods used, including in and out-patients, mobile units and health posts. Services are free to those with a government poverty identification card and minimal costs to others. • Client flow charts used to track progress (including referrals) and ensure follow-up. • Supported by NAC's recognition of importance of integration for key populations. 		
Lessons learned	<ul style="list-style-type: none"> • Challenges include that increased uptake of integrated services has increased the workload of staff – compounded by a lack of guidelines on integrated services. • Government funding means that the initiative is less dependent on external resources than many civil society programmes. • It is vital that an organisation's leadership understand/are committed to integration. • Where possible, it is important to make core services – such as FP and screening for cervical cancer – free for women PUD. 		

111 *Linking Sexual and Reproductive Health and HIV: Advocacy Brief on People Who Use Drugs*, Indonesia, IPPF East and South Asia and Oceania Region, 2011.

Organisation: Social Awareness Service Organisation (SASO)¹¹²			
Country	India (Imphal, Manipur)	HIV epidemic	Concentrated
Type of provider	Civil society	Donor	Elton John AIDS Foundation / India HIV/AIDS Alliance
Main programme type	Harm reduction and HIV	Intervention location	Facility-based; community outreach
Key population	Female PUD (plus female partners of male PUD)		
HIV/SRHR integration	<ul style="list-style-type: none"> • Drop-In Centre providing harm reduction and HIV services (such as HIV education, prevention counselling, needle and syringe exchange, management of opportunistic infections, care and support, group sessions, abscess management, Hepatitis C testing and treatment) and integrating SRHR (such as STI diagnosis and treatment, counselling, free condoms and negotiation skills for condom use). Entry point/referrals for HCT, ART, PMTCT, MCH, OST, detoxification and legal aid. Also provides recreational activities, vocational training and loans for income generating activities. [See Figure 20 for diagram of integrated programme]. • Female doctor provides free basic health care and check-ups for women who use drugs (many of whom are also involved in sex work). Drop-In Centre and night shelter are only specific support for women who use drugs in Manipur. • Programme has been scaled up to two more districts. • Before programme, women who use drugs reported: very low condom use (due to low negotiation power); selling sex to earn money for drugs; and concealing their drug use from health providers due to stigma. • Service provision complemented by: capacity building of local service centres on the needs of women who use drugs; advocacy to government and health care providers; and action on stigma (with a Core Advocacy Group, sensitisation of stakeholders and awareness raising among the public). • Organisation set up by people with experience of drug use. All of the staff and peer educators are from the community and receive training. 		
Lessons learned	<ul style="list-style-type: none"> • Challenges for integrated programming for women who use drugs include: lack of family support; lack of income generating opportunities; aggressive stakeholders (e.g. police); high percentage living with HIV and/or infected with Hepatitis C; and health not being a high priority for PUD. • Other challenges for integration include the need for strong follow-up mechanisms and provision of hands-on training for medical staff (on the complexities of the needs of women who use drugs or are the partners of men who use drugs). • Small group sessions are an effective way to engage women in HIV/SRHR, while Drop-In Centres need to ensure a women-friendly environment. 		

112 *Breaking New Ground, Setting New Signposts: A Community-Based Care and Support Model for Injecting Drug Users Living with HIV* (A SASO-Alliance Experience), India HIV/AIDS Alliance.

Figure 20: Framework for integrated harm reduction, HIV and SRHR services for women who use drugs, SASO (India)



7. Conclusions and key messages

This review confirmed that there are a growing number of interesting and important experiences in putting HIV/SRHR integration into practice among key populations in a variety of contexts. In many cases, such initiatives are beginning to demonstrate results – such as increasing the range and quality of HIV and SRHR services available to key populations. Often, the successes build upon the established reputations of key population organisations within communities and their ongoing use of creative and evidence-based approaches.

The review also demonstrated, however, that, despite the ‘push’ towards HIV/SRH integration for key populations, there remain a number of fundamental **challenges** [see **Figure 21**]. These require further acknowledgement and research in India and elsewhere.

Figure 21: ‘Top 10’ challenges in HIV/SRHR integration for key populations

1. **Stigma and discrimination related to HIV and key populations.** For example, government SRHR clinics being judgmental of sex workers and PLHIV experiencing self-stigma (such as not having the right to have children).
2. **Low demand for HIV/SRHR integrated services by key populations.** For example with young MSM not being aware of or empowered to demand their SRHR.
3. **Lack of rights-based approaches to HIV/SRHR.** For example, with programmes focusing on changing sex workers’ risk behaviours, rather than respecting their sexuality and promoting their SRH rights. Legal frameworks that violate sexual and reproductive rights serve as barriers to providing comprehensive services.
4. **Low attention to gender inequality in HIV/SRHR integration.** For example, with projects not recognizing the very different SRHR needs of male and female PLHIV or SRHR initiatives for people who use drugs not involving men.
5. **Missed obvious opportunities for HIV/SRHR integration.** For example, with organisations not using regular STI checks for sex workers or post-test counseling for PLHIV as ‘entry points’ for comprehensive contraceptive options.
6. **Low understanding of key populations’ specific and diverse HIV/SRH needs.** For example, people who use drugs may have very *different* needs for SRHR (such as depending on if they are male/female, young/old, living with HIV, etc.)

7.	Presumptions or lack of expertise among service providers. For example, with doctors presuming that anal STIs are only of relevance to male (not female) sex workers or counselors lacking skills to support transgender people.
8.	Lack of a strong referrals systems for HIV/SRHR. For example, weak referral systems may result in losses to follow-up when an individual is referred for further specialized services. Lack of sensitization of the service provider to which a sex worker is provider could lead to her being stigmatized.
9.	Inappropriate design of HIV/SRHR integration. For example, when programme design is not based on needs assessments and the quality of existing services, uses unsuitable delivery methods or does not follow community priorities.
10.	Lack of political, technical and financial support to create the enabling environment for scale-up of integrated services. For example, limited financial resources available for advocacy for integration, law reform and sexual and reproductive rights.

Furthermore, these challenges need to be taken into account when national responses aim to scale up SRHR/HIV integrated programming. While this approach clearly has the potential to increase reach and improve quality of interventions, integrating services and systems that are not ready may in the short-run actually compromise outcomes for key populations.

Based on the findings and conclusions of the review, a number of key messages can be identified about principles, practices and actions to increase and improve HIV/SRHR integration for key populations:

HIV/SRHR Integration for KPs: Key Messages

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



Annex 1: List of resources for review

Sources of information for review

The information for this report was predominantly sourced from the websites of the following organisations:

India:

- India HIV/AIDS Alliance
- PATH
- Government of India
- The Humsafar Trust
- MAMTA Health Institute for Mother and Child
- Social Awareness Service Organisation

Global:

- International HIV/AIDS Alliance
- International Planned Parenthood Federation
- Guttmacher Institute
- Family Health International
- Engenderhealth
- Marie Stopes International
- Interact Worldwide
- Global network for each key population:
 - Global Network of People Living with HIV
 - International Community of Women Living with HIV
 - International Network of People Who Use Drugs
 - Global MSM Forum
 - Network of Sex Worker Projects
- UN agencies – UNFPA, WHO and UNAIDS
- www.srhivlinkages.org online resource pack of Inter Agency Working Group
- www.hivandsrh.org website of the Centre for Communication Programs, Johns Hopkins University Bloomberg School of Public Health and Constella Group

Indian resources included in review

This report is informed by a review of the following resources from India:

Resources related to HIV/SRHR integration for key populations (general)

- *Options and Challenges for Converging HIV and Sexual and Reproductive Health Services in India: Findings from an Assessment in Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh*, PATH, June 2007.
- *Convergence of HIV and SRH Services in India: Impacts on and Implications for Key Populations: A Literature Review*, HIV-SRH Convergence Project (India), PATH, January 2007.
- *What is Convergence? Policy and Practice Update 2*, HIV-SRH Convergence Project (India), PATH, March 2007.
- *HIV-SRH Convergence, Policy and Practice Update 4*, HIV-SRH Convergence Project (India), PATH, December 2009.
- *Convergence of Sexual and Reproductive Health (SRH) and HIV/AIDS Services in India, Policy and Practice Update 3*, HIV-SRH Convergence Project (India), PATH, April 2009.
- *SRH-HIV Convergence Newsletter*, HIV-SRH Convergence Project (India), PATH, April 2006.
- *Integration of HIV/STI/AIDS in Family Planning Services: The FPAI Experience*, The Journal of Family Welfare (Volume 48), Professor Vimla Nadkarni, 2002.
- *Annual Report 2008-2009*, National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India.
- *NACP III: To Halt and Reverse the Spread of the HIV Epidemic in India*, National AIDS Control Programme, Ministry of Health and Family Welfare, Government of India.
- *Red Ribbon Clubs Programme (RRCP) Operational Guidelines for RRC Functionaries*.
- *Targeted Interventions for Migrants: Operational Guidelines*, 2008.
- *Towards Messages that Matter: Understanding and Addressing HIV and SRH Risks among Married Young People in India*, Population Council, March 2007.
- *Annual Report 2009-2010*, National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India.
- *Targeted Interventions Under NACP III: Operational Guidelines Volume 1: Core High Risk Groups*, National AIDS Control Organisation, October 2007.
- *Linking SRHR and HIV – A Community-Centred Approach to Achieving Universal Access*, (draft), India HIV/AIDS Alliance.
- *Community Action for Sexual and Reproductive Health and Rights Policies in Asia: Grant Application to the European Union*, India HIV/AIDS Alliance, 2008.
- *Interim Narrative Report: Community Action for Sexual and Reproductive Health and Rights Policies in Asia*, India HIV/AIDS Alliance, 2011.
- *Setting Up and Managing Sexual Health Clinical Services in Resource-Poor Settings: A Comprehensive Programmatic Guide for NGOs (Volume I)*, India HIV/AIDS Alliance.
- *Building Linkages and Referrals: A Step Towards Sustainability: Alliance India's Experiences*, India HIV/AIDS Alliance.
- *Learning from Our Role in the HIV Response in India: Annual Report 2009-10*, India HIV/AIDS Alliance, 2010.

- *Stories of Significance: Redefining Change: An Assortment of Community Voices and Articulations*, India HIV/AIDS Alliance, 2007.
- *Women and HIV/AIDS: The Changing Face of the Epidemic in India*, India HIV/AIDS Alliance.
- *SRHR/HIV Integration: Alliance India Experiences and Review* (powerpoint presentation), India HIV/AIDS Alliance, August 2011

Resources related to HIV/SRHR integration for specific key populations

- *What Works? Sexual and Reproductive Health (SRH) and HIV Linkages for MSM and Transgender People*, (Draft), International Planned Parenthood Federation, 2011.
- *Linking SRH and HIV to Meet the Needs of MSM and Transgender People: Experiences from India*, (powerpoint presentation), Family Planning Association India, August 2011.
- *Working Towards Better Sexual and Reproductive Health and Rights of PLHIV in India, Report to the European Union*, India HIV/AIDS Alliance, 2011.
- *Community-Based Care and Support Programme: 2000-2010*, MAMTA Health Institute for Mother and Child, 2011.
- *Sexual and Reproductive Health Needs of FSWs, MSMs and TGs: Research Report on Quantitative Findings from Warangal, Guntakal and Piler Sites of Alliance in Andhra Pradesh*, SWASTI Health Resource Centre, December 2008.
- *Integration of SRH Communication and Family Planning with STI/HIV Services among Female Sex Workers*, (poster presentation), India HIV/AIDS Alliance, Avahan Initiative and Mythri.
- *Focused STI Prevention and Treatment Services for Key Population*, (poster presentation), India HIV/AIDS Alliance, Avahan Initiative and Mythri.
- *Strengthening Access to Sexual and Reproductive Health Services for People with HIV and for People at Risk of HIV: Research Evidence to Promote Integration or Convergence of Sexual and Reproductive Health services into HIV Programmes in India*, Policy Brief, HIV-SRHR Convergence Project (India), PATH, 2008.
- *Integration of Sexual and Reproductive Health and HIV-Related Services for Men Who Have Sex with Men (MSM) and Transgender People in India*, (draft), Family Planning Association of India, 2010
- *Convergence of HIV and Sexual and Reproductive Health Service for People Living with or Most at Risk of HIV: A Toolkit for Capacity Building*, HIV-SRHR Convergence Project (India), PATH, December 2009.
- *Antiretroviral Therapy Guidelines for HIV-Infected Adults and Adolescents Including Post-Exposure Prophylaxis*, National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India, May 2007.
- *Guidelines for the Prevention of Mother to Child Transmission of HIV*.
- *Early Infant Diagnosis (EID) Guidelines*.
- *Operational Guidelines for Link ART Centres*, National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India, June 2008.

- *Issue Brief: Sexual and Reproductive Health and Rights – Key Issues for HIV-Affected Widows*, India HIV/AIDS Alliance.
- *Issue Brief: Sexual and Reproductive Health and Rights – Key Issues for Adolescents Affected by and Living with HIV*, India HIV/AIDS Alliance.
- *Samarth Project* (website of USAID India); http://www.usaid.gov/in/our_work/health/hiv_doc8.htm
- *Sexual and Reproductive Health of Women Living with HIV: A Flipbook*, India HIV/AIDS Alliance.
- *Foretelling the Crisis: HIV/AIDS, Sexual and Reproductive Health and Women in India: A Report Based on Knowledge, Attitude and Practice Survey*, India HIV/AIDS Alliance, 2006.
- *Spotlight on Women, Sexual and Reproductive Health and Rights and HIV/AIDS: Programme Brief*, India HIV/AIDS Alliance, 2007.
- *Sexual and Reproductive Health of People living with HIV in India: A Mixed Methods Study*, Indian Network of People Living with HIV, 2007.
- *Integrating HIV Prevention and Family Planning Services: The Aastha Project in Mumbai, India*, Family Health International, 2010.
- *Sexual and Reproductive Health of Males-at-Risk in India: Service Needs, Gaps and Barriers*, India HIV/AIDS Alliance, May 2008.
- *Priority HIV and Sexual Health Interventions in the Health Sector for Men Who Have Sex With Men and Transgender People in the Asia-Pacific Region*, WHO, UNDP, UNAIDS, APCOM and Department of Health of Hong Kong (China), 2010.
- *Barriers to Free Antiretroviral Treatment Access for Men Who Have Sex with Men (MSM) and Transgender Women in Chennai*, India, November 2008.
- *Training Manual: An Introduction to Promoting Sexual Health for Men Who Have Sex with Men and Gay Men*, Naz Foundation India Trust, 2001.
- *Grant Report Form: Mitigating the Impact of Injecting Drug Use and HIV/AIDS on Female Injecting Drug Users in Manipur*, India, India HIV/AIDS Alliance, 2010.
- *Chanura Kol Baseline Study on Women Who Inject Drugs in Manipur*, India HIV/AIDS Alliance.
- *Elton John AIDS Foundation: Project for Female Injecting Drug Users*, (powerpoint presentation), India HIV/AIDS Alliance.
- *Breaking New Ground, Setting New Signposts: A Community-Based Care and Support Model for Injecting Drug Users Living with HIV (A SASO-Alliance Experience)*, India HIV/AIDS Alliance.
- *Exploring the Links between Drug Use and Sexual Vulnerability among Young Female Injecting Drug Users in Manipur*, Population Council, 2008.

Global resources included in review

This report is also informed by a review of the following resources from around the world:

Resources related HIV/SRHR integration for key populations (general)

- *Integration of HIV and Sexual and Reproductive Health and Rights: Good Practice Guide*, International HIV/AIDS Alliance, December 2010.
- *Good Practice HIV Programming Standards: For Use in the Design, Implementation and Evaluation of Alliance Programmes*, International HIV/AIDS Alliance, June 2010.
- *Approaches to Gender and Sexuality: Responding to HIV*, International HIV/AIDS Alliance, February 2011.
- *Thematic Segment: Sexual and Reproductive Health (SRH) Services with HIV Interventions in Practice: Background Paper*, 26th Meeting of the UNAIDS Programme Coordinating Board, June 2010.
- *Mobilizing for RH/HIV Integration: Make or Break?*, Friends Africa, Global AIDS Alliance, Interact Worldwide, International HIV/AIDS Alliance, IPPF and Population International, 2010.
- *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide*, IPPF, UNAIDS, UNFPA, WHO, ICW, GNP+ and Young Positives, 2009.
- *A Framework of Priority Linkages*, WHO, UNFPA, UNAIDS and IPPF, 2005.
- *Integrating HIV Voluntary Counselling and Testing Services into Reproductive Health Settings – Stepwise Guidelines for Programme Planners, Managers and Service Providers*, UNFPA & IPPF (2004).
- *Linking Family Planning with HIV/AIDS Interventions: A Systematic Review of the Evidence*, Spaulding AB, Brickley DB, Kennedy C, Almers L, Packel L, Mirjahangir J, Kennedy G, Collins L, Osborne K & Mbizvo M, AIDS. 23, pp. S79-88, 2009.
- *A Five-year Research Project to Gather Evidence for Delivering Integrated HIV and SRH services in High and Medium HIV Prevalence Settings*, INTEGRA.
- *Integration of HIV and Sexual and Reproductive Health & Rights (SRHR): Report on Existing Alliance Programmes and Policy Work and Potential Strategic Partnerships*, International HIV/AIDS Alliance.
- *Exploring Integrated SRH and HIV Models and Programming Examples from a Variety of Settings in Countries/Areas with Concentrated HIV Epidemics*, Amitrajit Saha, Anna Zakowicz, Dawn Averitt Bridge, Jill Gay, Robert Carr, (Presentation at International AIDS Conference), July 2010.
- *Good Practice Update: Linkages and Integration of Sexual and Reproductive Health, Rights and HIV: The Alliance Approach*, International HIV/AIDS Alliance, March 2009.
- *Intimate Links: A Call to Action on HIV/AIDS and Sexual and Reproductive Health and Rights*, Interact Worldwide.
- *Hiding in Plain Sight: The Role of Contraception in Preventing HIV*, Susan A Cohen, Guttmacher Policy Review, Volume 11, Number 1, Winter 2008.
- *Despite Consensus and Mounting Evidence, Challenges to Improved HIV–Reproductive Health Linkages Remain*, Heather D. Boonstra, Volume 11, Number 4, Guttmacher Policy Review, Fall 2008.
- *Models of Care Project: Linking HIV/AIDS Treatment, Care and Support in Sexual and Reproductive Health Care Settings: Examples in Action*, International Planned Parenthood Federation, 2005.

- *In a Life: Linking HIV and Sexual and Reproductive Health in People's Lives*, IPPF, 2008.
- *In a Life: Linking HIV Treatment, Care and Support in Sexual and Reproductive Health Care Settings*, IPPF, 2006.
- *In a Life: Linking HIV and Sexual and Reproductive Health in People's Lives*, IPPF, July 2010.
- *Sexual and Reproductive Health and HIV Linkages: Evidence Review and Recommendations*, UCSF, WHO, UNAIDS, UNFPA and IPPF, 2009.
- *Integrating HIV/AIDS Treatment and Care into Reproductive Health Settings*, Spotlight No. 4, International Planned Parenthood Federation Western Hemisphere Region, 2006.
- *Special Theme: Strengthening Linkages between Sexual and Reproductive Health and HIV*, WHO Bulletin, Volume 87, Number 11, 805–884, November 2009.
- *Integration between Sexual and Reproductive Health and HIV and AIDS and Malaria: Opportunities and Strategies for the Global Fund to Fight AIDS, TB and Malaria*, IPPF, Global AIDS Alliance, International HIV/AIDS Alliance, Population Action International and Interact Worldwide, November 2006.
- *Consultation to Discuss Country Implementation of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages*, UNFPA, WHO, UNAIDS and WHO, December 2010.
- *Who Are We Failing? How Marginalisation and Vulnerability Affect Adolescents' Needs for and Access to SRHR*, Interact Worldwide, 2011.
- *HIV/AIDS and Reproductive Health: Sensitive and Neglected Issues – A Review of Literature, Recommendations for Action*, IPAS, 2005.
- *Young People Most at Risk of HIV: A Meeting Report and Discussion Paper*, Interagency Youth Working Group, USAID, IATT on HIV and Young People and FHI, 2010.
- *Planning and Implementing an Essential Package of Sexual and Reproductive Health Services Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services*, Population Council and UNFPA, 2010.
- *Programme Guidance for Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings*, IPPF, 2002.
- *Integration of HIV and STI Prevention, Sexuality and Dual Protection in Family Planning Counselling: A Training Manual*, Engenderhealth, 2009.
- *Counselling on Dual Protection: STD/HIV and Pregnancy: A Guide for Project Staff*, PATH, 2003.
- *The Balanced Counselling Strategy Plus: A toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings*, Population Council 2008.
- *Getting Closer – Linking HIV and Sexual and Reproductive Health: Self-Assessment Checklist*, NGO Code of Good Practice.
- *HIV/AIDS and Reproductive Health: Sensitive and Neglected Issues: A Review of Literature, Recommendations for Action*, IPAS, 2005.
- *Access to HIV-Related Health Services in Positive Women, Men who have Sex with Men (MSM), Transgender (TG) and Injecting Drug Users (IDU): Research Finding Highlights*, APN+, August 2009.
- *Assessing Integration Methodology (AIM) Toolkit: A Handbook for Measuring and Assessing the Integration of Family Planning and Other Reproductive Health Services*, Population Council, 2008.

Resources related to HIV/SRHR integration for people living with HIV

- *Increasing Access to Contraception for Clients with HIV: A Toolkit*, Family Health International, 2008.
- *Meeting the Sexual and Reproductive Health Needs of People Living with HIV*, Guttmacher Institute, UNAIDS, UNFPA, WHO, EngenderHealth, IPPF, ICW and GNP+, 2006.
- *Reproductive Choices and Family Planning for People Living with HIV – Counselling Tool*, WHO, 2006.
- *Positive Health, Dignity and Prevention: Technical Consultation Report*, GNP+ and UNAIDS, 2009.
- *Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A Guidance Package*, GNP+, ICW, Young Positives, EngenderHealth, IPPF and UNAIDS, 2009.
- *The People Living with HIV Stigma Index*, IPPF, GNP+, ICW and UNAIDS, 2008.
- *Amsterdam Statement on Sexual and Reproductive Health and Rights for People Living with HIV*, GNP+, December 2007.
- *Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls: Manual for Trainers and Programme Managers*, ENGENDERHEALTH and International Community of Women Living with HIV, 2006.
- *Integrating Family Planning and Antiretroviral Therapy Services in Uganda*, Family Health International, 2010.
- *Integrating Family Planning into HIV Care and Treatment Services in Kenya*, Family Health International, 2010.
- *Preventing Mother-to-Child HIV Transmission through Family Planning in Maternal and Child Health Services: Kenya, Rwanda, and South Africa*, Family Health International, 2010.
- *Increasing Access to Contraception for Clients with HIV: A Toolkit*, Family Health International and Engenderhealth, 2010.
- *Increasing Support for Contraception as HIV Prevention: Stakeholder Mapping to Identify Influential Individuals and Their Perceptions*, Family Health International, Plos ONE Volume 5, May 2010.
- *A Five-Country Study of Family Planning and HIV Integrated Services*, Family Health International, 2010.
- *Integrating Family Planning Services into Voluntary Counseling and Testing Centers in Kenya: Operations Research Results*, Family Health International, 2006.
- *Family Planning–Integrated HIV Services: A Framework for Integrating Family Planning and Antiretroviral Therapy Services*, The Acquire Project and USAID, June 2007.
- *Ten Essential Steps: How to Strengthen Family Planning and HIV Service Integration*, Family Health International.
- *Sexual and Reproductive Health of Women Living with HIV/AIDS: Guidelines on Care, Treatment and Support for Women Living with HIV/AIDS and Their Children in Resource-Constrained Settings*, WHO, 2006.
- *Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV, Report of Study on the Uptake of Prevention of Mother to Child Transmission of HIV Services by People Living with HIV in Nairobi, Kenya*, NEPHAK and GNP+, January 2010.
- *Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: Key Findings from Studies in Kenya, Nigeria and Zambia*, GNP+, NEPHAK, NZP+ and NEPHAN, April 2010.

- *Meeting the Sexual and Reproductive Health Needs of People Living with HIV*, (Article on website of Guttmacher Institute), November 2006.
- *Linking Family Planning to PMTCT: Empowering Women Living with HIV*, WHO.
- *Piecing It Together for Women and Girls: The Gender Dimensions of HIV-Related Stigma: Evidence from Bangladesh, Dominican Republic and Ethiopia*, IPPF, 2011.
- *HIV Discordant Couples – An Exploratory Study: Insights from South Africa, Tanzania and the Ukraine*, GNP+, HRSC and University of Witwatersr, 2009.
- *Healthy, Happy and Hot*, IPPF, 2010.
- *Becoming Pregnant When You're HIV Positive*, The Body, 2010.
- *Expanding Reproductive Rights and Knowledge Among HIV-Positive Women and Girls*, IPAS, September 2010.
- *HIV Discordant Couples: An Exploratory Study: Insights from South Africa, Tanzania and the Ukraine*, GNP+, HSRC and University of the Witwatersr, June 2009.
- *Needs, Challenges and Opportunities: Adolescents and Young People Living with HIV in Zambia: Briefing Paper*, International HIV/AIDS Alliance, 2011.
- *Gateways to Integration: A Case Study from Serbia*, WHO, UNFPA, UNAIDS and IPPF, 2009.
- *Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services*, WHO, USAID and Family Health International, 2009.
- *Gateways to Integration: A Case Study from Kenya*, WHO, UNFPA, UNAIDS and IPPF, 2008.
- *Gateways to Integration: A Case Study from Haiti*, WHO, UNFPA, UNAIDS and IPPF, 2008.
- *Caribbean: Country Study, Alliance Country Studies: A Global Summary of Achievements, Progress and Challenges under IMPACT 2010*, International HIV/AIDS Alliance.
- *Case Study: Zimbabwe, Integration of Family Planning and HIV Services in Zimbabwe: Hormonal Implants and Dual Protection Messages*, PSI Zimbabwe.
- *Tools for Facilitative Supervision in FP/ART-Integrated Services*, EngenderHealth, 2007:
 - Essential Elements of an FP-Integrated Antiretroviral Treatment (ART) Program
 - Supervision for FP-Integrated Antiretroviral Therapy Services
 - Checklist for Assessing Performance of the Off-Site Supervisor: FP-Integrated ART Services
 - Checklist for Assessing Performance of the On-Site Supervisor: FP-Integrated ART Services
 - Supervisory Style Self-Assessment Checklist.

Resources related to HIV/SRHR integration for sex workers

- *Advancing Sexual and Reproductive Health and Rights for Sex Workers*, (powerpoint presentation), UNFPA Asia Pacific Regional Office, August 2011.
- *Advancing the Sexual and Reproductive Health and Human Rights of Sex Workers Living with HIV: Policy Briefing*, GNP+ and NSWP, May 2010.
- *Sexuality and Development: Brazilian National Response to HIV/AIDS Amongst Sex Workers*, Associacao Brasileira Interdisciplinar de AIDS, 2010.
- *Sex Work, Violence and HIV*, International HIV/AIDS Alliance, 2008.
- *HIV and STI Prevention among Sex Workers in Eastern Europe and Central Asia*, UNAIDS, 2006.

- *Development Connections: A Manual for Integrating the Programmes and Services of HIV and Violence against Women*, UNIFEM 2009.
- *Addressing Violence against Women in HIV Testing and Counselling: A Meeting Report*, WHO, 2006.
- *Sex Work Harm Reduction*, Michael L Rekart, the Lancet Volume 366, December 2005.
- *Sex Work, Violence and HIV: A Guide for Programmes with Sex Workers*, International HIV/AIDS Alliance, May 2008.
- *Violence and Sex Work: Learning from the Results of Monitoring and Evaluating Community-Led Violence Responses among Female Sex Workers in India: Think Piece*, India HIV/AIDS Alliance.
- *Standard Package of Activities: Entertainment Workers*, Khmer HIV/AIDS NGO Alliance, July 2008.
- *Linking Reproductive Health to HIV & AIDS Prevention Projects: Case of Integrated Health Centers (IHCs) in Chittagong, Bangladesh*, Young Power in Social Action, 2008.
- *Working Together SRH & HIV/AIDS NGOs and CBOS in Ecuador: The Experience of Frontiers Prevention Programme*, Javier Hourcade Bellocq, LAC Team, (powerpoint presentation), International HIV/AIDS Alliance.

Resources related to HIV/SRHR integration for men who have sex with men and transgender people

- *Sexual and Reproductive Health Services for MSM and Transgenders in Asia and the Pacific: Challenges for Future Programming*, (powerpoint presentation), FHI 360 Asia Pacific Region, August 2011.
- *Summary Report of Key Findings and Programme Recommendations: From FHI MSM Programme Evaluations (Bangladesh, Indonesia and Nepal)*, Family Health International.
- *Advancing the Sexual and Reproductive Health and Human Rights of Men Who Have Sex with Men Living with HIV: Policy Briefing*, GNP+ and MSMGF, May 2010.
- *Advocacy Brief: Integration of Sexual and Reproductive Health and HIV-Related Services for Men Who Have Sex with Men (MSM) and Transgender People in India*, (draft), Family Planning Association of India, 2010.
- *Between Men: HIV/STI Prevention for Men Who Have Sex With Men*, International HIV/AIDS Alliance, August 2003.
- *Country Study: Morocco*, International HIV/AIDS Alliance.
- *Looking Back, Moving Forward: Understanding the HIV Risk and Sexual Health Needs of Men Who Have Sex With Men: Horizons Studies 2001 to 2008*, Horizons, 2010.
- *Developing Community-Based Organisations Addressing HIV/AIDS, Sexual Health, Welfare and Human Rights Issues for Males-Who-Have-Sex-With-Males, Their Partners and Families*, NAZ Foundation International.
- *Standard Package of Activities: Men Who Have Sex With Men*, Khmer HIV/AIDS NGO Alliance, July 2008.
- *Regional Consensus Meeting: Developing a Comprehensive Package of Services to Reduce HIV Among Men Who Have Sex with Men and Transgender Populations in Asia and the Pacific*, UNDP, ASEAN, WHO, UNESCO, UNAIDS, USAID, APCOM, 2009.
- *HIV and Men Who Have Sex With Men in Asia and the Pacific: UNAIDS Best Practice Collection*, UNAIDS, 2006.

- *Prevention and Treatment of HIV and Other Sexually Transmitted Infections Among Men Who Have Sex With men and Transgender Populations: Report of a Technical Consultation*, WHO, 2008.
- *UNAIDS Action Framework: Universal Access to Men Who Have Sex With Men and Transgender People*, UNAIDS, 2009.
- *The Value of Investing in MSM Program in the Asia-Pacific Region: Policy Brief*, Health Policy Initiative, 2008.
- *Peer Outreach and Education for Improving the Sexual Health of Men Who Have Sex with Men: A Reference Manual for Peer and Outreach Workers*, USAID, FHI, PSI Asia, International HIV/AIDS Alliance, UNESCO and Purple Sky Network, 2007.

Resources related to HIV/SRHR integration people who use drugs

- *Advancing the Sexual and Reproductive Health and Human Rights of Injecting Drug Users Living with HIV: Policy Briefing*, GNP+ and INPUD, May 2010.
- *Linking Sexual and Reproductive Health and HIV: Advocacy Brief on People Who Use Drugs*, Indonesia, IPPF East and South Asia and Oceania region, 2011.
- *Women, Harm Reduction and HIV*, International Harm Reduction Development Programme, OSI.
- *Module 11: Psychiatric Illness, Psychosocial Care and Sexual Health Treatment and Care for HIV-Positive Injecting Drug Users*, Family Health International, USAID, ASEAN and WHO, 2007.
- *Linking SRH and HIV: Advocacy Brief on People Who Use Drugs, Indonesia*, (draft) East and South East Asia and Oceania Region IPPF, 2011.
- *HIV and Drug Use: Community Responses to Injecting Drug Use and HIV: Good Practice Guide*, International HIV/AIDS Alliance, 2010.
- *Hidden Women* (web page on women who inject drugs in Malaysia) (page of www.aidsalliance.org; accessed 5.4.11)
- *Female Drug Users and Female Regular Sex Partners of Male Drug Users in Bangladesh: A Report*, UNAIDS, ICDDR, UNODC and WHO, 2010.
- *Developing HIV/AIDS Work with Drug Users – A Guide to Participatory Assessment and Response*, International HIV/AIDS Alliance.
- *Standard Package of Activities: Drug Users*, Khmer HIV/AIDS NGO Alliance, July 2008.
- *Making Harm Reduction Work for Women: The Ukrainian Experience*, OSI, 2010.

Annex 2: Key SRHR vulnerabilities for key populations: Alliance Good Practice Guide

The following is an extract from *Integration of HIV and Sexual and Reproductive Health and Rights: Good Practice Guide*, International HIV/AIDS Alliance, 2010:

Group	Key SRHR vulnerabilities	What change is needed?
People living with HIV	<ul style="list-style-type: none"> • Many people do not know that they have HIV and do not access safer sex and treatment services. • Many people suffer blame and violence upon disclosure of their HIV status, particularly women, who are often diagnosed first at antenatal clinics. • Stigma and discrimination can lead to loss of partner, children and home; poor access to services; poor quality care; isolation; and lack of work and housing. • Lack of financial resources to access services and commodities. • People share ART and food with children and partners. • Some people disapprove of people living with HIV engaging in sexual activity and having children, leading to stigma and discrimination. • Reluctance of health workers to give reliable contraceptives to people living with HIV because of the fear that they will stop using condoms. • Health providers may lack knowledge of safer methods of conception for people living with HIV and on ART. • In some parts of the world, it is difficult for HIV-positive women to assert their right to have a safe abortion. Other women are pressured to have an abortion because of their HIV status. • Increased risk of STIs, cancers and maternal mortality. 	<ul style="list-style-type: none"> • Increased access to HIV testing, safer sex information and treatment services. • Counselling on partner violence integrated into HIV and couples/family counseling. • Reduction in stigma and discrimination. • Access to ART and other treatment resources for better health. • Comprehensive information and services to allow a healthy and satisfying sexual life. • Choice about contraception, safe abortion and whether or not to have children. • Ability to reduce risk of HIV transmission to children.

People who use drugs

- Women who use drugs and female partners of men who use drugs lack services.
- Focus on preventing HIV transmission via injecting omits SRH needs.
- Babies may be abandoned at birth because of fear of arrest and because of poor access to opiate substitution treatment in pregnancy and labour.
- Childbearing is disapproved of and children taken into care.
- Multiple causes of stigma.
- Friendly SRH services for drug users, linked to harm reduction services. SRH and other health services must ensure they don't exclude active drug users.
- STI diagnosis and treatment services alongside or integrated into harm reduction services.
- Drug user-friendly pregnancy and maternal health services for women who use drugs, including PPTCT and opiate substitution treatment.
- Drug user-friendly contraception, dual protection, emergency contraception and safe abortion services. Women who use drugs may find longer acting contraceptives such as implants more acceptable than the pill.

Female sex workers

(In addition to the SRHR vulnerabilities of all women)

- Sex workers experience stigma and discrimination demonstrated through physical and verbal abuse, and often criminalization. The focus on HIV/STI prevention omits other SRH needs such as family planning and MNCH.
- The home life of sex workers, including their regular partners and children, is ignored.
- Only 21% of countries have anti-discrimination laws that protect the rights of sex workers.
- Social attitudes result in moralistic or punitive approaches to stop sex work rather than meet the SRH and HIV needs of sex workers.
- Emotional, psychological and physical violence is common and is exacerbated when sex work is forced underground e.g. selling sex in more hidden, unfamiliar areas; limiting the ability to develop solidarity with other sex workers to build support and social capital, and negotiate with health and social service providers.
- Lack of legal protection from the police and judiciary, even where sex work is legal due to societal attitudes or related activities such as soliciting for clients being illegal, making sex workers less likely to make a complaint to the authorities if they have experienced violence.
- Lack of understanding of sex workers' rights.
- Limited participation and prioritisation of sex workers in SRH and HIV responses.
- A large proportion of sex workers are invisible and difficult to reach.
- Counselling on preferred contraceptives, condoms and other safer sex methods (intrauterine devices alone may increase risk of HIV/STI infection).
- Discussion of the impact of hormonal pills, injections or implants on menstrual bleeding.
- Counselling for sex workers who want to conceive but ensure that their lover is the father.
- Counselling on sex work during pregnancy and reducing the risk of STIs and HIV for the mother and foetus.
- Discuss anti-violence strategies with sex workers, support collectivisation and creation of safe spaces and link up with sex-worker friendly legal, health and support service providers.
- Support the mother to attend antenatal care, and plan for where she will deliver, costs and care for the baby after it is born.

<p>Male and transgender sex workers</p>	<ul style="list-style-type: none"> • Multiple layers of stigma related to sex between men, sex work, gender identity and HIV status. • Social attitudes result in moralistic or punitive approaches to stop sex work rather than meet sex workers' SRH and HIV needs. • Sex between men and sex work is criminalised in many countries. • Less attention is given to male and transgender sex workers in the HIV and SRH response. • Male sex workers who also have female partners and children find it difficult to talk to them about their work and HIV risk. 	<ul style="list-style-type: none"> • Information on the risks of all sexual practices and how to reduce them. • Services for anal and oral STIs. • Learning sessions and counselling on reproductive health, fertility, protection of female partners and children, and PPTCT. • Interventions to increase self-esteem and reduce stigma.
<p>Men who have sex with men</p>	<ul style="list-style-type: none"> • Stigma, discrimination and criminalisation of same-sex relationships. • Lack of information on a range of sexual practices, including anal sex, and how to make them safer. • Lack of user-friendly services able to respond to the specific needs of men who have sex with men such as anal STIs. • Lack of information and services on reproductive health, including protecting fertility and preventing HIV transmission to female partners and children. • Difficulty disclosing HIV risk to female partners due to stigma and social inequality. • 41% of countries reported laws, regulations and policies that hinder the delivery of effective HIV-related services for men who have sex with men. 	<ul style="list-style-type: none"> • Specific information and services; for example, related to anus and rectum damage, oral and anal gonorrhoea, hepatitis and anal cancer. • Comprehensive information on the risks of sexual practices and how to make them safer. • Information about reproductive health including fertility, how to avoid STIs and HIV transmission to female partners and children, and PPTCT. • Positive role models to tackle issues around self-esteem. • Discreet services to help avoid stigma, such as trained, non-judgmental doctors. • Work to reduce stigma is vital.

Male to female transgender and transsexual people

- Multiple causes of stigma, discrimination and criminalization.
- Violence, rape and murder.
- Persecution by the law and state.
- Police abuse and imprisonment.
- Rejected by society, school and workplace and forced into sex work.
- Poverty.
- Prejudice, violence and discrimination by health service providers.
- Lack of comprehensive information and services to meet SRH and HIV needs.
- Unsafe surgery and hormone injections. Misuse of silicone and oils as implants.
- Low self-esteem and depression.
- Use of drugs and alcohol.
- Health care workers trained to treat transgender people with respect (using their preferred name, allowing the use of female toilets and being non-judgmental).
- Acknowledge geographic and social isolation and potential trauma history.
- Counselling and learning sessions on accepting being female.
- Provision of safer alternatives to prosthetic and implant materials.
- Vaccinations for hepatitis A and B.
- Information on STIs and timely treatment.
- Small condoms for neopenises and urgent consultation if condoms slip or break.
- Lubrication for neo-vaginas.
- Information on possible interaction between ART and hormones

Annex 3: Gender and SRHR issues for people who use drugs: Alliance Good Practice Guide

The following text is an extract from: *HIV and Drug Use: Community Responses to Injecting Drug Use and HIV: Good Practice Guide*, International HIV/AIDS Alliance, 2010.

Women

Women are affected by drug use in many ways. Some of these effects are similar or the same for men, but some are very different. When we speak about women's needs in relation to drug use and HIV we include:

- women who use drugs
- women who are partners of drug users, including wives and widows
- women who use drugs and sell sex
- pregnant women who are using drugs, and mothers who are using drugs
- women living with HIV who are using drugs
- young women and girls.

These different (and not mutually exclusive) social roles, behaviours and factors can lead to multiple vulnerabilities, needs and risk practices.

Large numbers of women are married to or in a sexual relationship with men who use drugs, yet they do not use drugs themselves. Because of high rates of HIV among men who use drugs, these women and their babies and children are very vulnerable to the sexual transmission of HIV. Many of them be unaware of their vulnerability.

Lack of “women-friendly” services

Most services for people who use drugs are directed towards the needs of men. This can mean that women feel like outsiders and that their needs are not met. For example, many drugs services, do not offer pregnancy or maternal health services or programmes for women with children. Support groups or peer education groups run by men who use drugs can exclude or intimidate women, or simply not meet their needs. Alongside this, services targeting women, such as SRH services or micro-financing programmes, often lack the skills and experience to work effectively with women who use drugs.

Gender and vulnerability

Gender is an important factor in vulnerability to HIV:

- Women have particular vulnerabilities to HIV related to injecting drug use.
- Drug use, including injecting drug use, is influenced by gender norms in different cultures or sub-cultures.
- Men who have sex with men, and transgender people who use drugs often experience multiple vulnerabilities in terms of HIV – sex work, marginalisation and increased exposure to violence and abuse.

Women and injecting – risks and vulnerabilities

Studies in nine European countries show that the average HIV prevalence among women who inject is 50% higher than among men who inject. Studies in China and Kenya also demonstrate higher HIV prevalence amongst women who inject.

Many women begin injecting drugs in the context of sexual relationships, and they often borrow or share injecting equipment from their male partners. Gender inequality in many developing and transitional countries is also reflected in social patterns that can affect injecting practices. For example, women:

- are more likely to be injected by their male partners – being injected by another person or being helped to inject is a predictor of HIV infection
- are more likely to be the last person to use shared injecting equipment
- who inject drugs are often dependent on their sexual partners to obtain drugs, which compromises their ability to negotiate safer sex or safe injecting practices.

Women who inject drugs have lower access to services than men who inject drugs. There is evidence of this among HIV prevention programmes in Central and Eastern Europe and South-East Asia, and among drug dependence treatment programmes in South Asia.

Women, sex work and drug use

Many women engage in commercial sex or transactional sex to deal with drug dependency, poverty and homelessness. Commercial sex is generally the exchange of sex for money, whereas transactional sex can be more informal and involve the exchange of sex for drugs, a place to stay or food. For example, women who use drugs in Imphal, Manipur, exchange sex for drugs and for a place to sleep.

Women who use drugs are more likely to take risks in sex work because of their drug habits or those of their partners, and are less likely to work in brothels. They are less likely to have access to or use condoms. A study in China showed that drug-using sex workers were likely to have more clients and use condoms less often than non-drug-using sex workers.

Pregnancy and motherhood

Women who use drugs and are pregnant need extra support. Often the reverse happens and they are marginalised as health care workers, families, partners and the women themselves assume that their drugs will be causing substantial harm to their unborn babies. In fact, drug-using pregnant women and their unborn babies are more likely to experience problems relating to malnutrition, lack of sleep, lack of medical care and tobacco and alcohol use than from illicit drug use itself. Because women who use drugs sometimes stop menstruating, pregnancies can go undetected. When pregnant women who use drugs are HIV positive as well, the need for supportive medical care intensifies, in particular ensuring access to prevention of mother-to-child transmission (PMTCT) programmes.

Women who use drugs in maternity wards rarely have access to OST. This means they give birth in states of withdrawal, and need to leave hospital immediately after giving birth in order to buy drugs. When women who use drugs discover they are pregnant, it can be a good opportunity to reassess their drug use and seek treatment for drug dependency and HIV, and promote maternal health. Mothers who use drugs may fear losing custody of their children. This means they become reluctant to use services, including HIV and drug dependency services, for fear that their children will be taken away by the authorities.

Annex 4: Ten essential steps to strengthen family planning and HIV service integration (Family Health International)

- 1. Generate demand for integrated services.** Advertise to your clients using posters, brochures, and leaflets. Encourage community health workers, volunteers, and local support groups to tell others.
- 2. Organize services.** Learn how your clients move through the facility. Draw a diagram of the available space; reduce costs by offering services in different rooms, modifying waiting areas, or rearranging moveable fixtures. Determine how services can be changed to reduce waiting time and client costs.
- 3. Ensure commodity security.** Register your facility with the appropriate authorities to receive contraceptives and HIV supplies. Develop a plan for a reliable supply system within the local network and within the facility.
- 4. Train providers.** Provide information and training in basic counseling skills to lower level cadres and community health workers. Learn the World Health Organization's medical eligibility criteria for contraceptive use by people living with HIV. Access free training materials on the Internet, organize in-house study groups, and use peer-to-peer support.
- 5. Screen all clients for an unmet need for contraception.** All women of child-bearing age and all men should be asked about their sexual activity, desire for pregnancy in the near future, and current contraceptive use. Screen clients at regular intervals and update information in their records.
- 6. Foster dual protection and dual-method use.** Develop counseling strategies to encourage male and female clients to use condoms correctly and consistently, and to use condoms with another contraceptive method. Stress the importance of preventing both pregnancy and sexually transmitted infections.
- 7. Challenge provider bias.** Address the tendency of providers to emphasize condoms and neglect other contraceptive methods. Correct the false belief that some contraceptive methods are inappropriate for people living with HIV. Support the right of people living with HIV to enjoy healthy sexual relationships and to become pregnant if desired.
- 8. Reinforce referral systems.** Map all available sources of contraceptive methods not provided on site (public and private facilities and those operated by nongovernmental organizations). Develop a contact list with phone numbers and e-mail addresses. Institute a monthly follow-up system to track completed referrals.
- 9. Strengthen skills for supportive supervision.** Update documents—supervision protocols, monitoring forms, provider job descriptions, and checklists—for consistency with the provision of integrated services. Make sure these documents address contraception and challenges in promoting dual protection and dual-method use.
- 10. Monitor and evaluate performance.** Determine whether the family planning service or the HIV service is responsible for reporting the delivery of integrated services. Collect relevant service data during an appropriate time frame, using standard indicators and reporting systems. Review the data as a team and use that information to improve the services you provide.

[Reference: *Ten Essential Steps: How to Strengthen Family Planning and HIV Service Integration*, Family Health International]



India HIV/AIDS Alliance

Kushal House, Third Floor

39 Nehru Place

New Delhi – 110019

+91-11-4163-3081

info@allianceindia.org

www.allianceindia.org