



Invited paper

Sexual and Reproductive Health and Rights: Integration as a Holistic and Rights-Based Response to HIV/AIDS

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A B S T R A C T

For decades, donors, governments, and civil society have recognized the importance of sexual and reproductive health and rights (SRHR) in efforts to alleviate poverty and advance gender equality and women's rights. More recently, in the battle against HIV/AIDS—and given the unique challenges the pandemic presents for health and development—the global community has acknowledged the benefits of synergizing sexual and reproductive health and HIV/AIDS interventions. However, the United States has been slow to incorporate lessons learned from the international experience when it comes to integrating HIV/AIDS, SRHR, and gender equality in the fight against HIV/AIDS. This article highlights the importance of SRHR and lessons learned from SRHR–HIV integration to inform U.S. domestic and global AIDS strategies and interventions.

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What are Sexual and Reproductive Health Rights and Why They are Important

The term “sexual and reproductive health and rights” (SRHR) was defined over 16 years ago at the Cairo International Conference on Population and Development, where the United States went as a world leader seeking consensus for a SRHR policy and plan of action. At Cairo, the International Conference on Population and Development comprehensively defined SRHR to consist of:

[A] state of complete physical, mental and social well-being ... [that] implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that

will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. [R]eproductive health ... also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

Reproductive rights ... rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence. (United Nations Population Fund, 1994).

SRHR as a framework is important because it links health issues related with sex and reproduction and delineates the vital health services individuals need to protect their health including family planning, care during pregnancy and childbirth, and prevention and treatment of HIV and other sexually transmitted infections (STIs) (United Nations Population Fund, 1994). Integrating and coordinating sexual and reproductive health services that are client-centered benefits health care users and providers alike, enabling related health needs to be addressed in a single visit, minimizing transport and other costs to clients, and can bring greater efficiency for health care providers.

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Making the Connections: Why SRHR is Important to HIV/AIDS

Although integration was not prominent at Cairo, since that time, numerous United Nations' agreements have highlighted the importance of integrating services, including the 2006 review of the United Nations General Assembly Special Session on HIV/AIDS (*The Joint United Nations Programme on HIV/AIDS, 2006*).

Today, women represent slightly more than half of those infected with HIV globally, and 60% of those living with HIV in sub-Saharan Africa (*Joint United Nations Programme on HIV/AIDS, 2010*). Young women in every region are also disproportionately vulnerable: In South Africa, HIV prevalence among women aged 20 to 24 years is approximately 21%, compared with about 7% among men in the same age range (*Karim, Sibeko, & Baxter, 2010*).

In the United States in 2007, women accounted for 26% of HIV diagnoses in 34 states where surveillance was conducted by the *Centers for Disease Control and Prevention (2009)*. Black women account for the largest share of new HIV infections among women at 61% (*Henry J. Kaiser Family Foundation, 2011a*), and the HIV incidence rate among Latinas is nearly four times the rate of white women (*Henry J. Kaiser Family Foundation, 2011b*). According to *Advocates for Youth (2003)*, whereas African American women and Latinas account for about 26% of young women between 13 and 24, they account for the majority of HIV infections in this age group.

The connection between SRHR and HIV/AIDS is undeniable; the majority of infections are sexually transmitted (*United Nations Population Fund, 1999*). Biologically, women are more vulnerable to HIV infection during heterosexual sex than men, and they often have less power to refuse sex or negotiate condom use. Poverty, gender inequality, and social marginalization are factors that contribute to both HIV/AIDS and poor reproductive health (*World Health Organization, 2006*).

For women, in the United States and globally, integration of HIV/AIDS and SRHR is particularly important because the majority of infections occur within stable, heterosexual relationships. In Asia, for example, it is estimated that more than 90% of the 1.7 million women living with HIV in Asia became infected from their husbands or partners while in long-term relationships (*Joint United Nations Programme on HIV/AIDS, 2009*).

In this context, women usually do not think of themselves as particularly at risk of infection and therefore are unlikely to search for a specialized HIV service. The risk of an unwanted pregnancy is usually much more salient for women in heterosexual relationships. In a very large number of countries, substantial proportions of women are already clients of sexual and reproductive health services.

The offer of HIV services in an integrated manner has numerous advantages, including reaching a larger number of women and doing so in an environment women are already familiar and comfortable with; offering a wider range of services in an efficient way, contributing to destigmatizing HIV; increasing access to family planning services and counseling for HIV-positive women who want to avoid or delay childbearing and for those who want to have children; and raising awareness about HIV among women who are unaware of their risk. Similarly, the provision of HIV services offers substantial opportunities for increasing access to sexual and reproductive health services.

Findings from a 2009 literature review corroborated the many benefits gained from linking sexual and reproductive health and HIV policies, systems, and services (*Joint United Nations Programme on HIV/AIDS, International Planned Parenthood Federation, United Nations Population Fund, University of California San Francisco, 2009*). Despite diverse settings and clients, the majority of studies reviewed found improvements in health outcomes, including access to and uptake of services, condom use, knowledge of HIV and STIs, and overall quality of health services. Similarly, a 2-year pilot program in Zimbabwe that integrated HIV and STI information and referrals to a community-based family planning program reported a significant increase in the use of male and female condoms. Referrals to voluntary counseling and treatment centers increased from less than 50 to more than 2000 (*Global AIDS Alliance, Interact Worldwide, International HIV/AIDS Alliance, International Planned Parenthood Federation, Population Action International, 2006*). Additionally, integration optimizes existing sexual and reproductive health delivery infrastructures, an especially important approach in resource-scarce settings.

More research on the impact of integrated services, particularly its impact on quality of care and cost effectiveness, is necessary to bolster the evidence base for promoting integration and to ensure implementation at the national and local levels.

Promising Practices: Lessons from the International Experience with Girls and Women and HIV

The International Planned Parenthood Federation (IPPF) has been a champion of integration for many years, having published together with the World Health Organization, the Joint United Nations Programme on HIV/AIDS, and other organizations and United Nations agencies, several studies and reports on the advantages of integration, its challenges, and the mechanisms for its implementation. The IPPF has also acquired extensive experience through its practice in the large network of clinics of member associations in 150 countries around the world. Two important lessons learned from experiences with integration that can inform the HIV response in the United States are 1) addressing the importance of combating stigma, and promoting the rights of people living with HIV, particularly women, and 2) the empowerment of young women and the promotion of their sexual rights.

Often, policies and programs that seek to reduce stigma and discrimination related to HIV status are targeted to gay men and men who have sex with men. Although the harm these groups have experienced as a result of HIV/AIDS stigma is significant everywhere, what is frequently overlooked is that the stigma and discrimination against women living with HIV in developing countries can be much stronger than against men living with HIV.

The IPPF, in partnership with the Joint United Nations Programme on HIV/AIDS, the Global Network of People Living with HIV, and the International Community of Women Living with HIV, developed the Stigma Index to document and measure the stigma experienced by people living with HIV to provide advocates an evidence base for effective programmatic interventions and policy change. A recent study featured on the Stigma Index conducted in the Dominican Republic by IPPF member association Profamilia illustrates the discrimination and stigma HIV-positive women face clearly. In collaboration with

two networks of people living with HIV, Red Dominicana de Personas que Viven con VIH+ and the Alianza Solidaria Para la Lucha Contra el VIH/SIDA, 1,000 interviews were conducted with men and women living with HIV. In almost all aspects that were studied, women were in a severely disadvantaged position (Caceres, 2009).

Both men and women living with HIV had a much higher unemployment rate than the general population, but women's rate was more than twice that of men (58% vs 28%). Both men and women living with HIV tended to come from the poorer sectors of the population, but women were even poorer: 74% of them lived in a household with an annual income of less than US\$3,000. Women suffered discrimination more than men in 10 to 12 categories of discrimination listed in the index. In addition to these 12 types of discrimination, which were perpetrated mostly by social agencies and other relatives, women were frequently victims of physical, sexual, and emotional violence from their partners. Substantial numbers of women said that in the previous 12 months they had been physically abused (42%), forced to have sex (22%), or even threatened with a gun (11%). When asked about violence since the age of 15 years, 53% of the women interviewed said they had experienced violence, more than twice the percentage of women in the general population in the Dominican Republic, pointing to domestic violence as a factor for HIV risk.

Some rights violations are common to both women and men. The power to give informed consent to medical procedures is an important case. In the Profamilia study, 7% of people living with HIV said they had not given their consent to be tested for HIV, and 19% said their status was revealed to other people without their consent. But even in the health care settings, women are at a disadvantage: 20% of women and 11% of men said they were coerced into being sterilized after their HIV diagnosis. Many of the interviewees did not even know what their rights are. Thirty-one percent of the interviewees had never heard of the Dominican law about HIV/AIDS, which had been frequently mentioned in the media for many years. So, the take-home lesson is the importance of educating both patients and providers about clients' rights.

The other important lesson learned—that effective prevention requires the empowerment of young women and the promotion of their sexual rights—can be best illustrated through the work of Profamilia, Colombia, another member of IPPF. Profamilia and IPPF have a long history of promotion of reproductive rights. More recently, inspired by the emerging worldwide awareness of the importance of human rights related to sexuality and the great damage caused by sexual rights violations, IPPF has approved a Declaration of Sexual Rights. Prominent in the Declaration—which was drafted with the help of key human rights experts—are the rights of young people, including their rights to autonomy according to their evolving capacity, a principle already enshrined in the Universal Declaration of the Rights of the Child. Violations of these rights lead to disastrous health consequences, including the spread of HIV.

Concerned with the rapid spread of HIV among young women, as well as with the rapid increase in adolescent pregnancy, Profamilia conducted a Demographic and Health Survey study that revealed a low use of contraceptives and a low level of awareness of risk of infection among sexually active adolescents. Profamilia then conducted another study supported by the World Health Organization to examine in-depth the reasons for the non-use of condoms (Sanchez, 2004). Adolescent girls stated they did not dare to ask for the use of condoms because they

were afraid of what their partners would think, and they found it difficult to have a conversation about sexuality and contraception. Traditional gender relations were prevalent, where sexual initiative was an exclusive male prerogative.

Based on these data, Profamilia launched a major media and education campaign to destigmatize condoms and promote young women as autonomous human beings. Through online courses as well as face-to-face discussions with 1,300 teachers, Profamilia prepared educators to conduct classroom discussions with secondary school students in 93 cities to examine values regarding gender and sexuality, as part of a project of the Ministry of Education. Adolescents then participated in a 42-hour course designed to help empower young women to decide about their sexuality and their lives, not to feel pressured to initiate sexual activity and to do so only when they feel ready, and to feel comfortable in buying, carrying, and requiring the use of condoms when they decide to have sex. With the tag line, "The condom, I am the one who carries it," the campaign engaged Emmy award winner Diana Angel and other well-known young actresses and pop singers to bring the message to adolescent girls and their partners, shaking old preconceived ideas.

The take-home lesson is that for effective prevention, innovative methods are needed to change harmful cultural norms that disempower young women and violate their right to decide about their sexuality. The use of media was very important to reinforce the lessons in the classroom and to counteract the highly visible campaign of disinformation that was rampant in Colombia, where conservative groups distorted scientific information about the condom's efficacy in the prevention of sexually transmitted diseases and pregnancies. It had to disseminate solid evidence, but it also had to address the submissive role assigned to young women to create a new cultural environment of gender equality for shared responsibility and decision-making power.

Promising Practices in the United States: Bidirectional Linkages Between Sexual and Reproductive Health and HIV/AIDS Programs

The White House Office on National AIDS Policy released its National HIV/AIDS Strategy in July 2010. The strategy acknowledges the importance of expanding the availability of health care providers to address HIV/AIDS, pointing to integration with reproductive health care as an effective strategy to reduce the risk of HIV infections. Although the United States has been slow to acknowledge the importance of sexual and reproductive health-HIV integration, there are some examples of where family planning programs have integrated HIV/AIDS, and HIV/AIDS programs have integrated reproductive health.

Sexual and Reproductive Health Integrating HIV

Planned Parenthood of Metropolitan Washington (PPMW) provides comprehensive reproductive health programs that include family planning and HIV prevention. Its youth outreach program, Sexuality and Life Skills Education for Youth, is an important example of sexual and reproductive health-HIV integration in the United States. PPMW educators bring a wide range of comprehensive, medically accurate, interactive, educational programs to local schools, community-based organizations, and faith-based settings. PPMW offers accessible sexual health education that helps young people to make decisions that support their ability to lead healthy lifestyles. PPMW educators

meet young people where they are in their lives, so programs range from reinforcing the need to abstain from sex to protecting against STIs, HIV, and teenage pregnancy.

PPMW's youth program links HIV/AIDS and sexual and reproductive health also through youth health messengers. Teenagers receive 40 hours of training to become peer educators on comprehensive reproductive health. They counsel their friends and family on safer sex—including abstinence, contraception, and STI/HIV prevention—and refer them to Planned Parenthood health centers for services. Youth health messengers also act as media spokespeople and educate and lobby members of Congress (Galeas, S., personal communication, 2011).

In addition, PPMW holistically screens each person who walks through the door. For example, patients are not only asked about their number of sexual partners or whether they are using contraception, but they are also questioned about the last time they were tested for STIs and HIV. If a patient chooses to be tested for HIV and tests positive, he or she receives immediate counseling and referral to area hospitals or clinics for treatment (Galeas, S., personal communication, 2011).

HIV Integrating Sexual and Reproductive Health

The Pediatric AIDS Chicago Prevention Initiative (PACPI) is dedicated to eliminating deaths from pediatric AIDS and to reducing the transmission of the virus from mothers to their children in Illinois. PACPI recognizes that women, particularly those of childbearing age, face unique challenges in the fight against HIV/AIDS. Many women, including most of the women that PACPI encounters, experience extreme poverty and lack control in their sexual relationships (Statton, A., personal communication, 2011). The men in their relationships resist wearing condoms and discussing safe sex behaviors, refuse STI/HIV testing, or will not allow the women to say no to sex. For these reasons and various high-risk factors, many women (over half of PACPI's clients) do not know they are HIV-positive until their first prenatal HIV test or at labor and delivery (for women not accessing prenatal care).

PACPI is firmly committed to the overall health of both mothers and their children and works to ensure that all women in need of support receive high-quality, holistic services. In addition to its own programming, PACPI connects women with public assistance and referrals for other social services needs identified. The organization reaches out to women who may otherwise fall through the cracks; for example, PACPI has facilitated prenatal classes at county jails for pregnant women who are detained and awaiting trial. Women remain enrolled in PACPI's programs until at least 6 months after delivery, when they are then referred by PACPI for longer term case management (Statton, A., personal communication, 2011).

To further address the sexual and reproductive health needs of women, PACPI works with the AIDS Foundation of Chicago, which coordinates a collaborative centralized HIV case management cooperative. During the mandatory 40-hour training for new case managers, PACPI is invited to present on perinatal HIV transmission prevention as well as reproductive health counseling for all clients. Through PACPI's work, they have found that most HIV providers do not discuss reproductive health (other than condoms and pregnancy prevention). PACPI's training is designed to destigmatize pregnancy and to encourage both men and women to think about their reproductive lives as whole persons. At each visit, the case managers are encouraged to ask about pregnancy plans; if clients are not interested,

prevention supports are offered. In the cases where pregnancy is being considered, appropriate referrals are offered to the clients to help them plan for successful childbearing. Although assisted reproductive technologies are often not available at low or no cost to uninsured persons, providers are available to discuss options and risk reduction options (Statton, A., personal communication, 2011).

Lack of prenatal care increases the risk of perinatal transmission; however, women with HIV may avoid services because of the complex issues of denial and fear of child welfare involvement or loss of custody. Issues around substance abuse, multiple sex partners, socioeconomic marginalization, negative interactions with health care and child welfare systems, or lack of social support prevent many women from wanting to learn their status or to treat their HIV infection. The refusal of an HIV test increases the risk of perinatal transmission. Although rapid testing of laboring women and mandatory testing of newborns “forces” disclosure of HIV status, PACPI addresses issues of mistrust and fear of disclosure through developing positive, supportive social relationships with HIV-positive pregnant women. By building a model of support through effective case management and coalitions with Illinois' hospitals, PACPI identifies high-risk women early in pregnancy and gives them the opportunity to know their HIV status so their babies are born free of HIV infection and so the women can live healthy lives themselves.

Through its participation with the National Perinatal HIV Prevention Stakeholders, PACPI is working with the Centers for Disease Control and Prevention (CDC), National Institutes of Health, CityMatCH, and other federal, national and statewide groups to eliminate mother-to-child HIV transmission. The group is working on many fronts including developing national recommendations and/or standards for reproductive health counseling of HIV-positive persons, improving testing and outreach, and identifying pregnancy among HIV-positive persons as well as HIV infection among pregnant women. PACPI has also participated in international learning exchanges with other nongovernmental organizations, working on the prevention of perinatal HIV transmission and integrated approaches, such as Mothers2Mothers in South Africa and Women's Equity in Access to Care and Treatment in Rwanda.

Challenges

Siloed Funding Streams that Lack Flexibility

Traditionally, public health funding silos have created barriers for integrated service delivery in health care settings. There has been a damaging lack of coordination among agencies focused on HIV/AIDS, family planning, and maternal and child health services.

Lack of Coordination Among Government Agencies

U.S. government agencies that address HIV/AIDS and reproductive health are not closely coordinated, presenting an obstacle for successful integration of sexual and reproductive health and HIV services. Federal agencies need to stipulate stronger and measurable harmonization of communications between agencies that provide HIV- and reproductive health-related services.

Opposition to Comprehensive Sexuality Education

Over the past decade, there has been considerable attention and visible opposition to comprehensive sexuality education. This has led to funding for abstinence-only and abstinence-until-marriage only programs and the denial of medically accurate information for youth. Even though there is increasing information and evidence to support a comprehensive approach, some political leaders continue to ensure that abstinence-only programs continue to be funded. Ongoing education and advocacy for comprehensive sexuality education are urgently needed to overcome this challenge.

Need for Attention to Human Rights

The protection of the right of women to make informed decisions for themselves and their infants at every phase of diagnosis and treatment is critical. Federal policies and programs tend to avoid explicit acknowledgement of the right of individuals living with HIV to choose or refuse procreation and often fail to concretize that right through real access to associated medical and social services.

Recommendations

Based on the lessons learned and challenges from international and domestic integration programs, the following are recommendations to advance integration in the U.S. response to HIV and AIDS domestically and globally.

1. Both family planning and HIV/AIDS programs should address stigma and discrimination by:
 - Providing accurate and nonjudgmental services and information to ensure voluntary and informed consent for medical procedures and services;
 - Including screening for physical and emotional violence, sexual coercion and forced sex, and provide meaningful referrals for legal, social, and medical services;
 - Increasing community-based integrated health services;
 - Providing male and female condoms, in addition to nonjudgmental education and skills for condom use negotiation, as dual protection for family planning and HIV prevention; and
 - Proactively educating providers and patients about their rights, and have policies that establish disciplinary action for providers who violate rights or perpetuate stigma.
2. Both family planning and HIV/AIDS programs should require empowerment of young women and promotion of sexual rights by:
 - Providing comprehensive and medically accurate sexuality education that is age appropriate and youth friendly;
 - Designing and implementing education campaigns and programs that destigmatize condom use and promote female and male condoms as responsible methods to prevent HIV infection and unintended pregnancies; and
 - Teaching the skills to initiate and negotiate protected sex and to overcome harmful cultural norms that disempower young women.
3. The U.S. federal government should improve integration and coordination of services by:
 - Creating a mechanism for federal agencies to coordinate and synchronize communication and services among all federal

agencies that provide HIV and reproductive health services; and

- Ensuring that those who staff sexual and reproductive health and HIV services are adequately trained to provide integrated services and referrals with compassion and respect for individual rights.

Conclusion

A serious shortcoming to the U.S. response to HIV/AIDS is the failure to fully develop programs and collaborative efforts among relevant government agencies that are based in human rights and address linkages between sexual and reproductive health and HIV risk. If the world is to effectively address HIV/AIDS among women and girls in the United States and abroad, it is critical to ensure coordination and integration of sexual and reproductive health services with all aspects of HIV care—prevention, diagnosis, treatment, care, and support—and meet the diverse needs of women, men, and young people.

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