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

Overview of sexual and reproductive health services for people with HIV and people at risk of HIV

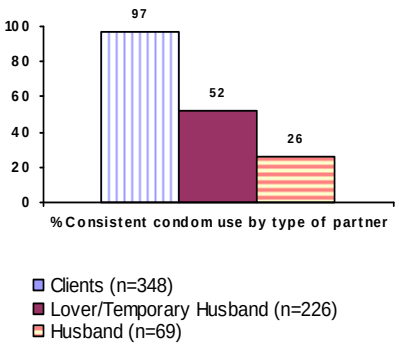

Figure 1 - Sex workers report consistent condom use with different sexual partners.

(Source: Population Council)

There are 2-3 million people living with HIV in India and up to 90% of these people do not know their HIV status. [1] There are approximately 6.7 million induced abortions every year [2] and 5% of the whole population of reproductive age in India (approximately 25 million people) suffer from a reproductive tract (RTI) or sexually transmitted infection (STI). The presence of RTIs and STIs can increase the chance of HIV infection, but 78% of these infections go unnoticed. In addition, only 35% of women know that consistent condom use can reduce the chance of getting HIV and only 48.5% of currently-married women use a modern method of contraception - the vast majority of these women (77%) using female sterilisation. [3]

The HIV epidemic in India is concentrated in certain key populations*, which include people who sell sex, people who inject drugs, males who have sex with males and transgenders. The National AIDS Control Organisation (NACO) estimates that there are 22 million people who are at risk of HIV in India. Whilst there is evidence to show that messages about safer sex are being put into practice with casual or commercial partners, key populations have much more difficulty putting these messages into practice with regular partners or spouses. A recent study by the Population Council with sex workers in India showed that 97% reported high levels of consistent condom use with clients. Of those with lovers, only half reported consistent condom use and only a quarter of those sex workers who were married reported condom use with their husband (Fig. 1). [4]

Sex workers, MSM and people who inject drugs are highly stigmatised by society and as a result have great difficulty in getting their sexual and reproductive health (SRH) needs met and in accessing critical services.

* We use the term 'key' populations because people with HIV and those at risk of HIV are important both to the dynamics of the epidemic and to finding the right solutions.

PATH
A catalyst for global health

Priya is a 24-year-old HIV-positive woman. Her husband also has HIV, and they do not use condoms when they have sex. Priya suffers regularly from vaginal thrush, which she treats with a home remedy. She is worried about other reproductive tract infections (RTIs) and has heard that positive women are more susceptible to cervical cancer. She hopes very much to have a child, but not yet. She does not know what might happen to her or the child and needs more information. In the mean time, she would like to access family planning and have regular gynaecological check-ups but hears from others that the health workers will only offer sterilisation and tell her to abstain from sex. Although she is a member of the local network for positive people, these issues are not part of their agenda, and she does not know who she can go to for information.

(Case study from Srikakulam)

Rani is a 24-year-old street-based sex worker in Patna. She has two children. Although she has learned through awareness campaigns conducted by peer educators that condoms prevent sexually transmitted infections (STIs) and other diseases, she cannot insist on condom use with her customers and often has unsafe sex. She complains of heavy bleeding and that her uterus comes out frequently. She does not go to the doctor, for fear she may be stigmatised and discriminated against. As a result, she has accessed services from less than fully qualified practitioner who provide herbal treatment. Her actual problems have never been diagnosed by any qualified health care provider/doctor.

(Case study from Patna)

Whilst it is obvious that HIV prevention, care and treatment interventions should be targeted to these key populations, it is less clear why it is necessary to include SRH** services beyond STI prevention and treatment in NACP III. Addressing the SRH needs of key populations can, however, contribute significantly to reducing HIV infections in India. For example, the number of mother-to-child transmissions can be reduced by avoiding unwanted pregnancy, providing access to safe abortion and by promoting safe delivery and PPTCT for those choosing to have children. The dual protection role of condoms (for preventing infection and pregnancy) can be promoted through family planning counseling and discordant couples*** can be assisted to make safe fertility choices. Regular partners of key populations can also be reached through SRH services and offered access to HIV testing and prevention, care and treatment services.

Study objectives and methodology

The Government of India has already recognised the need for converging or linking HIV and SRH services in the Reproductive and Child Health Programme (RCH II), the National AIDS Control Programme launched in 2007 (NACP III), and in the National Rural Health Mission (NRHM). To provide evidence to help operationalise these national policies, PATH assessed the demand and opportunities for and the challenges of implementing HIV and SRH convergence in four states—Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh. The assessment was carried out with HIV and SRH service providers and policymakers and with people at risk of HIV and unintended pregnancy (female sex workers, sexually active young men and women, and people with HIV).

Background information and secondary data on the assessment districts were collected first. This was followed by participatory mapping and analysis of potential convergence options with 1,545 sex workers, young people, and people living with HIV. Semi-structured interviews were then conducted with 159 service providers and 60 policymakers to assess the opportunities for and challenges of implementing the convergence options suggested during mapping activities. The preliminary findings and key convergence options that emerged from the assessment were verified with state and district stakeholders. Local advisory groups in each state were convened to support the assessment process.

** SRH services in this context include STI services, PPTCT and condoms, we also mean counselling about fertility, sex and sexuality; family planning advice and services, prevention and treatment of cervical cancer, counselling and services to manage unwanted pregnancy, ANC and safe delivery, information on rights and services.

*** Where one partner is HIV positive and the other is HIV negative.

Convergence options for strengthening SRH services for people with HIV and people at risk of HIV

Two main options for strengthening government SRH services for people with HIV and people at risk of HIV emerged from the study:

I. Promote access to mainstream SRH, MCH services for key populations – at district hospitals, community health centres, primary health centres etc.

II. Converge SRH services into NGO targeted interventions, ICTCs, ART and Care Centres.

Promoting access to mainstream SRH services for key populations

The study showed that sex workers and men at risk of HIV **rarely** access mainstream government services for any SRH related needs and that in order to strengthen their access it is necessary to:

- Reduce stigma experienced by key populations at mainstream government SRH services.
- Strengthen service providers' knowledge about SRH needs of key populations and HIV positive people.
- Strengthen key population knowledge about SRH issues – to generate demand for SRH services that cater to their needs.

Converging SRH services into NGO targeted interventions (TIs), ICTCs, ART, and Community Care Centres

The study showed that government HIV services, such as ART and ICT centres, are seen by key populations as less stigmatising than government SRH services. Also that there is a demand from key populations for family planning as well as STI services to be added to TIs, ART and ICT centres. Study participants felt that this type of convergence would increase access to SRH services for HIV positive men, who rarely use mainstream government SRH services. Despite a clear demand for converging SRH into HIV programmes, sign-posting or branding of ICT and ART centres as 'HIV' services is off-putting for key populations who requested that the red ribbon signage be reviewed. In many places TIs, let alone ICTCs are not yet rolled out and HIV service providers need training on SRH needs of key populations. NACP III does not provide for NGO TIs adding SRH services beyond STI management and does not yet prioritise adding family planning, abortion services etc. to ICTCs. In addition, although in India there are some successful NGO pilots, there is no research on scaling up convergence of SRH into HIV programmes. Around the world, however, there has been some success. A study in Ethiopia reported reasonably high uptake of modern contraceptive methods in some VCT and PMTCT settings [5] and in Rwanda, 90 percent of HIV-positive women who were offered family planning at a PMTCT-VCT site accepted a method. [6]

Recommendations for national policy

At an International Conference on Actions to Strengthen Linkages between Sexual and Reproductive Health and HIV/AIDS, held in February 2007 in Mumbai, there was a strong recommendation made to take forward India specific action plans for converging HIV and SRH services. This was followed up in November 2007 by WHO and NIRRH at a workshop to develop an India-specific action plan to implement strategies for linking SRH and HIV Programmes. At this workshop the PATH study and other research was presented on strengthening access to SRH services for people with HIV and people at risk of HIV and a series of policy recommendations were made.

These included that India should:

- Review national policy and develop operational guidelines on the SRH needs of key populations for inclusion in NACP III and NRHM/RCH 2.
- Include and emphasise policy on zero tolerance for stigma and discrimination in any health care setting in NACP III and NRHM/RCH 2 and amend operational guidelines to reflect this.
- Commission research particularly on injecting drug users (IDU), males who have sex with males (MSM) and transgender (TG) vulnerabilities to show where we need to concentrate efforts to strengthen SRH.
- Add other SRH communications and services (such as family planning) to HIV programmes in NACP III, particularly to NGO targeted interventions and to ICTCs.
- Develop and roll out: (i) integrated communications packages for peer educators in targeted interventions, that include both SRH and HIV components, (ii) training for HIV service providers in addressing the SRH needs of sex workers, IDUs, MSM and TGs (iii) training for mainstream government providers in stigma reduction.
- Develop standards and indicators to monitor (i) convergence of SRH services into HIV programmes and (ii) stigma and discrimination experienced by key populations particularly in mainstream government health facilities.
- Encourage development partners to support HIV and SRH service convergence in India.

For more information, please contact:

Dr. Amitrajit Saha,
Associate Director, SRH India,
PATH, A-9, Qutab Institutional Area, New Delhi 110067
Tel: +91.11.26530080-88; Fax: +91.11.26530089
Email: asaha@path.org

References

[1] National AIDS Control Organisation (NACO) website. Available at www.nacoonline.org. Accessed January 12, 2008.
[2] Khan ME, Barge S, Kumar N, Almorth S. Abortion in India: Current situation and future challenges. In Pachauri, S (ed.) *Implementing a Reproductive Health agenda In India. The beginning*. New Delhi. Population Council; 1998.
[3] International Institute for Population Sciences (IIPS) and ORC Macro. National Family Health Survey (NFHS 3). Mumbai. IIPS; 2007.
[4] Mahendra VS, Mehrotra S, Srikanthi S, Panda S, Sarna A, Jayasree AK, Prasad R, and Rutenberg N. *Identifying areas for linkages between HIV and SRH for vulnerable populations: An exploratory study to assess female sex workers' sexual and reproductive health needs.* Research Update. New Delhi: Population Council, 2007.
[5] Asnake M and Abera Y. Integrating family planning services in VCT and PMTCT sites: The experience of Pathfinder International-Ethiopia in the Amhara Region. Presented at: International Conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, UN Conference Center, Addis Ababa, Ethiopia , October 9-10, 2006.
[6] Ngendahimana G and Blyth K. Family planning integration in PMTCT-VCT programs in Rwanda. Presented at: International Conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, UN Conference Center, Addis Ababa, Ethiopia , October 9-10, 2006.