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PATHWAYS TO THE INTEGRATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES: POLICIES, PROGRAMS, PRACTICES

The international target of universal access to reproductive health is vital to the success of the Millennium Development Goals (MDGs) and to the effective implementation of population, health and development policies. Attaining sexual and reproductive health and rights for all requires an essential policy package, which originated at the 1994 International Conference on Population and Development (ICPD) and remains relevant today, consisting of:

- a core group of integrated and universally accessible sexual and reproductive health services; buttressed by
- comprehensive sexuality education for adolescents in and out of school; and
- the implementation of laws and policies that protect the human rights of all persons, including their sexual and reproductive rights.

This brief defines the core group of sexual and reproductive health services (SRH) in the essential policy package; explains the advantages of integrated services over separate vertical programs; and identifies a number of pathways to accomplishing their integration. Companion briefs describe the policy package as a whole and the elements of comprehensive sexuality education.[1]

DELIVERING THE CORE GROUP OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Universal access to reproductive health requires the effective delivery of a core group of integrated sexual and reproductive health services to everyone who needs them – when and where they need them:

- contraceptive services and supplies, including female and male condoms, a full array of temporary and long-lasting methods, and emergency contraception;
- safe and accessible abortion and the humane treatment of complications from unsafe abortion;
- maternal care, including antenatal care, skilled attendance at delivery, emergency obstetric care, post-partum, and newborn care; and
- prevention, diagnosis, and treatment of sexually transmitted infections (STIs) including HIV/AIDS and human papilloma virus (HPV), as well as cancers of the reproductive system, infertility, and other sexual and reproductive disorders.

Interventions to eliminate harmful practices such as female genital mutilation (FGM), sexual coercion, and violence against girls and women are applicable to each of these services.

ADVANTAGES OF INTEGRATED OVER STAND-ALONE SRH SERVICES

Integration means that clients who are seeking information or health care for one purpose have their other needs met simultaneously, preferably at the same time in the same location, but otherwise by effective referral. An HIV positive woman, for example, may wish to obtain contraceptives to prevent unwanted pregnancy; learn how to achieve a wanted pregnancy safely by reducing the risks of HIV transmission to her partner and to the child; or, if she is already pregnant, have a safe abortion or obtain antiretroviral therapy and comprehensive antenatal and delivery care, among other services.[2]

Numerous reviews have demonstrated that the integrated approach to delivering SRH services—despite its challenges—has many advantages for both clients and health systems,[3] such as:

- serving clients better with the cross-utilization of services and continuity of care;
- attracting a new and diverse clientele who might otherwise not receive SRH care at all;
- emphasizing prevention, early intervention, and harm reduction across all services; and
- introducing cost-saving measures and encouraging more efficient, effective, and equitable use of health systems.

The systematic coordination of sexual and reproductive health information and services across an array of governmental, private and non-governmental providers and delivery points is superior to stand-alone, vertical programs in family planning, maternal and child health, and HIV/AIDS. Whereas vertical programs compete with one another for policy and programmatic priorities as well as for financial and human resources, horizontally integrated SRH programs support a coordinated constellation of services while strengthening systems of primary health care.

Achieving integrated services requires a national (in some case, subnational) strategy, which must often be implemented incrementally. Careful mapping and planning are needed to identify the needs of clients and communities; the quality, accessibility and affordability of existing services; the training and logistical requirements of expanding the mix of services; and existing resource constraints.

RESPONDING TO THE MULTIPLE SRH NEEDS OF CLIENTS AND COMMUNITIES

To maximize their effectiveness, health services must meet the multiple and simultaneous needs for sexual and reproductive health information, counseling, and health care of diverse individuals and groups living in different communities. These include married and unmarried women and men; adolescents in and out of school; persons with disabilities; temporary and long-term migrants; male and female sex workers; persons with diverse sexual or gender identities; children and adults subjected to sexual violence; ethnic and linguistic minorities; and other groups.

To be accessible and affordable to different types of clients, SRH information and services are best delivered in a variety of venues and ways. These include hospitals, pharmacies, women's health centers, specialized clinics (e.g., family planning or STI/HIV clinics), community health posts, youth centers (ensuring safe spaces for girls), schools and universities, workplaces, drop-in clinics, doctors' offices, hotlines, and mobile units. Specialized or comprehensive SRH training needs to be provided to a variety of providers such as community health workers, nurses and midwives, pharmacists, physicians, HIV counselors, and other health care and social service personnel.

INTEGRATED SERVICES IN COMMUNITY-BASED FACILITIES AND CROSS-REFERRALS

At the facility level, the group of core SRH services, including information and counseling, is—from the client's perspective—best delivered at the same time in the same location ("one-stop shopping"). Individual providers can be trained in several core competencies, and/or multiple providers with different skills can be clustered in each service site.[4] An effective cross-referral system can fill in the gaps (e.g., referrals from HIV clinics to family planning clinics and vice versa), but referrals may also result in significant drop-offs in clients' use of services, resulting in crucial missed opportunities for prevention and early treatment. To maximize client satisfaction, retention and access to multiple services:

- antenatal services could add routine counseling, screening and treatment for STIs (particularly syphilis and HIV) to help prevent maternal-to-child transmission as well as miscarriage, preterm birth, and infant death; assist clients to plan for safe delivery or refer for pregnancy termination; provide contraceptive advice; and address violence.
- family planning services—including services for men and for adolescents—could routinely promote dual protection from STIs/HIV and pregnancy by offering male and female condoms with other contraceptives; counsel and screen clients (including couples) for STIs/HIV; advise HIV-positive couples (one or both infected) on fertility options; screen women for cervical cancer and other gynecological problems; perform pregnancy tests and offer counseling on options, including services or referrals for antenatal care or safe abortion; provide infertility counseling and referrals; and address sexual coercion and violence, among other issues.
- STI/HIV clinics and services likely to attract men could routinely offer male and female condoms and information and counseling on contraceptive methods (including vasectomy options), safe sex practices, and men's responsibilities to support their female partners' birth control decisions and to renounce sexual coercion and other forms of violence.

Reports of community-based facilities that demonstrate how to expand the mix of services and referrals to meet the multiple needs of many types of clients include:

- In Kenya, Family Health Options, working closely with the Government of Kenya, has linked STI counseling, testing and treatment (including prevention of mother-to-child HIV transmission) and maternity care to its traditional family planning services, and has added men-only clinics and youth centers, the latter offering recreational and vocational training as well as SRH counseling and care.[5] Also in Kenya, APHIAPlus Service Delivery, a program coordinated by five non-governmental organizations (NGOs), works through the provincial health system of Nairobi Province to build sustainability and deliver integrated services for HIV/AIDS, family planning, maternal and child health, tuberculosis and malaria, especially to poor and marginalized sectors.[6]
- In Haiti, most women, men and adolescents initially approach GHESKIO (Groupe Haïtien d'Etude du Sarcome de Kaposi et des Infections Opportunistes) community health centers for HIV testing. Everyone is routinely offered additional services such as condoms, other contraceptives, diagnosis and treatment of other STIs, and antiretroviral therapy. Clinics also provide treatment for rape survivors as well as a youth program.[7]
- In Mumbai, India, the Aastha clinics provide sex workers with integrated contraceptive services, counseling on condom negotiation skills, pregnancy testing, and gynecological care with STI/HIV testing, counseling and treatment referrals.[8]

NATIONAL POLICIES AND PROGRAMS: THE FRAMEWORK FOR INTEGRATION

National level health policies must provide for the core group of services and for their integrated delivery. Each country needs to decide which services to deliver and how, based on current circumstances but aiming for the entire package. A positive example is Bangladesh, which designed a new national Health and Population Program based on an "essential services package" that fit within limited financial resources yet strengthened health workers, parts of the health system, and infrastructure to deliver the package.[9] Emergency obstetric care was added to existing contraceptive services, "menstrual regulation" (early abortion), basic child health interventions and communicable disease control. Programs to encourage contraception among newlyweds, reproductive health education for adolescents and young people, and STI surveillance and AIDS control were also initiated. A crucial policy decision was local level integration of separate health and population wings of the Ministry of Health in order to streamline training, supervision, information, logistics and supply systems.

Once policy choices are made about which services will be provided by what providers, governments need to work out where and how such services will be delivered throughout the health system, in collaboration with private-sector health care providers, NGOs, and representatives of civil society. National efforts in this direction are underway or in the planning/experimental stages in Kenya, South Africa, and other Sub-Saharan African countries.

At the international level, a number of significant donors and several major health initiatives such as the UN Global Strategy for Women's and Children's Health and the US Government's Global Health Initiative emphasize integrated service delivery (including SRH services) and support for national health strategies based on the strengthening of health systems for the coordinated delivery of good quality and universally accessible care.

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[1] International Women's Health Coalition, 2012, "Sexual & Reproductive Health & Rights: What does an essential package of policies and programs look like?," and, 2011, "Comprehensive Sexuality Education: Overview and Lesson Plans for Building Effective Programs," http://www.iwhc.org/.

[2] Rose Wilcher and Willard Cates, 2009, "Reproductive choices for women with HIV," *Bulletin of the World Health Organization* 87(11):833-839.

[3] E.g., WHO, UNFPA, UNAIDS, IPPF and UCSF, 2009, Sexual & Reproductive Health and HIV Linkages: Evidence Review and Recommendations, http://www.unfpa.org/public/publications/pid/1341, among others.

[4] WHO, 2010, *Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health*, and WHO, 2011, *Sexual and Reproductive Health: Core Competencies in Primary Care* (Geneva: WHO).

[5] WHO, UNFPA, UNAIDS and IPPF, 2008, Linking sexual and reproductive health and HIV/AIDS. Gateways to integration: a case study from Kenya, http://who.int.reproductivehealth/publications/linkages/91728/en/index.html.

[6] Pathfinder International, 2011, *Programs: Kenya: Projects: APHIAplus Nairobi-Coast,* http://www.pathfind.org/site/PageServer?pagename=Programs_Kenya_Projects_APHIA_Plus_Nairobi.

[7] WHO, UNFPA, UNAIDS and IPPF, 2008, Linking sexual and reproductive health and HIV/AIDS. Gateways to integration: a case study from Haiti, http://who.int.reproductivehealth/publications/linkages/91724/en/index.html.

[8] Family Health International, 2010, *The Case for Integrating Family Planning and HIV/AIDS Services: Evidence, Policy, Support, and Programmatic Experience* (Research Triangle Park, NC: FHI).

[9] Rounaq Jahan, 2007, "Securing maternal health through comprehensive reproductive health services: lessons from Bangladesh," *American Journal of Public Health* 97(7):1186-1190.