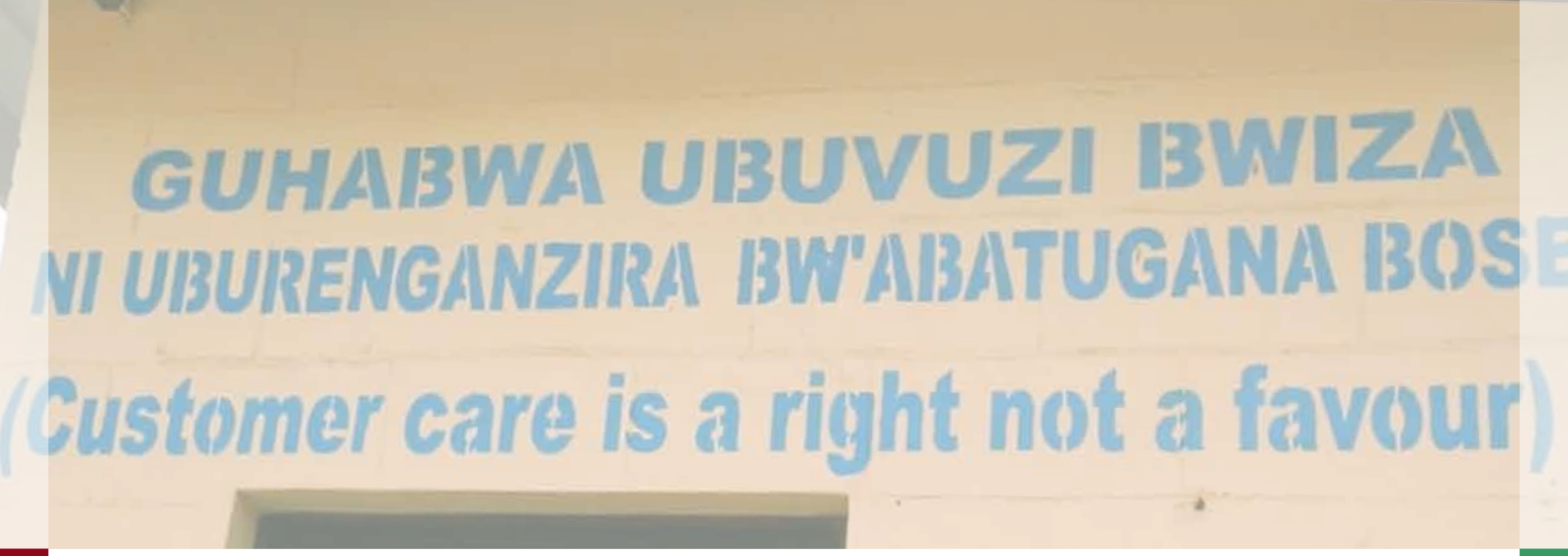
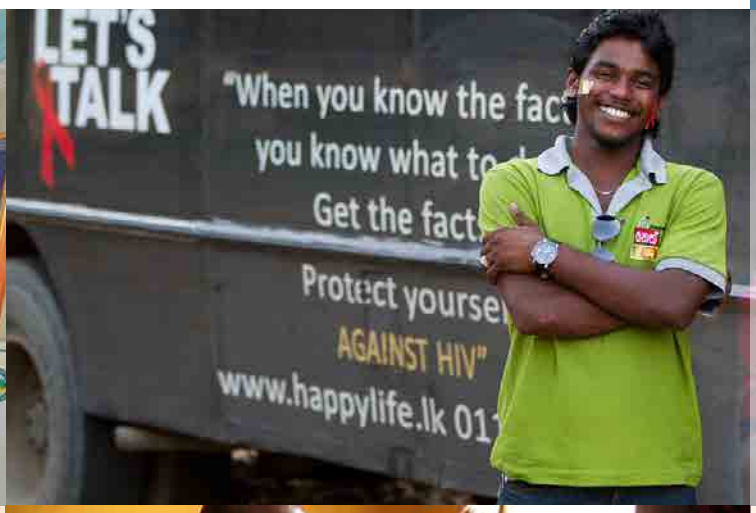


SRH AND HIV LINKAGES COMPENDIUM

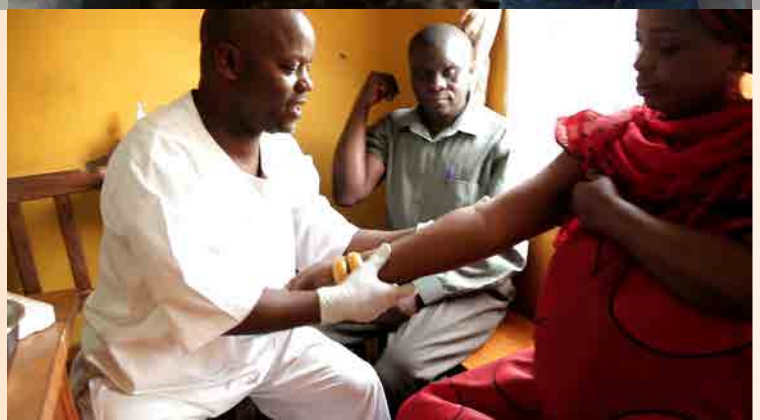
Indicators & Related Assessment Tools



IPPF International Planned Parenthood Federation

UNFPA

World Health Organization



SRH AND HIV LINKAGES COMPENDIUM

Indicators & Related Assessment Tools

A product of the Inter-agency Working Group on SRH and HIV Linkages*

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Middle (left to right) – IPPF / Neil Thomas / 2011; IPPF SARO / 2011
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*see www.srhhivlinkages.org for more information

Disclaimer

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Contents

Introduction

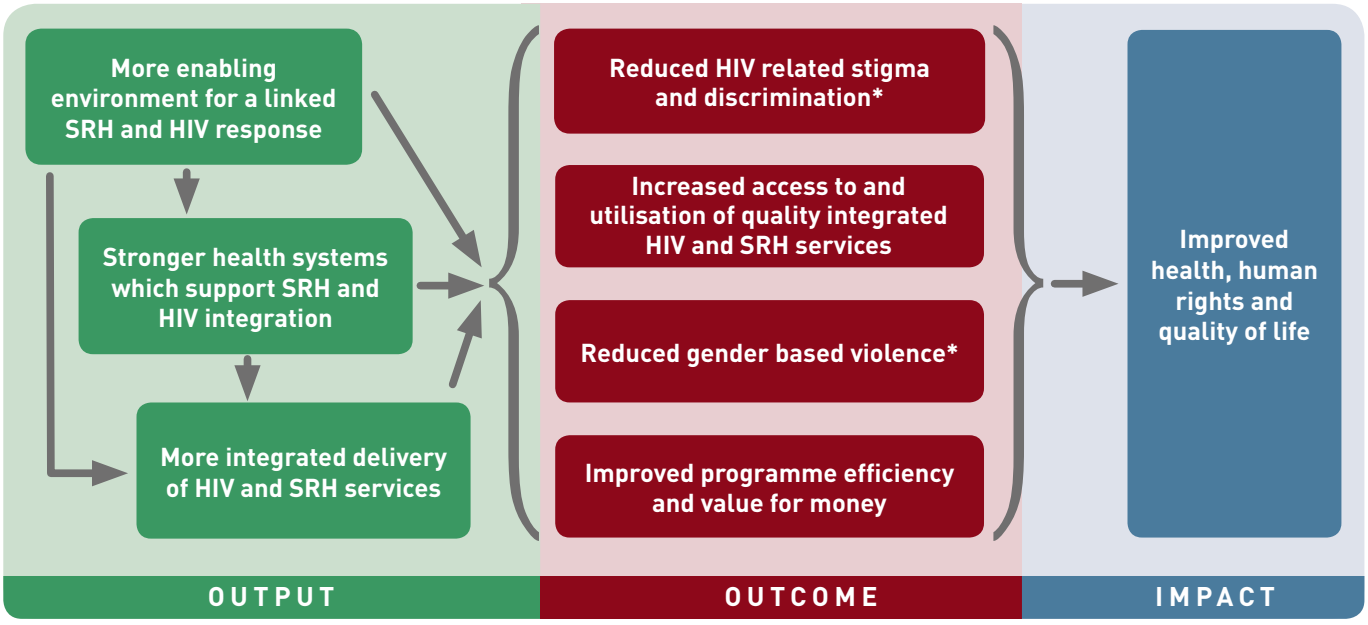
Ensuring universal access to sexual and reproductive health and rights and HIV prevention, treatment, care and support are essential for development, including in the post 2015 agenda. However, while there are many separate sexual and reproductive health (SRH) related and HIV-related indicators, a key challenge has been the lack of internationally agreed indicators to measure progress in linking SRH and HIV. In 2012, a Steering Group of SRH and HIV linkages and M&E experts, which included country, donor, UN agency and civil society representatives, launched an initiative to assess existing indicators and related assessment tools and provide recommendations for a compendium of indicators that can be used to measure SRH and HIV integration and linkages at the policy, systems and service delivery levels as well as at output, outcome and impact levels.

The Steering Group developed a theory of change (see figure 1 below), which was used to identify and assess indicators and related assessment tools to measure SRH and HIV linkages and provide a thematic structure to the compendium. The areas in the theory of change can broadly be categorised as outputs (enabling environment, integrated service delivery and stronger health systems), outcomes (reduced stigma and discrimination and gender-based violence, increased access to and utilisation of services, improved efficiency) and impact (improved health, human rights and quality of life).*

The importance of linking SRH and HIV is now widely recognised.

This Compendium is built around the different themes in the theory of change and includes a focused set of indicators and related assessment tools that have direct and indirect relevance to tracking the links between SRH and HIV programmes at national and sub-national levels. Related assessment tools are used to capture progress where individual indicators are not available. As efforts to link these programmes continue to gain traction in countries around the world, the compendium will evolve to include additional indicators and related assessment tools that provide useful data on critical issues related to SRH and HIV linkages.

Figure 1: Theory of Change for SRH and HIV Linkages



* It is recognised that reducing stigma and discrimination and gender-based violence are also impact level measures and the outcome measures influence each other.

Linkages:
The bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV. It refers to a broader human rights based approach, of which service integration is a subset.

Integration:
Different kinds of SRH and HIV services or operational programmes that can be joined together to ensure and perhaps maximize collective outcomes. This would include referrals from one service to another, for example. It is based on the need to offer comprehensive and integrated services.

Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages: A Generic Guide, prepared and published by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives, 2009.]

The current version of the compendium includes indicators and related assessment tools at output, outcome and impact levels. The compendium is designed to provide basic background information that can be used to identify potential indicators that would be applicable and practical in specific settings and/or contexts. The background information for each indicator includes an overview, a brief description of its relevance to SRH and HIV linkages and a hyperlink to a detailed definition. The output and outcome indicators also include information on their key strengths and weaknesses.

The use of hyperlinks in the compendium, which lead to the source material for individual indicator definitions, will help ensure that users have access to the most current and most widely acknowledged version(s) of the indicator. The expert team responsible for maintaining the compendium will regularly confirm the accuracy of the linked definitions and update the links as necessary.

All the indicators in this compendium have passed through a rigorous evaluation based on the indicator standards of the UNAIDS Monitoring and Evaluation Reference Group. In this constantly evolving field new related metrics may be added to the compendium, pending an assessment of their performance against these same rigorous standards. In the future, detailed information on key issues such as how measures can be implemented, how data can be analysed and used and examples of past performance in different countries and settings may also be added to the compendium.

Users are encouraged to provide feedback on the use and value of the indicators in the compendium so that it can reflect and incorporate practical experience from real-world situations. Users are also encouraged to suggest additional indicators and related assessment tools that could be assessed for inclusion in the compendium.

Overview of the indicators and related assessment tools in the compendium

Clicking on the indicator titles – **underlined in black** – will take users directly to background information for each indicator which includes an overview, a brief description of its relevance to SRH and HIV linkages and a hyperlink to a detailed definition. In addition, the background for the output and outcome indicators includes information on their key strengths and weaknesses.

OUTPUT LEVEL

Enabling environment

- **Rapid Assessment Tool for SRH and HIV Linkages**

Stronger health systems

- **Number of health workers per 10,000 population**
- **Rapid Assessment Tool for SRH and HIV Linkages**

Integrated delivery of services

- **Using 'marker' services**
  - Percentage of service delivery points providing HIV services that are delivering an SRH 'marker service' to clients;
  - Percentage of service delivery points providing SRH services that are delivering an HIV 'marker service' to clients; and
  - Percentage of service delivery points routinely providing general health services that are delivering an SRH and an HIV 'marker service' to clients.
- **Using 'baskets' of services**
  - Percentage of service delivery points providing one or more HIV service and one or more SRH services to clients.
- **Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission**
- **Rapid Assessment Tool for SRH and HIV Linkages**

OUTCOME LEVEL

Reduced HIV-related stigma and discrimination

- **People Living with HIV Stigma Index**

Increased access to and utilisation of quality HIV and SRH services

- **Percentage of pregnant women who know their HIV status**
- **Percentage of pregnant women attending ANC whose male partner was tested for HIV**
- **Percentage of antenatal care attendees tested for syphilis at first antenatal care visit**
- **Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse**

continued over

- **Percentage of people who inject drugs who report the use of a condom at last sexual intercourse**
- **Percentage of sex workers reporting the use of a condom with their most recent client**
- **Percentage of men reporting the use of a condom the last time they had anal sex with a male partner**

Reduced gender based violence

- **Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months**

Improved programme efficiency and value for money

At the time of publication no commonly used indicators or related assessment tools were found that measured programme efficiency and/or value for money for integrated SRH and HIV services. Related research and modeling is ongoing and may result in relevant indicators and assessment tools being developed. For more information see www.integrainitiative.org and http://integrationforimpact.org

IMPACT LEVEL

Improved health, human rights and quality of life

- **Maternal mortality ratio, due to HIV**
- **Under-five mortality rate, due to HIV**
- **Neonatal mortality rate** *(relates to SRH and HIV)*
- **Mother-to-child transmission of HIV**
- **HIV prevalence in young people, sex workers, men who have sex with men and people who inject drugs**
- **Percentage of antenatal care attendees who test positive for syphilis** *(relates to SRH and HIV)*
- **Unmet need for family planning among people who are living with HIV**
- **Quality-Adjusted Life Years (QALY)** *(relates to SRH and HIV)*
- **Disability-Adjusted Life Years (DALY)** *(relates to SRH and HIV)*

ENABLING ENVIRONMENT

Rapid Assessment Tool for SRH and HIV Linkages

Overview:

In 2009, the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide* was published. This comprehensive tool was prepared and published by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives. By the end of 2013 it had been undertaken in 49 countries. An abridged version of the tool is currently under development to provide users with a straightforward way of assessing the state of the enabling environment and health system to support the delivery of integrated SRH and HIV services.

The tool uses a brief series of simple questions to collect relevant data on the enabling environment, health system and integrated delivery of services. The enabling environment component has questions about political leadership and policy environment, laws and funding. The health systems component has questions about partnerships; coordination, planning and budgeting; human resources; logistics; and monitoring and evaluation. The service delivery component has questions for service providers and clients.

Strengths:

The Rapid Assessment Tool for SRH and HIV Linkages can provide an extremely useful overview of the existing state of SRH and HIV linkages at the enabling environment, health systems and service delivery levels. In many countries/settings, the political, legal, policy and economic environment and the way the health system is organised are major impediments to improving linkages and using this tool will highlight issues that must be address if SRH and HIV services are going to be successfully integrated. The tool is also useful in identifying gaps and the findings can be used in the development of country-specific action plans.

Weaknesses:

Although the tool is easy to use, it can be a time-consuming process to collect and analyze the relevant information. Consequently, it may be challenging to secure the necessary resources (people, time and finances) to complete the assessment.

Tool:

The Rapid Assessment Tool for SRH and HIV Linkages is available from http://srhhivlinkages.org/rapid-assessment-tool/

STRONGER HEALTH SYSTEMS

Number of health workers per 10,000 population

Overview:

An awareness of the number of health workers can provide some basic information on the health system's ability to deliver services. In principle, a low density of health workers can limit and/or compromise service delivery, including the ability to link SRH and HIV services.

Where the number of health workers is low, there are likely to be corresponding challenges in developing and maintaining integrated SRH and HIV services, particularly in countries where there is a generalized HIV epidemic. However, given the possibility that linked services can be an efficient and cost-effective way to deliver these services, a low density of health workers could signal an opportunity to pursue linking SRH and HIV services.

Tracking the ratio of health workers to population can provide useful data on the ability of a health system to deliver integrated SRH and HIV services.

Strengths:

The primary strength of this indicator is its ability to use a single number to provide an insight on the capacity of the health system to provide services. While both the minimum number and optimal number of health workers per 10,000 population will vary by country, this indicator provides a useful snapshot of the current situation, which, in turn, provides some indication that SRH and HIV linkages can or do exist.

Weaknesses:

There is no consistent or verifiable threshold at which the density of health workers ensures that SRH and HIV services will be linked. It is possible that services are not linked even in settings where there are more health workers per 10,000 population.

Indicator definition:

www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf (page 29)

Rapid Assessment Tool for SRH and HIV Linkages

See page 10

INTEGRATED DELIVERY OF SERVICES

Using 'marker' services

Overview:

The international community recognises that key development goals will not be achieved without ensuring expanded and ready access to HIV and SRH services. Given the overlaps and connections between these two types of services and the ability to improve access to each of them by integrating HIV and SRH within service delivery points, it is useful to assess the extent of this service integration.

This indicator uses 'marker' services – i.e. testing and counselling for HIV and modern contraceptive services for SRH – to measure if the provision of core HIV and SRH services is integrated at the service delivery point, and how. The provision of the HIV marker service at SRH service delivery points and the provision of the SRH marker service at HIV service delivery points – and the models used for each – are an indication of the extent and type of integration.

Strengths:

The strength of this indicator is its ability to quickly and easily provide a 'snapshot' of the current situation. For example: is a core SRH service available at service delivery points providing HIV-related services and vice versa? The proxy measures selected for this indicator (e.g. modern contraceptive services and HIV testing and counselling) provide valuable information on a basic level of SRH and HIV integration, which is useful for a wide audience, ranging from policy makers to programme implementers. It is also possible to show the model(s) of integration being used.

Weaknesses:

As integration between HIV and SRH services become more common and/or extends beyond the integration of contraceptive services and HIV testing and counselling, the value of this indicator will diminish. The use of marker services as proxy measures will not provide detailed information about specific models of integration and whilst this indicator provides a useful measure of the ability of a service delivery point to provide integrated SRH and HIV services it does not measure the uptake of these integrated services.

Indicator definition:

See Annex A. This is a new indicator. It has been field tested in multiple countries and has been reviewed by an independent panel of experts before and after the field test. It is also included in the UNAIDS Indicator Registry in the following place – http://indicatorregistry.unaids.org/?q=node/1077)

Using 'baskets' of services

Overview:

The international community recognises that key development goals will not be achieved without ensuring expanded and ready access to HIV and SRH services. Given the overlaps and connections between these two types of services and the ability to improve access to each of them by integrating HIV and SRH within service delivery points, it is useful to assess the extent of this service integration.

This indicator uses predefined 'baskets' of core HIV and SRH services to measure if, how, and to what extent the provision of these services is integrated at the delivery point. The delivery of one or more services from different HIV baskets *and* the delivery of one or more services from different SRH baskets at the service delivery point, and the model(s) used, will be an indication of the extent and type of integration.

Strengths:

The strength of this indicator is its ability to collect a significant amount of data on HIV and SRH service delivery using a simple and straightforward questionnaire. The reported data can be used in multiple ways to assess integration between SRH and HIV services at the level of the service delivery point.

Weaknesses:

Given the currently low level of integration between HIV and SRH services, this indicator may provide limited information on the breadth and depth of linkages. However, over the long term, as integration between HIV and SRH services become more common, the indicator will be increasingly useful for assessing linkages generally and integration between individual services more specifically. Whilst this indicator provides a useful measure of the ability of a service delivery point to provide integrated SRH and HIV services it does not measure the uptake of these integrated services.

Indicator definition:

See Annex B. This is a new indicator. It has been field tested in multiple countries and has been reviewed by an independent panel of experts before and after the field test. It is also included in the UNAIDS Indicator Registry in the following place – http://indicatorregistry.unaids.org/?q=node/1078]

Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission

Overview:

The provision of antiretroviral treatment for pregnant women who are living with HIV – as treatment or as prophylaxis – combined with antiretroviral prophylaxis for the infant, safe delivery practices and safer infant feeding can significantly reduce the risk of mother-to-child transmission of HIV.

The indicator measures elements of both SRH service provision (e.g. antenatal care) and HIV service provision (e.g. HIV testing and treatment). A high percentage of pregnant women who are living with HIV receiving antiretroviral treatment as part of antenatal care demonstrates one form of integrated services.

Strengths:

Programmes that reduce the risk of mother-to-child transmission by providing pregnant women with antiretroviral drugs are an example of integrated SRH and HIV services. Given the current emphasis on preventing mother-to-child transmission, data for this indicator is available from a significant number of countries.

Weaknesses:

The denominator for this indicator is often calculated using modeled data, which many countries feel does not accurately reflect their actual number of affected women. As a result, the percentage may be misleading. The indicator also uses a complex numerator to capture data on the types of antiretroviral therapy in use. This disaggregation is not relevant when using this indicator to track SRH and HIV integration.

Indicator definition: http://indicatorregistry.unaids.org/?q=node/856

Rapid Assessment Tool for SRH and HIV Linkages

See page 10

REDUCED HIV-RELATED STIGMA AND DISCRIMINATION

The People Living with HIV Stigma Index

Overview:

The People Living with HIV (PLHIV) Stigma Index is a tool that measures and detects changing trends in relation to stigma and discrimination experienced by people living with HIV. In the initiative, the process is just as important as the product. It aims to address stigma relating to HIV while also advocating on the key barriers and issues perpetuating stigma - a key obstacle to HIV treatment, prevention, care and support. Between 2008 and 2013 more than 50 countries completed the study.

Strengths:

The PLHIV Stigma Index increases understanding of how stigma and discrimination is experienced by people living with HIV. The Index includes a number of questions covering access to health services, including family planning and sexual and reproductive health; rights, laws and policies; disclosure and confidentiality; treatment, and having children, which are relevant for measuring stigma and discrimination around HIV as it relates to sexual and reproductive health. The information gathered from the tool will provide the evidence needed to support the collective goal of Governments, NGOs and activists alike to reduce the stigma and discrimination linked to HIV.

Weaknesses:

Although the tool is easy to use, it can be a time-consuming process to collect and analyse the relevant information. Consequently, it may be challenging to secure the necessary resources (people, time and finances) to repeat the assessment periodically.

Indicator definition: More information is available from www.stigmaindex.org

INCREASED ACCESS TO AND UTILISATION OF QUALITY HIV AND SRH SERVICES

Percentage of pregnant women who know their HIV status

Overview:

The prevention of mother-to-child transmission of HIV hinges on women knowing their HIV status while they are pregnant. Consequently, antenatal care is a critical entry point for HIV testing and counselling. This indicator can provide useful data on the link between SRH and HIV services, e.g. antenatal care and HIV testing, respectively. In countries where many women may not know their HIV status, increasing percentages of pregnant women who *do* know their status is likely to be an indication of increased access to integrated SRH and HIV services.

Strengths:

The indicator makes it possible to monitor trends in HIV testing among women attending antenatal care. If increasing numbers of pregnant women know their HIV status, it may be indicative of improvements in linkages between SRH and HIV services. For example, the Integra Initiative (www.integrainitiative.org) found that people who had a greater exposure to integrated service facilities had a higher uptake of HIV counseling and testing services. Variants of this indicator are in use by the Global Fund, PEPFAR, UNICEF and WHO, which means that country level data is widely available.

Weaknesses:

There is a risk for double-counting with this indicator, as a pregnant woman can be tested more than once during antenatal care, labour and delivery or postpartum care, particularly: when women are retested in different facilities; when they come to antenatal care or labour and delivery services without documentation of their previous results; or when they are retested after a previous negative test result during the pregnancy. Given that double counting reduces the accuracy of the data systems should be in place to minimize this problem.

Indicator definition: http://indicatorregistry.unaids.org/?q=node/524

Percentage of pregnant women attending ANC whose male partner was tested for HIV

Overview:

Male involvement is a critical component of family-focused services for pregnant women living with HIV, their infants and family members. Partner testing is an important first step in involving the male partner, regardless of the couple's HIV status. Knowledge of one's HIV status can help couples who are seronegative to remain seronegative; conversely, this knowledge can be a gateway to treatment.

In countries with generalized epidemics, where many people have not been tested for HIV, increasing percentages of male partners of women attending ANC who *are* tested is likely to be an indication of increased access to integrated SRH and HIV services.

Strengths:

The indicator makes it possible to monitor trends in HIV testing among male partners of women attending antenatal care. If increasing numbers of these partners know their HIV status, it may be indicative of improvements in linkages between SRH and HIV services. Variants of this indicator are in use by the Global Fund, UNICEF and WHO, which means that country level data is available.

Weaknesses:

The value of this indicator may be undermined by generally low rates of HIV testing among male partners in countries with generalized epidemics. The indicator does not take into account ANC clients that have more than one partner or that partners may change over time. It also does not include partners that received HIV testing at non-ANC settings and which are not linked to ANC (e.g. general VCT or provider initiated testing).

Indicator definition: http://indicatorregistry.unaids.org/?q=node/879

Percentage of antenatal care attendees tested for syphilis at first antenatal care visit

Overview:

There is evidence that sexually transmitted infections, including syphilis, are associated with a higher risk of HIV infection. Congenital syphilis can be prevented if pregnant women are tested and treated sufficiently early in pregnancy, before this negatively affects the fetus. Given that syphilis testing is part of the recommended basic antenatal services package, this indicator is also a quality marker for the provision of essential ANC services, which, in turn, makes it a valuable measure of linkages across SRH and HIV services in countries with generalized or concentrated HIV epidemics.

Strengths:

The indicator makes it possible to monitor trends in syphilis testing among women attending antenatal care. Given the connection between HIV risk and other sexually transmitted infections, if increasing numbers of pregnant women know their syphilis status, it may be indicative of improvements in linkages between SRH and HIV services. Data from this indicator could be triangulated with data from the indicator on 'percentage of pregnant women who know their HIV status' to provide a better sense of the situation.

Weaknesses:

Countries may not be able to track testing at first ANC visit versus subsequent visits. Testing at first visit is important because syphilis treatment must be done early in a pregnancy to avoid early fetal loss and stillbirth. Although the connection between HIV risk and other STIs is well known, ANC attendees could be tested for syphilis without effective linkages between SRH and HIV services.

Indicator definition: http://indicatorregistry.unaids.org/?q=node/884

Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse

Overview:

Condom use is an important measure of protection against HIV and other sexually transmitted infections, especially among people with multiple sexual partners. They are equally useful in preventing pregnancy.

Although condom use cannot be directly correlated to the provision of integrated SRH or HIV services their dual protection role means that the indicator provides useful data on SRH and HIV prevention behaviours and trends, particularly in countries with generalized or concentrated HIV epidemics.

Strengths:

Data for this indicator is widely available, having been collected in many countries over multiple rounds of UNAIDS global reporting. The longitudinal data can be used to track trends in condom use among people who are likely to have higher-risk sex.

Weaknesses:

The maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator does not provide information on the level of consistent condom use. However, it is assumed that the trend in condom use during the most recent sex act generally reflects the trend in consistent condom use.

Indicator definition: http://indicatorregistry.unaids.org/?q=node/842

Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

Overview:

Safer sexual practices among people who inject drugs are an essential component of an effective prevention response focused on this key population. Condom use is an important measure of protection against HIV and other sexually transmitted infections as well as unintended pregnancy.

Although condom use cannot be directly correlated to the provision of integrated SRH or HIV services their dual protection role means that the indicator provides useful data on SRH and HIV prevention behaviours and trends, particularly in countries with HIV epidemics among people who inject drugs.

Strengths:

Data for this indicator is widely available, having been collected in many countries over multiple rounds of UNAIDS global reporting. The longitudinal data can be used to track trends in condom use among people who inject drugs.

Weaknesses:

Collecting data on sexual behavior from people who inject drugs can be challenging. Consequently, data that is collected may not be a representative sample of the key population as a whole. In addition, the maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator does not provide information on the level of consistent condom use. However, it is assumed that the trend in condom use during last sexual intercourse generally reflects the trend in consistent condom use.

Indicator definition: http://indicatorregistry.unaids.org/?q=node/852

Percentage of sex workers reporting the use of a condom with their most recent client

Overview:

Various factors increase the risk of exposure to HIV among sex workers, including multiple, non-regular partners and more frequent sexual intercourse. However, sex workers can substantially reduce the risk of HIV transmission and other sexually transmitted infections, both from clients and to clients, through consistent and correct condom use. Condoms are equally useful in preventing pregnancy.

Although condom use cannot be directly correlated to the provision of integrated SRH or HIV services their dual protection role means that the indicator provides useful data on SRH and HIV prevention behaviours and trends, particularly in countries with generalized or concentrated HIV epidemics.

Strengths:

Data for this indicator is widely available, having been collected in many countries over multiple rounds of UNAIDS global reporting. The longitudinal data can be used to track trends in condom use among sex workers.

Weaknesses:

Collecting data on sexual behavior from sex workers can be challenging. Consequently, data that is collected may not be a representative sample of the key population as a whole. In addition, the maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator does not provide information on the level of consistent condom use. However, it is assumed that the trend in condom use with their most recent client generally reflects the trend in consistent condom use.

Indicator definition: http://indicatorregistry.unaids.org/?q=node/663

Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Overview:

Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for men who have sex with men because of the high risk of HIV transmission during unprotected anal sex. In addition, men who have anal sex with other men may also have female partners, who could become infected as well.

Although condom use cannot be directly correlated to the provision of integrated SRH or HIV services their dual role in preventing HIV and other STIs means that the indicator provides useful data on SRH and HIV prevention behaviours and trends, particularly in countries with HIV epidemics among men who have sex with men.

Strengths:

Data for this indicator is widely available, having been collected in many countries over multiple rounds of UNAIDS global reporting. The longitudinal data can be used to track trends in condom use among men who have sex with men.

Weaknesses:

This indicator does not provide any data on risk behaviors or condom use during sex with women among men who have sex with both women and men. In addition, collecting data on sexual behavior from sex workers can be challenging. Consequently, data that is collected may not be a representative sample of the key population as a whole. Also, the maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator does not provide information on the level of consistent condom use. However, it is assumed that the trend in condom use during last anal sex generally reflects the trend in consistent condom use.

Indicator definition: http://indicatorregistry.unaids.org/?q=node/664

REDUCED GENDER BASED VIOLENCE

Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months

Overview:

There is growing recognition that women and girls' risk of, and vulnerability to, HIV infection is shaped by deep-rooted and pervasive gender inequalities, in particular, violence against them. Studies from Rwanda, Tanzania, and South Africa show up to three-fold increases in risk of HIV among women who have experienced violence compared to those who have not.

The connections between intimate partner violence, HIV transmission and women's reproductive health makes this indicator a valuable metric for assessing linkages across SRH and HIV services. As integration of SRH and HIV services that include screening, support and counselling for intimate partner violence (IPV) increase, this will lead to a decrease in IPV and gender equality will improve.

Strengths:

The indicator assesses progress in reducing the proportion of women who have experienced recent IPV, as an outcome in of itself. In addition, the data can also be used as a proxy for gender equality. A change in the prevalence level of recent violence over time will indicate a change in the level of gender equality. Gender equality has a clear, inverse relationship with IPV. In countries where IPV is high, gender equality, women's rates of education, and women's reproductive health and rights are low.

Weaknesses:

Even after adhering to the WHO ethical and safety guidelines and providing a good setting in which to conduct interviews, there will always be some women who will not disclose information about intimate partner violence. Consequently, findings will likely be more conservative than the actual level of violence that has taken place in the surveyed population.

Indicator definition: http://indicatorregistry.unaids.org/?q=node/863

IMPROVED PROGRAMME EFFICIENCY AND VALUE FOR MONEY

At the time of publication no commonly used indicators or tools were found that measured programme efficiency and/or value for money for integrated SRH and HIV services.

IMPROVED HEALTH, HUMAN RIGHTS AND QUALITY OF LIFE

Maternal mortality ratio, due to HIV

Overview:

One of the targets for Millennium Development Goal (MDG) 5: *Improve maternal health* is to reduce the maternal mortality ratio (MMR) by three quarters between 1990 and 2015. Globally, an estimated 287 000 maternal deaths occurred in 2010, a decline of 47% from levels in 1990. However, a 2013 report suggests that 24% of deaths in pregnant or postpartum women are attributable to HIV in sub-Saharan Africa.

As linkages between SRH and HIV services improve, there will be a range of opportunities to reduce maternal mortality due to HIV. For example, the relationship between the quality of antenatal care provided at health facilities and the successful implementation of antiretroviral treatment to prevent mother-to-child HIV transmission; health benefits for both HIV-negative and HIV-positive women and their children of outreach by community-based health workers, including increased condom use; and reductions in maternal mortality associated with women with HIV receiving treatment for their own health instead of only to prevent transmission to their child.

Indicator definition:

- www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf (See Appendix 5.)
- www.cpc.unc.edu/measure/prh/rh_indicators/specific/sm/maternal-mortality-ratio-mmr (This indicator definition is for tracking the 'maternal mortality ratio' generally; the approach would have to be modified to collect data specifically on maternal mortality ratio, due to HIV.)

Data source(s):

data.worldbank.org/indicator/SH.STA.MMRT

Under-five mortality rate, due to HIV

Overview:

One of the targets for Millennium Development Goal (MDG) 4: *Reduce child mortality* is to reduce the under-five mortality rate by two thirds between 1990 and 2015. Since 1990, the global under-five mortality rate has dropped 47% and, despite population growth, the number of deaths in children under five worldwide declined from 12.4 million in 1990 to 6.6 million in 2012.

The percentage of under-5 deaths due to HIV has been declining in recent years; for example, in sub-Saharan Africa it fell from 5.4% in 2000 to 3.6% in 2009. The decline has been driven by a combination of factors including scale-up of PMTCT programmes and treatment for pregnant women and children. As linkages between SRH and HIV services improve and mother-to-child transmission of HIV decreases, there should be further and/or accelerated reductions in under-five mortality.

Indicator definition: www.childinfo.org/mortality_methodology.html

(This indicator definition is for tracking the 'under-five mortality rate' generally; the approach would have to be modified to collect data specifically on under-five mortality rate, due to HIV.)

Data source(s):

- data.worldbank.org/indicator/SH.DYN.MORT/countries
- www.childmortality.org/

Neonatal mortality rate

Overview:

Globally, the neonatal mortality rate declined from 33 deaths per 1,000 live births in 1990 to 21 per 1,000 in 2012. The overall result was a reduction of neonatal deaths from 4.6 million in 1990 to 2.9 million in 2012. However, neonatal deaths are growing as a share of global under-five deaths. The proportion of under-five deaths that occur within the first month of life (the neonatal period) has increased 19 percent since 1990, from 37 percent to 44 percent, because declines in the neonatal mortality rate are slower than those in the mortality rate for older children.

As linkages between SRH and HIV services improve, there should be a reduction in neonatal mortality as mother-to-child transmission of HIV decreases and more mothers have easier and better access to critical SRH and HIV services.

Indicator definition: http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/nb/neonatal-mortality-rate-nmr

Data source(s):

- data.worldbank.org/indicator/SH.DYN.NMRT
- www.childmortality.org/

Mother-to-child transmission of HIV

Overview:

The provision of antiretroviral treatment for pregnant women who are living with HIV – as treatment or as prophylaxis – combined with antiretroviral prophylaxis for the infant, safe delivery practices and safer infant feeding can significantly reduce the risk of mother-to-child transmission of HIV.

Linked SRH and HIV services can contribute to a declining percentage of children infected with HIV through mother-to-child transmission by ensuring easier and better access to critical services. For example, women living with HIV attending ANC during pregnancy are potentially more likely to receive PMTCT services if they are an integral part of antenatal care.

Indicator definition: http://indicatorregistry.unaids.org/?q=node/858

HIV prevalence in young people, sex workers, men who have sex with men and people who inject drugs

Overview:

The HIV prevalence rate in different populations is an important measure of the effectiveness of the response. Among young people, trends in HIV prevalence are an indication of recent trends in HIV incidence and risk behaviour. Among sex workers, men who have sex with men and people who inject drugs, reducing prevalence is critical because of the inherently higher prevalence rates among key populations.

Improved linkages between SRH and HIV services can contribute to reductions in the HIV prevalence rate in key populations by improving access to and the delivery of these services.

Indicator definitions:

- http://indicatorregistry.unaids.org/?q=node/844 (young people)
- http://indicatorregistry.unaids.org/?q=node/847 (sex workers)
- http://indicatorregistry.unaids.org/?q=node/850 (men who have sex with men)
- http://indicatorregistry.unaids.org/?q=node/855 (people who inject drugs)

Percentage of antenatal care attendees who test positive for syphilis

Overview:

Syphilis affects large numbers of pregnant women worldwide, causing serious health problems to their babies, even death. Like HIV, syphilis can also be transmitted from mother to unborn child. People infected with syphilis are also at significantly greater risk of HIV infection.

The provision of linked SRH and HIV services can contribute to a declining percentage of antenatal care attendees who test positive for syphilis by ensuring easier and better access to the critical services. For example, the increasing use of rapid testing for syphilis, which can be done in settings without laboratory capacity, means that women can be tested and treated more efficiently and effectively.

Indicator definition:

- apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=3249
- www.who.int/hiv/data/UA2012_indicator_guide_en.pdf (page 18)

Unmet need for family planning among people who are living with HIV

Overview:

Unmet need for family planning is one of the indicators for MDG Target 5.B: *Achieve, by 2015, universal access to reproductive health.* Unmet need is also the second prong of the four-pronged *Global plan towards elimination of new HIV infections among children by 2015 and keeping their mothers alive*; it focuses on the prevention of unintended pregnancies among women living with HIV with the target of reducing unmet need for family planning to zero. For example, Tanzania's national plan for the elimination of mother-to-child transmission (2012-2015) includes the following impact result: Reduction of unmet need for family planning among women of child bearing age living with HIV by 100% by 2015.

A reduction in the unmet need for family planning among people who are living with HIV would provide useful corroborating data on the impact of linkages across SRH and HIV services (i.e. if the linkages are strong and effective, one impact would be a decline in unmet need for people who are living with HIV).

Indicator definition:

- apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=6
- http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/unmet-need-for-family-planning

(Both of these indicator definitions are for tracking 'unmet need for family planning' generally; the survey instrument would have to be modified to collect data specifically on the unmet need for people who are living with HIV).

Notes:

1) Met need/demand (i.e. modern contraceptive use) may be valuable impact measure. In general, it can be calculated by subtracting the percentage of unmet need from 100%.

2) One alternative indicator is the *percent of female clients of reproductive age attending HIV-related service delivery points with unmet need for family planning*. This indicator does not appear to be widely used but it is well documented.

- www.cpc.unc.edu/measure/prh/rh_indicators/specific/family-planning-and-hiv/proportion-of-female-clients-of-reproductive-age-attending-hiv-related-service-delivery-points-with-unmet-need-for-family-planning

Quality-Adjusted Life Years (QALY)

Overview:

One QALY is equal to one year of life in perfect health. QALYS are calculated by estimating the years of life remaining for a patient following a particular treatment or *intervention* and weighting each year with a quality of life score (on a zero to one scale). It is often measured in terms of the person's ability to perform the activities of daily life, freedom from pain and mental disturbance.

As the delivery of integrated services improves health outcomes in the areas of sexual and reproductive health and HIV, it is possible there will be a corresponding improvement in quality-adjusted life years. However, depending on the overall situation at the country level, it is possible that any improvement in QALY due to linkages may not be attributable or discernable.

Indicator definition:

- www.nice.org.uk/newsroom/features/measuringeffectivenessandcosteffectivenesstheqaly.jsp

(There are multiple ways to measure QALY, which means that a user will have to select a method best suited for their situation. The above link provides information on one approach as well as some broader information on the indicator.)

Note:

Measuring quality-adjusted life years can be a complex and resource intensive process. In addition, there are ongoing discussions amongst experts in this area about the value and accuracy of QALY findings with strong arguments both for and against.

Disability-Adjusted Life Years (DALY)

Overview:

One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

As the delivery of integrated services improves health outcomes in the areas of sexual and reproductive health and HIV, it is possible there will be a corresponding improvement in disability-adjusted life years. However, depending on the overall situation at the country level, it is possible that any improvement in DALY due to linkages may not be attributable or discernable.

Indicator definition:

www.who.int/healthinfo/global_burden_disease/metrics_daly/en/index.html

Annex A: Measuring the integration of HIV and SRH services: Using 'marker' services

Definition

This is a three-part indicator:

1. Percentage of service delivery points providing HIV services that are delivering an SRH 'marker service' to clients;[1]
2. Percentage of service delivery points providing SRH services that are delivering an HIV 'marker service' to clients;[2] and
3. Percentage of service delivery points routinely providing general health services that are delivering an SRH and an HIV 'marker service' to clients.[3]

A *service delivery point providing HIV services* focuses primarily on HIV-related services. It provides one or more, core HIV-related services, including but not limited to HIV testing and counselling, prevention of mother to child transmission, ART, screening and prophylaxis for opportunistic infections (OI) and other health services for people living with HIV. A *service delivery point* includes fixed locations and/or mobile operations providing routine and/or regularly scheduled services.

A service delivery point providing SRH services focuses primarily on SRH services. It provides one or more, core SRH services, including but not limited to family planning, antenatal and postnatal care, STI diagnosis and treatment and emergency contraception. A *service delivery point* includes fixed locations and/or mobile operations providing routine and/or regularly scheduled services.

A *service delivery point routinely providing general health services* provides health services that are not limited to either HIV or SRH services. These services may be broad, e.g. primary health care, or may be more specific, e.g. TB services. A *service delivery point* includes fixed locations and/or mobile operations providing routine and/or regularly scheduled services.

The *HIV 'marker service'* is HIV testing and counselling; the *SRH 'marker service'* is modern contraceptive services.

Purpose

The purpose of this indicator is to determine if the provision of core HIV and SRH services is integrated at the service delivery point. The provision of the HIV marker service at SRH service delivery points and provision of the SRH marker service at HIV service delivery points will be an indication of the extent of the integration.

Rationale

The international community recognises that key development goals will not be achieved without ensuring expanded and ready access to HIV and SRH services. Given the overlaps and connections between these two types of services and the ability to improve access to each of them by integrating HIV and SRH within service delivery points, it is useful to assess the extent of this service integration. A better understanding of the extent of HIV and SRH integration will contribute to ongoing efforts to strengthen and improve the integration as well as the quality and availability of integrated services.

1 Use Questionnaire A – page 31
2 Use Questionnaire B – page 34
3 Use Questionnaire C – page 37

Method of Measurement

The indicator is measured using three simple questionnaires: One questionnaire for service delivery points primarily providing HIV-related services; one questionnaire for service delivery points primarily providing SRH services; and one questionnaire for service delivery points that routinely provide general health services.

A service delivery point can include fixed locations and/or mobile operations offering routine and/or regularly scheduled services. Examples include clinics, hospitals, health facilities and community-based organizations (government, private or NGO). Individual community health workers are not considered to be individual service delivery points. Rather, the organizations with which they are affiliated are considered to be the service delivery point.

The questionnaire for service delivery points primarily providing HIV-related services includes a follow-up question about modern contraceptive methods other than condoms. There are two options for this question. Option 1 uses *modern contraceptive methods other than condoms* as a proxy. Option 2 provides respondents the opportunity to list the modern contraceptive methods other than condoms that are available.

For *service delivery points primarily providing HIV-related services*, the numerator is the number of service delivery points that provide modern contraceptive services other than condoms to their clients/patients. The denominator is the number of service delivery points included in the sample.

For *service delivery points primarily providing SRH services*, the numerator is the number of service delivery points that provide HIV testing and counselling to their clients/patients. The denominator is the number of service delivery points included in the sample.

For *service delivery points routinely providing general health services*, the numerator is the number of service delivery points that provide both HIV testing and counselling and modern contraceptive services other than condoms to their clients/patients. The denominator is the number of service delivery points included in the sample.

Data reported by service delivery points about how services are provided (e.g. same healthcare worker on the same day, same healthcare worker on a different day) could be used to assess the characteristics of the HIV and SRH integration. In addition, data reported by service delivery points about core services could be used to categorise them by type.

Data reported by service delivery points about population groups could be used to provide more detailed information on one or more specific population. (Note: If the indicator is being used to track services provided to a specific population, the denominator should be adjusted to reflect the number of service delivery points serving that population.)

Data collection method

A representative sample of service delivery points in the selected survey area (e.g. national, province, district, urban, rural) should be identified to complete the questionnaire. The appropriate questionnaire should be used with different types of service delivery points (e.g. primarily providing HIV-related services, primarily providing SRH services or routinely providing general health services). One or more knowledgeable and authorised representative from the participating service delivery point should complete and submit the questionnaire.

Measurement frequency

Given the simplicity and minimal reporting burden of the questionnaire, it would be possible to collect information for this indicator on an annual or biannual basis to assess the current situation and to track changes and/or trends.

Disaggregation of data

There is an inherent disaggregation of data by the type of service delivery points (i.e. providing primarily HIV-related services, primarily providing SRH services or routinely providing general services). The data can also be disaggregated by how services are provided to clients/patients. It can be disaggregated by the different services and/or combination of services provided by participating service delivery points or by the different population group served by the delivery points. In addition, if participating service delivery points are coded by location, it may be possible to disaggregate data by this factor as well.

Interpretation

This indicator is not designed to be a conclusive measure of the integration between HIV and SRH services at the level of service delivery. However, it is a simple and straightforward way to quickly and easily assess if there is growing acceptance and implementation of HIV and SRH integration, using the 'marker services' as a proxy.

The follow-up question for HIV service delivery points about the availability of *modern contraceptive methods other than condoms* uses the availability of these methods as a proxy. However, it also flags the overlapping use of condoms for disease and pregnancy prevention. In general, HIV service delivery points distribute condoms to prevent the spread of HIV, not to prevent pregnancy. *To simply count condom distribution by HIV service delivery points as an SRH service could provide misleading data on the integration between HIV and SRH services.*

Strengths and weaknesses

The primary strength of this indicator is its ability to quickly and easily provide a 'snapshot' of the current situation. For example: Is a core SRH service available at service delivery points providing HIV-related services and vice versa? Given the currently low level of integration between HIV and SRH services, the proxy measures used in this indicator provide valuable information on the situation, which is useful for a wide audience, ranging from policy makers to programme implementers.

Over the long term, as integration between HIV and SRH services become more common, the value of this indicator will diminish. The use of marker services as proxy measures will not provide detailed information about specific models of integration that are contributing to more effective approaches to service delivery.

Questionnaire A: For service delivery points primarily providing HIV Services

1. What are the core HIV-related services currently provided at your service delivery point? (Select all that apply)

Services	Tick if available (√)
HIV testing and counselling	
PMTCT (At a minimum, PMTCT Prong 3: Access to antiretroviral drugs to prevent vertical transmission and for ongoing treatment for mothers)	
TB screening	
Other OI screening and prophylaxis	
Treatment for opportunistic infections	
Male circumcision	
STI screening, diagnosis and treatment	
ART	
Condom provision	
Positive health, dignity and prevention[4]	
Other: Specify	

2. Are modern contraceptive services[5] currently available for clients/patients at your service delivery point?

- If yes, are modern contraceptive methods other than condoms available?

4 Positive health, dignity, and prevention helps people living with HIV lead a complete and healthy life and reduce the risk of transmission of the virus to others. It is characterized by its systematic delivery of a range of combination, behavioral, and sociocultural services within local communities. For more information see www.gnpplus.net/resources/positive-health-dignity-and-prevention-operational-guidelines/

5 The SRH service mentioned in this question will depend on the SRH marker service that has been chosen. Modern contraceptive services is included here as an example of how the question should be formulated.

3. If modern contraceptive services are available at your service delivery point, how are they provided to clients/patients who are using different HIV-related services? (Select all that apply.

Modern contraceptive services and the different HIV-related services listed below are:	Provided at the same location by the same healthcare worker on the same day	Provided at the same location by the same healthcare worker on a different day	Provided at the same location by a different healthcare worker on the same day	Provided at the same location by a different healthcare worker on a different day	Clients/ patients are referred to a different service delivery point within the same facility*	Clients/ patients are referred to a different service delivery point outside the facility
HIV testing and counselling						
PMTCT						
TB screening						
Other OI screening and prophylaxis						
Treatment for opportunistic infections						
Male circumcision						
STI screening, diagnosis and treatment						
ART						
Condom provision						
Positive health, dignity and prevention						
Other:						

* Some facilities – e.g. hospital complexes – may house multiple service delivery points.

4. Your service delivery point provides services to clients/patients in which of the following population groups? (Select all that apply.)

Population	Male	Female
General population		
Young people		
People living with HIV		
Sex workers		
Men who have sex with men		
People who inject drugs		
People living with disability		
Other (Specify)		

5. Are all the services you mentioned currently available or have been available within the last month?
Yes/No

6. If No why are the services not available?

Questionnaire B: For service delivery points primarily providing SRH Services

1. What are the core SRH services currently provided at your service delivery point? (Select all that apply)

Services	Tick if available (√)
Modern contraceptive methods other than condoms	
Pregnancy testing	
Emergency contraception	
Antenatal care	
Labour and delivery	
Postnatal care	
Newborn and child health	
STI/RTI screening, diagnosis and treatment	
Condom provision	
Cervical cancer screening	
Post-exposure prophylaxis for victims of gender-based violence	
Other:	

2. Do you offer HIV testing and counselling[6] for clients/patients at your facility?

Yes/No

6 The HIV service mentioned in this question will depend on the HIV marker service that has been chosen. HIV testing and counselling is included here as an example of how the question should be formulated..

3. If HIV testing and counselling are available at your service delivery point, how are they provided to clients/patients who are using different SRH services? (Select all that apply.)

HIV testing and counselling and the different SRH services listed below are:	Provided at the same location by the same healthcare worker on the same day	Provided at the same location by the same healthcare worker on a different day	Provided at the same location by a different healthcare worker on the same day	Provided at the same location by a different healthcare worker on a different day	Clients/ patients are referred to a different service delivery point within the same facility*	Clients/ patients are referred to a different service delivery point outside the facility
Modern contraceptive methods other than condoms						
Pregnancy testing						
Emergency contraception						
Antenatal care						
Labour and delivery						
Postnatal care						
Newborn and child health						
STI/RTI screening, diagnosis and treatment						
Condom provision						
Cervical cancer screening						
Post-exposure prophylaxis for victims of gender-based violence						
Other:						

* Some facilities – e.g. hospital complexes – may house multiple service delivery points.

4. Your service delivery point provides services to clients/patients in which of the following population groups? (Select all that apply.)

Population	Male	Female
General population		
Young people		
People living with HIV		
Sex workers		
Men who have sex with men		
People who inject drugs		
People living with disability		
Other (Specify)		

5. Are all the services you mentioned currently available or have been available within the last month?

Yes/No

6. If No why are the services not available?

Questionnaire C: For service delivery points routinely providing general health services

1. What are the core HIV-related services currently provided at your service delivery point? Select all that apply:

Services	Tick if available (√)
HIV testing and counselling	
PMTCT (At a minimum, PMTCT Prong 3: Access to antiretroviral drugs to prevent vertical transmission and for ongoing treatment for mothers)	
TB screening	
Other OI screening and prophylaxis	
Treatment for opportunistic infections	
Male circumcision	
STI screening, diagnosis and treatment	
ART	
Condom provision	
Positive health, dignity and prevention[7]	
Other:	

2. What are the core SRH services currently provided at your service delivery point?

Select all that apply:

Services	Tick if available (√)
Modern contraceptive methods other than condoms	
Pregnancy testing	
Emergency contraception	
Antenatal care	
Labour and delivery	
Postnatal care	
Newborn and child health	
STI/RTI screening, diagnosis and treatment	
Condom provision	
Cervical cancer screening	
Post-exposure prophylaxis for victims of gender-based violence	
Other:	

7 Positive health, dignity, and prevention helps people living with HIV lead a complete and healthy life and reduce the risk of transmission of the virus to others. It is characterized by its systematic delivery of a range of combination, behavioural, and socio-cultural services within local communities. For more information see www.gnpplus.net/resources/positive-health-dignity-and-prevention-operational-guidelines/

3. If *HIV testing and counselling* and *modern contraceptive methods* are both available at your service delivery point, how are the two services provided to clients/patients? (Select all that apply.)

Services	Tick (√)
Provided at the same location by the same healthcare worker on the same day	
Provided at the same location by the same healthcare worker on a different day	
Provided at the same location by a different healthcare worker on the same day	
Provided at the same location by a different healthcare worker on a different day	
Referred to a different service delivery point within the same facility*	
Referred to a separate facility	
Provided at the same location by the same healthcare worker on the same day	
Provided at the same location by the same healthcare worker on a different day	

* Same facilities – e.g. hospital complexes – may house multiple service delivery points.

4. Your service delivery point provides services to clients/patients in which of the following population groups? (Select all that apply.)

Population	Male	Female
General population		
Young people		
People living with HIV		
Sex workers		
Men who have sex with men		
People who inject drugs		
People living with disability		
Other (Specify)		

5. Are all the services you mentioned currently available or have been available within the last month?

Yes/No

6. If No why are the services not available?

Annex B: Measuring integration of HIV and SRH services: Using 'baskets' of services

Definition

Percentage of service delivery points providing one or more HIV service and one or more SRH services to clients.

A *service delivery point* includes fixed locations and/or mobile operations providing routine and/or regularly scheduled services.

To assess HIV and SRH integration, the indicator uses a fixed set of core HIV and SRH services, which are grouped into six different baskets, including three baskets of HIV services and three baskets of SRH services; see table below. (Note: In some situations, it may be appropriate to customize the list of services to the local context; e.g. needle exchange and opioid substitution therapy.)

Baskets of HIV and SRH services

HIV services		SRH services	
HIV prevention	• HIV testing and counselling, including serodiscordant couples • Prevention of mother to child transmission (At a minimum, PMTCT Prong 3: Access to antiretroviral drugs to prevent vertical transmission and for ongoing treatment for mothers) • Infant diagnosis • Positive prevention • Male circumcision • Condom provision • Post-exposure prophylaxis	Family Planning / Reproductive Health	• Family planning (counselling on and provision of modern contraceptive methods) • Pregnancy testing • Emergency contraception • Prevention of unsafe abortion • Management of post-abortion care
HIV care	• TB screening • Other OI screening • OI prophylaxis • Psychosocial support • Clinical staging • Clinical monitoring and restaging	Maternal & Child Health	• Antenatal care • Labour and delivery • Postnatal care • Newborn and child health
Antiretroviral Therapy (ART)	• ART (not including post-exposure prophylaxis) • ART adherence counselling • Psychosocial support • Treatment as prevention	Sexual health	• Sexual health counselling • STI/RTI screening, diagnosis and treatment • Condom provision • Cervical cancer screening • Post-exposure prophylaxis for survivors of gender-based violence

Purpose

The purpose of this indicator is to determine if the provision of core HIV and SRH services is integrated at the delivery point. The delivery of one or more services from different HIV baskets *and* the delivery of one or more services from different SRH baskets at the service delivery point will be an indication of the extent of the integration.

Rationale

The international community recognises that key development goals will not be achieved without ensuring expanded and ready access to HIV and SRH services. Given the overlaps and connections between these two types of services and the ability to improve access to each of them by integrating HIV and SRH within service delivery points, it is useful to assess the extent of this service integration. A better understanding of the extent of HIV and SRH integration will contribute to ongoing efforts to strengthen and improve integration as well as the quality and availability of integrated services.

Method of Measurement

The indicator is measured using a simple questionnaire that asks service delivery points to identify the services they provided. The questionnaire uses baskets of HIV and SRH services to gauge the extent of the integration between the two types of services.

The data collected by this indicator can be used in multiple ways with different numerators, depending on the level of detail desired. In all cases, the denominator would be the number of service delivery points included in the sample.

The simplest approach is to designate the numerator as the number of service delivery points that provide services from one or more HIV basket and from one or more SRH basket. A service delivery point can include fixed locations and/or mobile operations offering routine and/or regularly scheduled services. Examples include clinics, hospitals, health facilities and community-based organizations (government, private or NGO). Individual community health workers are not considered to be individual service delivery points. Rather, the organizations with which they are affiliated are considered to be the service delivery point.

Other options for the numerator include but are not limited to:

- The number of service delivery points that provide services in each of the six baskets included in the questionnaire. Using this numerator would highlight delivery points with the highest degree of integration between HIV and SRH services.
- The number of service delivery points that provide a specific HIV-related service (e.g. ART) and also provide one or more SRH service from one or more SRH basket. Using this numerator would focus attention on specific relationships between HIV and SRH services that could provide useful information for improving HIV and SRH integration.
- The number of service delivery points that provide a specific SRH service (e.g. ANC) and also provide one or more HIV service from one or more HIV basket. As mentioned above, using this numerator would focus attention on specific relationships between HIV and SRH services that could provide useful information for improving linkages.
- The number of service delivery points that provide services from at least two HIV baskets and two SRH baskets to a specific population group (e.g. female sex workers).

In every case, the denominator would be the number of service delivery points included in the relevant sample. (If population group is being factored into the denominator, it would be possible to limit the denominator to service delivery points that provide services to the specified population(s).)

Data collection method

A representative sample of HIV and/or SRH service delivery points in the selected survey area (e.g. national, province, district, urban, rural) should be identified to complete the questionnaire. The questionnaire should be sent to participating service delivery points. One or more knowledgeable and authorised representative from the participating service delivery points should complete and submit the questionnaire.

Measurement frequency

Given the simplicity and minimal reporting burden of the questionnaire, it would be possible to collect information for this indicator on an annual or biannual basis to assess the current situation and to track changes and/or trends.

Disaggregation of data

There is an inherent disaggregation of data by: 1) HIV and SRH basket and 2) individual HIV and SRH service. Disaggregation can also be by the main focus of service delivery points and/or the different population group reached by service delivery points. In addition, if participating service delivery points are coded by location, it may be possible disaggregate by that factor as well.

Interpretation

This indicator is not designed to be a conclusive measure of the integration between HIV and SRH services at the level of service delivery point. However, it can provide significant insights into this integration, depending on the designated numerator and how the response data are analysed.

Assuming respondents provided information on the full range of services provided in both HIV and SRH, the reported data can be analysed using different numerators, depending on the type and level of detail desired.

For example, a basic numerator – e.g. the number of sound/proven service delivery points that provide services in each of the six baskets included in the questionnaire – would highlight delivery points with the highest degree of integration between HIV and SRH services. Conversely, a more focused numerator – e.g. the number of sound/proven service delivery points that provide ART as well as sexual health counselling and emergency contraception – could indicate if specific HIV and SRH integration is taking place.

The ability to compare and contrast data points by using different numerators also makes it possible to do more comprehensive analysis with the data collected by this indicator.

Strengths and weaknesses

The primary strength of this indicator is its ability to collect a significant amount of data on HIV and SRH service delivery using a simple and straightforward questionnaire. The reported data can be used in multiple ways to assess integration between SRH and HIV services at the level of the service delivery point.

Given the currently low level of integration between HIV and SRH services, this indicator may provide limited information on the breadth and depth of linkages. However, over the long term, as integration between HIV and SRH services become more common, the indicator will be increasingly useful for assessing linkages generally and integration between individual services more specifically.

One potential weakness of the indicator is the inclusion of STI screening, diagnosis and treatment as an HIV service as well as an SRH service. The delivery of STI services can and should vary based on the context and the population. For example, STI services available at a delivery point may not be sensitive to the specific circumstances facing people living

with HIV. Similarly, not all delivery points providing STI services are capable of dealing with key populations, such as female sex workers or men who have sex with men. As a result, the reported data may show integration in STI services that are not necessarily practical, desirable and/or effective.

There is a parallel concern about condom provision, which also appears under HIV and SRH services. Including condom provision under both types of services flags the overlapping use of condoms for disease and pregnancy prevention. In general, service delivery points focused on HIV-related services distribute condoms to prevent the spread of HIV, not to prevent pregnancy. To simply count condom distribution by service delivery points as an SRH service could provide misleading data on the integration between HIV and SRH services.

Questionnaire for the Basket Indicator

1. From the following list, please select all of the services that are provided at your service delivery point.

Service Baskets	Tick (√)
HIV prevention	
• HIV testing and counselling	
• Prevention of mother to child transmission	
• Infant diagnosis	
• STI screening, diagnosis and treatment	
• Positive health, dignity and prevention[8]	
• Male circumcision	
• Condom provision	
• Post-exposure prophylaxis	
HIV care (pre-ART)	
• TB screening	
• Other OI screening	
• OI prophylaxis	
• Psychosocial support	
• Clinical staging	
• Clinical monitoring and restaging	
ART	
• ART (not including post-exposure prophylaxis)	
• ART adherence counselling	
• Psychosocial support	
• Treatment as prevention	

8 Positive health, dignity, and prevention helps people living with HIV lead a complete and healthy life and reduce the risk of transmission of the virus to others. It is characterized by its systematic delivery of a range of combination, behavioural, and socio-cultural services within local communities. For more information see www.gnpplus.net/resources/positive-health-dignity-and-prevention-operational-guidelines/

SRH services

Service Baskets	Tick (√)
Family Planning / Reproductive Health	
• Family planning (counselling on and provision of modern contraceptive methods)	
• Pregnancy testing	
• Emergency contraception	
• Prevention of unsafe abortion	
• Management of post-abortion care	
Maternal and Child Health	
• Antenatal care	
• Labour and delivery	
• Postnatal care	
• Newborn and child health	
Sexual Health	
• Sexual health counselling	
• STI/RTI screening, diagnosis and treatment	
• Condom provision	
• Cervical cancer screening	
• Post-exposure prophylaxis for victims of gender-based violence	
Family Planning / Reproductive Health	
• Family planning (counselling on and provision of modern contraceptive methods)	
• Pregnancy testing	
• Emergency contraception	

2. How are your different HIV and SRH services provided to clients/patients at your service delivery point? (Tick all that apply.)

Services	Tick (√)
Provided at the same location by the same healthcare worker on the same day	
Provided at the same location by the same healthcare worker on a different day	
Provided at the same location by a different healthcare worker on the same day	
Provided at the same location by a different healthcare worker on a different day	
Referred to a different service delivery point within the same facility*	
Referred to a separate facility	

3. Your service delivery point provides services to clients/patients in which of the following population groups? (Select all that apply.)

Population	Male	Female
General population		
Young people		
People living with HIV		
Sex workers		
Men who have sex with men		
People who inject drugs		
People living with disability		
Other (Specify)		

4. How would you describe the main focus of the services provided by your service delivery point?

- HIV-related
- SRH
- A combination of HIV-related and SRH

5. Are all the services you mentioned currently available or have been available within the last month? Yes/No

6. If No why are the services not available?

While there are many separate indicators related to sexual and reproductive health (SRH) and HIV, a key challenge has been the lack of internationally-agreed indicators to measure progress in linking SRH and HIV. Based on a theory of change, this SRH and HIV Linkages Compendium contains a focused set of indicators and related assessment tools that have relevance to tracking the links between SRH and HIV programmes at national and sub-national levels. Each indicator includes an overview, a brief description of its relevance to SRH and HIV linkages, and a hyperlink to a detailed definition. All the indicators in this compendium have passed through a rigorous evaluation based on the indicator standards of the UNAIDS Monitoring and Evaluation Reference Group.