The U.S. Global Health Initiative and Sexual and Reproductive Health and Rights: Integration

October 2011

PROLOGUE

A pregnant woman living in poverty is likely confronting multiple issues at once. She requires good prenatal care and nutrition throughout the pregnancy, and access to a skilled provider to educate her about healthy childbirth and attend her delivery. She may also already be infected or at high-risk of becoming infected with HIV. Her rights need to be respected in terms of pregnancy decisions, and in terms of HIV testing and treatment. If she wishes to postpone or stop childbearing following the pregnancy, she needs access to voluntary family planning services from a provider who respects her rights and listens to her concerns. Logic and evidence strongly suggest that this woman is much more likely to receive the care she needs when these services are integrated and grounded in respect for her human rights.

INTRODUCTION

President Obama's Global Health Initiative (GHI), announced in May 2009, elevates global health to an essential component of the larger U.S. foreign policy agenda alongside diplomacy, development, and national security.[1] The GHI—an approach to global health that links major health concerns including maternal and child health, family planning, HIV/AIDS, malaria, tuberculosis, and neglected tropical diseases—builds upon U.S. leadership and successful health initiatives that have reduced infant and maternal mortality, increased family planning access, and expanded prevention and treatment for HIV and AIDS.

Three of the GHI core principles that are critical to advancing sexual and reproductive health and rights include country ownership (specifically civil society participation); a focus on women, girls, and gender equality; and integration of health sectors. This policy brief focuses on the GHI principle of integration among health sectors, specifically those related to sexual and reproductive health.

Integration of maternal health, family planning, and sexual health (including HIV/AIDS) programming, as envisioned in the 1994 International Conference on Population and Development's Programme of Action,[2] has been long championed by global health advocates as critical to women's health and rights. Moreover, integrating these sectors has been proven by many studies[3, 4] to promote optimal health outcomes and facilitate access to care, particularly for women and girls. Based on this evidence, some U.S. Missions[5] have intentionally crafted support for integrated programming. Yet until the GHI, U.S. attempts to integrate these sectors have been limited in scale and geographic scope.

For integrated programming to reach its full potential, programs must:

- Integrate family planning, maternal health, and HIV programming;
- Elevate the importance of human rights;
- Address gender inequality and other socio-cultural barriers to accessing health;
- Ensure that the needs of marginalized populations are met;
- Ensure health workers are equipped with appropriate technical and human rights training; and
- Be freed from U.S. policies that obstruct successful integration.

Beyond the initial policy documents issued by GHI officials in Washington, GHI country strategies[6] shed additional light on how GHI will be implemented. But these strategies, while they certainly do not reflect a full exploration of existing integration efforts in each country, reveal limitations and obstacles to integration that threaten to undermine the impact of GHI's approach. The following are six key components for successful integration in programming.

1. Full Integration of Basic Sexual and Reproductive Health Services

Integration of sexual and reproductive health services is of vital importance for the well-being of women and girls. Lack of integration causes critical gaps that are glaringly obvious because the major cause of maternal mortality and HIV is unprotected sex. Women living with HIV may go untreated because their family planning provider does not test for HIV. Others may receive treatment at an HIV clinic, yet face stigma if they seek prenatal care. Girls facing unintended pregnancy may receive prenatal and maternity care, yet no information on contraceptive methods. By linking sexual and reproductive health care in a rights-based framework, health providers can significantly reduce these gaps.

Kenya's AIDS, Population and Health Integrated Assistance (APHIA) program is a promising example of a successful approach to integrating services: the chronically underfunded services of maternal and child health (MCH) were co-located with HIV services, combining the President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID) MCH funding to create positive impact on the health of women and girls in particular. The clinic serves as an entry point for women and their children to receive a range of services that may be otherwise inaccessible to them, including antenatal and postnatal care; prevention of mother to child transmission (PMTCT) programs; HIV counseling, testing, and treatment; and family planning (FP) services.[7]

Bangladesh's country strategy fully recognizes that family planning is essential not only to sexual and reproductive health care, but to development more broadly. The strategy pledges to support "one-stop shopping" access to a package of 10 essential health services designated by the government, including family planning, maternal health, and HIV.[8] But it also goes further by supporting advocacy among key stakeholders in Bangladesh "to reposition family planning as a development priority."[9]

In striking contrast, country strategies for Mali and Guatemala fail to address sexual and reproductive health (SRH) issues comprehensively. The Mali strategy discusses the government's "integrated packages of services," yet HIV testing and counseling are only offered in some antenatal care locations, and there is no apparent plan to expand into others. There is also no mention of integration of maternal health and family planning services into existing HIV services.[10] Although Guatemala's country strategy recognizes "the synergies resulting from an integrated approach to health"[11] and mentions "accessible, affordable quality family planning services, with special emphasis on integrated MCH/FP/RH services,"[12] there is no inclusion of HIV prevention, and no coordination or integration with primary health care interventions.[13]

Even integration of family planning and maternal health programs is in doubt in Guatemala. The country has been "graduated" from U.S.-provided contraceptive supplies and provides contraceptives solely through the Ministry of Health and the private sector. Therefore, U.S. support for MCH/FP integration will center on technical assistance to improve supply chain issues and contraceptive security in rural areas.[14] Yet considering the Guatemalan government's current limited investments in contraception, the U.S. cannot guarantee contraceptive supply to meet existing or increased demand. Guatemala also has plans to scale up proven MCH programs, including providing primary care to mothers and children, but does not mention including family planning services as part of its scale-up efforts.[15]

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2. User-Based Integration

Systemic integration at a structural level as discussed in the GHI strategy is essential to ensure U.S. foreign assistance programs and agencies coordinate with each other, with Ministries of Health, and with other donors. However, such institutional coordination should not be the end goal. Rather, integration's primary focus should be seamless service delivery for individuals across health sectors.[16]

Integrating health care services so that clients have

access to a wide range of information and services at one location is a cost-effective, client-centered, and successful way to reach those who may not otherwise seek the care they need. The need for co-located or closely connected care is particularly important for women, as some services that are critical components of comprehensive reproductive health, such as family planning, sexual health, and maternal health, work best when they are offered at the same location, or can be seamlessly offered at another accessible location. Integrating reproductive health and HIV/AIDS is also essential to ensuring that the reproductive health needs of those living with HIV are met.[17]

While co-location of services facilitates a patient's diverse health needs being met without significant interruption, it is not always necessary or the most efficient way to create a workable system. The creation of a robust referral system administered by staff trained to assess individual needs and make referrals across different levels in the system may be an optimum solution.[18] However, such referral systems must be as easily-navigable as possible to ensure positive health outcomes. Malawi's country strategy captures the failures of referral systems not designed with the user in mind. "Facilities, where available, are often so poorly designed that loss-to-follow-up and death arise as women move in search of the next referred service."[19]

User-based integration is clearly at the heart of the Ethiopian country strategy. "GHI in Ethiopia supports a focus on the creation of a quality health system that satisfies the community's health care needs, delivering safe and optimum quality of health services in an integrated and user-friendly manner."[20] Crafters of the document make repeated reference to a continuum of care and a life-cycle approach. Both of these concepts are centered on the needs of the individual. The first activity under their strategy to increase access to health care services is: "Integrated FP/RH/HIV services will be provided in all U.S. government (USG)-supported sites and integrated into HCT, PMTCT, ARV services."[21]

Country strategies do not always reflect the need to ensure integration at the user-level. For example, the Guatemala strategy states that the U.S. "does not support 'platforms' separate from the [Guatemalan government] and therefore integration is not an issue at that level." [Boldface in original text removed.] It instead emphasizes the strategic coordination among U.S. government agencies.[22] Coordination among U.S. foreign assistance agencies is positive, but cannot substitute for critical integration at the user level, which has not been adequately addressed in this strategy.

3. Adopting a Human-Rights-Based Framework that Addresses the Needs of All People

As progress on GHI implementation continues, the U.S. strategy for comprehensive, integrated programs must be grounded in human rights to ensure that marginalized populations are not left behind. Stigma and discrimination often prevent young people, people with disabilities, gay, lesbian and transgender people, sex workers, men who have sex with men, people who are incarcerated, those who use drugs, and people living with HIV from obtaining basic rights and health.[23] For example, integrated programming must recognize that women living with HIV have needs, desires, and rights to sexual and reproductive health. Just as other women, they should have full access to modern contraception, emergency contraception, safe and legal abortion, and the best available health care for healthy pregnancies and healthy children.[24]

This means health workers must be trained to be sensitive to a diverse community of patients that will come with a diverse set of issues. Maternal health providers must understand the human right of women living with HIV to bear children or access family planning. Adolescents must be able to access respectful and confidential care, including family planning counseling and treatment for HIV. Sex workers must have access to HIV prevention and treatment, in addition to their other sexual and reproductive health needs.

The overall lack of human rights as an expressed priority at the country-level for GHI implementation represents a missed opportunity to clearly articulate the relationship between rights and quality of care. Of the seven released GHI country strategies, only the Bangladesh strategy mentions human rights or a rights -based approach. Only the strategies from Ethiopia and Malawi pledge to increase access to youth-friendly

family planning services.

Future country strategies would benefit from a close examination of the Global Health Initiative Supplemental Guidance on Women, Girls and Gender Equality Principle. The guidance references human rights in a variety of contexts, including consultation with human rights groups, promotion of citizen monitoring of gender equality, and human rights education as a tool to promote behavior change and mitigate gender-based violence.[25] Most notably, the guidance specifically requires that GHI country teams "ensure that human rights are embedded in programs."[26] This requirement must be reflected in country strategies and future implementation documents to ensure it is meaningfully considered and integrated at the programming level. Without it, it is not possible to adequately meet the health priorities of all individuals in need, regardless of age, social or marital status, occupation, sexual orientation, race or ethnicity.

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4. Establishing a Holistic Approach that Addresses Gender Inequality and other Sociocultural Barriers to Health

A holistic, woman-centered approach to integration means that when programs are co-located or linked, critical socio-cultural issues that serve as barriers to accessing health services are adequately addressed, including child marriage, gender-based violence, and traditional harmful practices.

The Bangladesh country strategy demonstrates a clear understanding of the links between social issues and health concerns. The strategy envisions linking with civil society groups funded by USAID's Democracy and Governance program "to address gender-based violence and human rights." Moreover, it pledges to focus on the delay of early marriage and unintended pregnancy through girls' education.

Similarly, Malawi's country strategy notes that HIV risk decreases sharply with increases in educational attainment, and pledges continued collaboration between the USAID education program that supports girls in primary school with PEPFAR's initiative to support secondary school for girls. The Malawi strategy also describes how it will use the Global Health Initiative Supplemental Guidance on Women, Girls and Gender Equality Principle to ensure implementers "focus on issues such as equitable access, empowerment and inclusion of women and girls, and engagement of men and boys."[27]

Such engagement of men and boys is critical to overcoming barriers to integrated health care. Family planning providers have long known that male acceptance of contraception is an important factor in continued use. Also, women report serious challenges in disclosing their HIV-positive status to their partners and families for fear of being beaten or shunned, and as a result are reluctant to bring home medicine for themselves or their children.[28] Advocates suggest that engaging men will lead to better overall health outcomes for the whole family.

But many of the country strategies are silent about the admittedly difficult challenge of engaging men and boys. Guatemala's strategy mentions attention to gender-based violence and includes the training of health workers on gender issues, but there is no mention of engaging men and boys in promoting gender equality or combating practices that put adolescent girls at risk for ill-health, like early marriage. Ethiopia's country strategy prioritizes women's leadership and participation in its global health agenda, and addresses harmful traditional practices and other barriers for women to access health. Even in Ethiopia, where its established health extension program has been creating an enabling environment to increase demand for and access to health services, the critical factor of engaging men and boys as an intervention to reduce gender-based violence is missing.[29] While these countries all likely have pilot projects for engaging men and boys, GHI country strategies should highlight promising projects for scale up.

5. Creating a Sustainable, Compassionate Health Work Force

One of the challenges of integrated programming is the increasing strain it will put on health systems and the health workforce. For example, in Ethiopia, where the government has undertaken a holistic, integrated approach to address its health challenges through its health extension program, health extension workers complained that the workload was overly burdensome. USAID representatives in Ethiopia also expressed that the challenge of a successful program like the health extension program is resisting the temptation to try to solve all other development challenges by lumping them into this successful program, thus increasing the strain even more on the health extension worker.[30] Malawi's strategy reports a similar issue with that country's Disease Control Assistants, who have successfully taken on health care provision that used to require doctors or nurses, yet "are either overworked, providing inadequate care, or are in such high demand that the facilities have absorbed them from the community."[31]

The GHI strategy recognizes that large-scale integrated programming must take into account the necessary inevitability of transforming health systems to adapt to the new demands placed on the system. In addition, health worker attitudes must be adequately assessed to determine the needs at the country-level, and consistent training programs must be established nationwide to adequately train health workers on professionalism, non-discriminatory and rights-based patient care, and cultural sensitivity to youth and marginalized populations. While systems are undergoing these growing pains, they must include frameworks and policies that promote and protect the rights of health workers and recruit and retain women in the workforce.

All of the strategies mention training of health personnel, but in many strategies this is not explored fully. Strategies do not detail what training will entail, such as a rights-based curriculum, or a strategy for recruiting and retaining women workers. Strategies from Guatemala and Nepal are notable in their acknowledgement that health workers need to be trained in gender, cross-cultural literacy, and respect for quality health care, a tacit recognition of the importance of human rights and respect to quality health care.[32, 33] However, the majority of strategies do not explore the importance of training providers in human-rights-based care. If providers increase their technical skills, yet maintain prejudices and negative attitudes toward certain populations, their quality of care will likely remain poor and their attitudes will continue to serve as a deterrent for women to seek care.

Health worker performance is also strongly affected by their level of compensation and support. The challenge of ensuring that health systems reward and sustain compassionate care is particularly severe in rural areas. While GHI cannot be expected to fully resolve these structural issues, the health systems strengthening component of GHI should contribute to the solution.

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6. Ending U.S. Policy Restrictions

Current and threatened restrictions in U.S. policy undermine the success of the GHI, including its integration approach, and continue to impact progress already made in the fight against HIV. For example, although the Global Gag Rule was overturned by the Obama administration, Congress has recently tried to reinstate it. The Global Gag Rule prohibits organizations that choose to take U.S. family planning funds from using their own, non-U.S. funds to provide information, referrals or services for legal abortion, or advocate for the legalization of abortion in their country. By restricting organizations that provide access or referral to all a woman's legal reproductive health options or zeroing out family planning funding for that organization, the Global Gag Rule undermines efficient, comprehensive integrated programs. This

means that an organization must choose between either refusing U.S. family planning funds, which would result in drastically fewer resources available to provide any type of family planning services, or taking U.S. family planning funds, curtailing the services and information they can provide. The vacillation as this policy is instated and repealed results in a chilling effect among organizations that struggle to change their entire business model every time the U.S. changes the status of the Gag Rule.

Although maternal mortality is a central concern in all the country strategies, there is little to no mention of unsafe abortion as a cause of maternal death. In some countries such as Ethiopia, unsafe abortion causes approximately one of every three maternal deaths, and a significant proportion of the country's maternal morbidity. Many countries, like Ethiopia, have liberalized their abortion laws in recognition of the brutal toll criminalization has taken on women. Yet U.S. global health policy is almost silent about this issue. The Helms amendment prohibits U.S. funding of abortions "used as a method of family planning," but does not prohibit such care in cases of rape, incest, or health of the mother. Despite this, country strategies do not address safe abortion for women included in these exceptions. Safe abortion and post-abortion care are essential components to sexual and reproductive health care and the GHI cannot effectively confront maternal mortality without acknowledging their importance.

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The anti-prostitution loyalty oath (APLO) is another example of a U.S. policy restriction that undermines a successful global health agenda and is counterproductive to the fundamental principles in the GHI. The APLO requires organizations that take certain U.S. funds to explicitly adopt a policy "opposing prostitution." Because there is no official guidance interpreting the parameters of the APLO, organizations on the ground tend to self-censor their work to ensure compliance. The result is that the oath can dramatically impact an organization's ability to provide high quality, essential, non-discriminatory services to sex workers, a population that is already at a heightened risk of HIV.

RECOMMENDATIONS

The Obama administration and GHI country teams should:

- Ensure **successful integration of maternal health, family planning, and HIV programs** in as many locations as strategic and possible, based on needs assessment, mapping, and meaningful engagement of civil society and communities;
- Ground the integration of programs **within a human rights framework that addresses the needs of all populations, especially marginalized** and hard to reach youth;
- Employ a **holistic model that addresses gender inequality and other socio-cultural barriers to accessing health** for the most vulnerable populations, especially women;
- Ensure that the growth and evolution of health systems invests in health worker training to create a **professional work environment free from stigma and discrimination** and that respects the rights of users and workers, especially women; and
- **Ask Congress to eliminate policy restrictions** – including the Helms amendment and the APLO – that undermine the success of the Global Health Initiative and its integrated approach.

CONCLUSION

Integration within the GHI should mean that a woman or girl can access the health services she needs from compassionate providers who ensure that she receives the highest possible standard of care and the education she needs to be healthy. It should mean that she receives such care regardless of her HIV status, her age, marital status, occupation and ethnicity. She should be able to access this care in one location, or through meaningful referral to another location close by. This is the care that most people in the Global North expect, yet is exceedingly rare in the Global South.

In assessing the Global Health Initiative's progress in

strategic coordination and integration through review of country strategies, it is clear that GHI has increased coordination among U.S. foreign assistance agencies and between these agencies and host governments. In some cases, GHI has also advanced true integration of sexual and reproductive health service delivery. While these are important gains, in many cases, country strategies demonstrate incomplete attention to integration. Sexual and reproductive health services continue to be siloed, and are not approached with appropriate consideration of the human rights of women, girls, and marginalized groups.

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As GHI moves forward, it will largely be judged on the success or failure of integrated service delivery. In order to maximize chances of success, GHI decision makers must ensure that sexual and reproductive health integration truly and equitably reaches those it is intended to reach: women and girls.

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[5] A U.S. Mission is a delegation of U.S. officials placed within a foreign country to implement foreign policy initiatives.

[6] Eight countries were chosen by the Obama administration under the Global Health Initiative to be GHI+ countries. These countries "serve as learning labs for a new global health strategy aimed in part at reducing maternal and child deaths and combating preventable diseases," such as HIV/AIDS. The eight countries are Bangladesh, Ethiopia, Guatemala, Kenya, Malawi, Mali, Nepal and Rwanda. (Obama Administration Names Eight 'GHI Plus' Countries. Kaiser Family Foundation. http://globalhealth.kff.org/Daily-Reports/2010/June/18/GH-061810-GHI-Plus.aspx.)

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