Tab 2: Defining & Understanding HIV Integration

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Defining HIV Integration

People travel by landmarks. We move from one point to another and look for cues along the way to help guide us. Ask for directions on any reservation, and you will hear something like, "Drive a ways on that dirt road there, until you come to a ditch, then turn left. Drive past the old Begay ranch, but not too far, then you are going to turn towards the big rock and cross a small old bridge across a dried up wash…." and so on and so forth. On the journey down the road to HIV prevention integration what would be "the landmarks"? How would we know when we have come to the old ranch, or when to cross the bridge? We need cues to guide us as well. How would you know an agency clinic has HIV integrated services?

What constitutes integration? Service integration can mean several different things and is open to different interpretations by different people, agencies or clinic. Does it mean that services are new to an agency/clinic/department are being structured to supplement what is currently happening? If a tribal health clinic is placing HIV education pamphlets in the waiting room, has that clinic integrated HIV prevention? If a reproductive health setting only offers HIV prevention education and HIV prevention counseling, is it integrated? If an IHS clinic uses exiting forms such as counseling checklists and adds another form on HIV counseling, is it integrated?

As integration has become an important topic for discussion in the health care community, it might be useful to discontinue the questions and review some of the formal definitions that have proposed.

The Substance Abuse and Mental Services Administration (SAMHSA) proposes these definitions that focus on substance use and mental provision:

> *Integration*: As used in this paper, integration refers to strategies for combining mental health and substance abuse services and/or systems, as well as other health and social services to address the needs of individuals with COD.
>
> *Services Integration*: Any process by which mental health and substance abuse services are appropriately integrated or combined at either the level of direct contact with the individual client with a co-occurring disorder or between providers or programs serving these individuals.

The Centers for Disease Control and Prevention lays forth the following definition:

> *Program collaboration and service integration:* a mechanism of organizing and blending interrelated health issues, separate activities, and services in order to maximize public health impact through new and established linkages between programs to facilitate the delivery of services.
>
> *HIV family planning integration* (developed by CDC HIV Integration Grantee, February, 2006): HIV integration into family planning clinics is the routine provision of easily accessible and client-centered HIV prevention and care services in reproductive health programs. These services may include but are not limited to information and education, counseling, testing, referral, and treatment.

And the International Planned Parenthood Federation believes this:

> *HIV integration:* the incorporation of the prevention, detection and treatment of HIV into sexual and reproductive health services. HIV integration makes explicit the connection between sexuality, contraceptive choice and STI/HIV prevention and harnesses the inherent synergy between preventing unwanted pregnancy and preventing STI/HIV.

As varied as the definitions may be, they all focus on the same central, combining resources to provide more comprehensive health care that encompasses HIV prevention. HIV service integration can occur on many levels such as a clinic, several clinics, substance abuse treatment facility, at a tribal health level or even an IHS service unit. Integrating HIV services may even require the restructuring of services at an administrative and/or programmatic level. The level and scope of service integration depends on what services currently exists, what is feasible to introduce, and what is needed by the community.

A commentary published in International Planning Perspectives (June 2002) on integration of STD and HIV services into family planning defines integration as, "Any two services can be considered to be integrated when they are offered at the same facility during the same operating hours, and the provider of one service actively encourages clients to consider using the other service during that visit.

According to this definition, integrated services may or may not be offered in the same physical location within the facility and may or may not be offered by the same service provider."

The end goal is to improve the health outcomes of Native people by reducing the high rate of new HIV infections among the Native population. HRSA, as part of a report on its American Indian/Alaska Native Initiative, SPNS Project, stated that initiatives that have sought to integrate HIV care, substance abuse treatment, and mental health treatment and link them to primary care have been shown to decrease morbidity and mortality for all three health issues.

Popular movements to integrate services have already happened in many healthcare arenas – like integrating mental health services into primary care settings, like screening for substance abuse concerns during routine physicals and visit. And Indian Health Service National STD Program has been working with the IHS Division of Epidemiology to develop an integration plan for STD, HIV, AIDS, and hepatitis prevention and control activities for years.

HIV Integration may be implemented differently from one health care setting to the next. One clinic may only offer education and counseling and refer clients to other agencies for testing, another may offer education, counseling and on-site testing, and another one may offer a full-range of HIV services including education, counseling, testing and care services for HIV positive women. This is one area where the expression, "one size fits all" is not applicable.

Before you begin integration of HIV services it's important to ask the questions, "Why are we integrating HIV services into reproductive health?", and most importantly "How will we recognize integration in our clinic?"

Why Integrate HIV Services

HIV in Native communities, while not widely discussed, is a major problem. And the problem represents a significant health disparity. Here are some of the facts:

HIV/AIDS among American Indian And Alaska Native Populations

- Since the beginning of the epidemic through 2007, 3,492 American Indians/Alaska Natives (AI/AN) have been diagnosed with AIDS.[11]
- 1,792 AI/ANs with HIV/AIDS have passed away.[1]
- In 2007, there was an estimated 2,281 AI/ANs living with HIV/AIDS – 1,644 men, 614 women and 23 children.[1] However, the number of AI/AN people living with HIV/AIDS may actually be higher than noted.

HIV/AIDS among Native Hawaiian & Other Pacific Islander Populations

- 721 Native Hawaiians/Other Pacific Islanders (NHOPI) have been diagnosed with AIDS.[1]
- 291 NHOPIs with HIV/AIDS have passed away.[1]
- During a 5 year average, the rate of AIDS cases for Native Hawaiians/Part Hawaiians was 10.0 per 100,000 compared to Hawaii's total rate of 7.8 per 100,000.[2]
- Data for NHOPI are typically subsumed in the category "Asian/Pacific Islander". Because of this misclassification, data for Native Hawaiians is difficult to classify.

HIV/AIDS Compared to Other Ethnic Groups

- AI/ANs have the 3rd highest rate of new HIV infections. In 2007, the rate was 14.6 per 100,000 persons, compared to 83.7 for Black/African Americans, 29.3 for Hispanic/Latinos, 11.5 for Whites, and 10.3 for Asian/Pacific Islander.[1]
- Of persons who were diagnosed with AIDS, AI/ANs had that shortest overall survival rate and NHOPIs second.[1]
- At the end of 36 months, AI/ANs had survived at 73% and NHOPIs at 77%, compared to 79% for Black/African Americans, 84% for Whites, 85% for Hispanic/Latinos, and 89% for Asians.[1]

The need for prevention efforts continues to grow while resources continue to dwindle. This alone creates a solid case for the need for integration – which asks programs, agencies, department, clinics, and/or tribes to work to enhance and expand services, while streamlining budgetary impacts.

This can be difficult, especially when other health issues overshadow HIV in their priority and impact. Issues like substance use, diabetes, tobacco use, obesity, and tuberculosis all have garnered more dollars and have also found more success and uptake in Native communities. All of these issues have manifested themselves more visibly in Native communities and as such received more attention. These issues carry less taboo (with the potential exception of substance use) than does HIV which involves open and honest discussions about sex, sexuality, and drug use. This alone is another reason to integrate. Integrating HIV into other health issues that carry less stigma may serve to normalize the discussions required for HIV prevention. This has been a very successful strategy in many Native communities, where discussions around health have transformed (largely due to the holistic cultural context of health) into discussions of wellness. A holistic approach, which is grounded in Native worldviews, parallels the goals of service integration. Do not focus on a singular health issue, when the connection between several different issues is evident and the benefit from addressing all of them cannot be ignored.

As we examine health and the determinants (what is promoting the behavior) of the healthy or unhealthy individuals, it becomes obvious that many health conditions overlap. By addressing these determinants, we can truly begin to perform prevention work by combating an issue before it becomes a significant health problem. We can also tackle more than one issue at a time.

In addition to the cultural appropriateness of a holistic heath approach and destigmatizing HIV services, there are several other reasons to integrate HIV services.

- More efficient client services – clients may end up receiving multiple services from a single location, or from a single provider.
- Resolve turf issues – by combining resources and working together, boundary and competition may slowly dissolve
- Program collaboration – proof of collaboration is desirable among funders and provides a more comprehensive community approach to health and wellness
- Increase agency expertise – by cross-training and raising skill levels of current providers, and agency is enhancing its ability to combat a wider variety of health issues, as well as teaching them to innovatively explore options for further integration opportunities.
- Comprehensive risk assessment v. routine risk assessment – conducting an assessment that seeks to gather information regarding more than one health condition rather than putting an individual multiple assessment tools for multiple conditions decreases assessment time, increases the breadth of information in client files, and may serve to normalize what could potentially be an uncomfortable HIV risk assessment.

Why Integrate in Family Planning Settings

Why should we integrate HIV prevention into family planning? Although there are not more than a handful of dedicated Native-specific family planning clinics operating on reservations or in urban areas, it would be ill-advised to ignore the importance of focusing integration efforts at these specific locations. Family planning clinics are designed to meet the specific reproductive health needs of women, and looking to the future and protecting future generations is of vital interest to all Native peoples.

To stop the spread of HIV, women need to understand the behaviors that put them at risk for exposure to HIV. They must learn their serostatus and do so earlier in their disease progression. To achieve this, real and perceived barriers to HIV prevention must be reduced. One strategy for achieving this is to integrate HIV prevention services into family planning clinics and other reproductive health care settings.

Nearly all women attending family planning or reproductive health clinics are sexually active, and sexual intercourse is a principle mode of HIV transmission. Family planning encounters offer valuable opportunities for HIV risk reduction. Family planning clinics already do risk assessment, STI diagnosis and treatment activities, and condom promotion and HIV education, as well as some counseling. Family planning clinics thusly offer valuable additional opportunities to:

- Increase recognition of HIV risk;
- Recognize the relationship of HIV to other STIs, mother-to-child transmission of HIV, infertility, and other related risks.
- Affect reproductive health decisions and enhance reproductive health planning; and
- Ensure timely identification and intervention activities in the case of an HIV positive diagnosis.

Client-provider encounters offer valuable opportunities for HIV prevention. Currently, family planning providers conduct some ongoing activities related to the diagnosis and treatment of Sexually Transmitted Infections (STI), promotion of condom use, and HIV education and counseling. Many STI diagnoses among U.S. women are made in reproductive health care settings. Also family planning providers often offer HIV counseling and testing, and many make appropriate referrals for HIV prevention, behavioral interventions and treatment. These prevention efforts can extend from clients to their sex partner(s), friends, family, and others in the community. Nevertheless, data from various studies suggest that multiple opportunities to provide clients and their male sexual partners with HIV prevention education are missed each year by not taking full opportunity of client-provider contacts.

Furthermore reproductive health care providers are unique in their relationships with clients. Reproductive health care providers usually have a trusted relationship with clients. In many cases, it is the only access for health care services for economically disadvantaged women and the only opportunity to receive HIV counseling and testing. Providers receive extensive training regarding reproductive health care issues including diagnosis and treatment of sexually transmitted diseases. STIs are a major risk factor for the transmission of HIV.

Early in the epidemic, HIV infection and AIDS were diagnosed for relatively few women and female adolescents. Today, women account for more than one quarter of all new HIV/AIDS diagnoses. Women of color are especially affected by HIV infection and AIDS.

In the same year, HIV infection was the 5th leading cause of death among all women aged 35-44 years and the 6th leading cause of death among all women aged 25-34 years. The only diseases causing more deaths of women were cancers and heart disease.

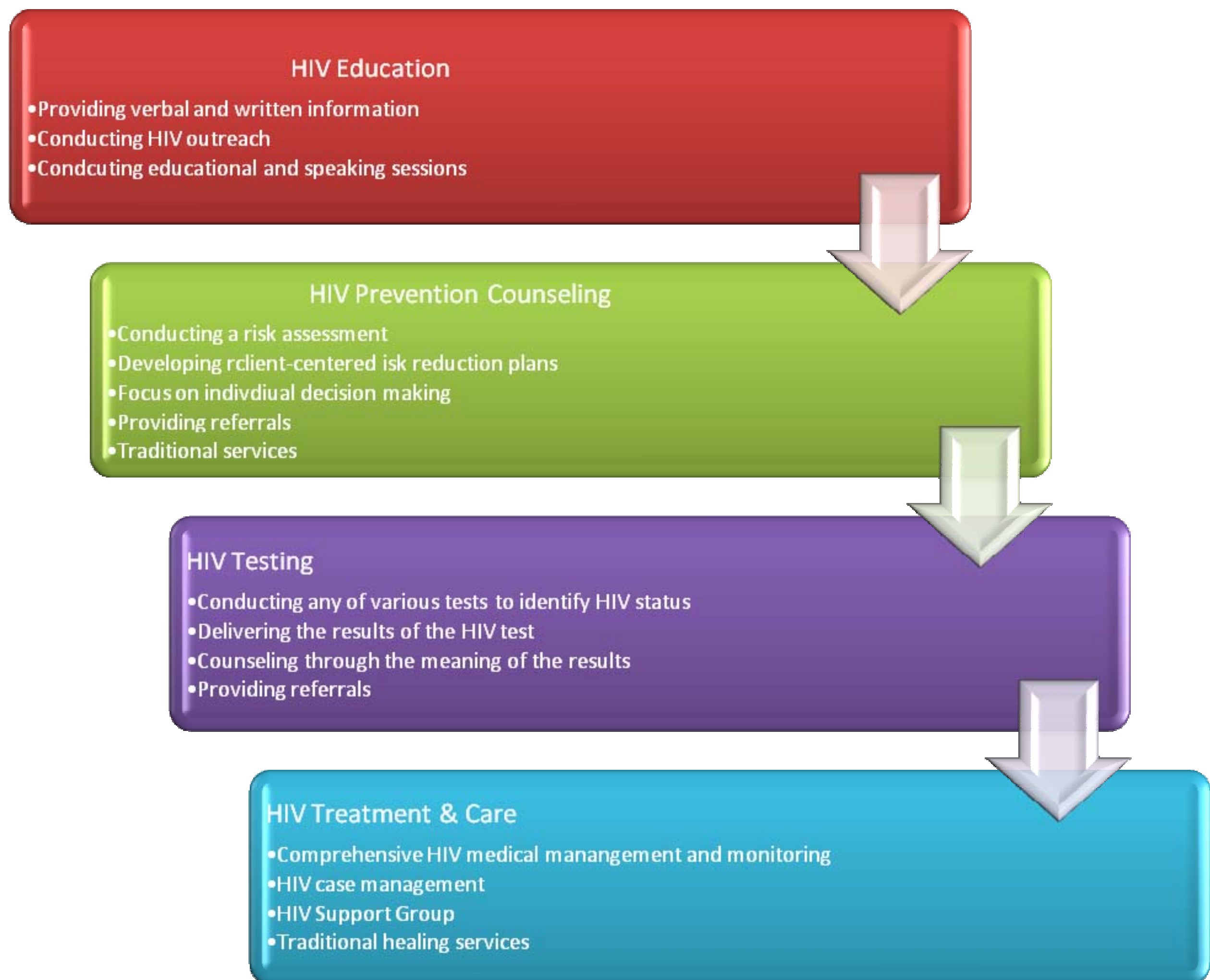
[i] Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2007. Vol. 19. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2009: http://www.cdc.gov/hiv/topics/surveillance/resources/reports/.
[2] Hawaii Department of Health. (2007). HIV/AIDS surveillance semi-annual report for Hawaiian/Part Hawaiian AIDS cases. Honolulu: Hawaii. Department of Health, HIV/AIDS Surveillance Program.

Levels of HIV Service Integration

There are four layers of integration, each one building upon the foundation created by the previous service:

- Education
- Counseling
- Testing
- Treatment

There are a variety of activities/services that can be initiated at each layer that can complement not only other HIV/STD services, but can work with other clinical services as well. Integration is about creating a variety of services within a framework that utilizes existing resources, does not duplicate work, and creates a seamless and wrap around service delivery to the community recipients.



A Continuum of Different Integration Activities

This triangle represents how integration activities can begin and how they can vary. The simplest form of HIV education is on the bottom of the triangle whereas more advanced integration of HIV testing is at the top of the triangle and the activities in between create a natural service growth chart.