Voices from the Field

The Role of Integrated Reproductive Health and HIV/AIDS Programs in Strengthening U.S. Policy

A Report of the CSIS Task Force on HIV/AIDS

Executive Director
J. Stephen Morrison

Author
Janet Fleischman

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The CSIS Press
Center for Strategic and International Studies
1800 K Street, N.W., Washington, D.C. 20006
Tel: (202) 775-3119
Fax: (202) 775-3199
Web: www.csis.org

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Voices from the Field

The Role of Integrated Reproductive Health and HIV/AIDS Programs in Strengthening U.S. Policy

Janet Fleischman

Introduction

The HIV/AIDS Task Force of the Center for Strategic and International Studies (CSIS) hosted a major conference on October 30, 2007, titled, "Integrating Reproductive Health and HIV/AIDS Services: Lessons from the Field for PEPFAR Reauthorization." In the context of reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR), and looking ahead to the strategy that will be developed by the next U.S. administration, the conference sought to focus high-level attention on the opportunities and challenges of integrating reproductive health (RH) and HIV/AIDS programs. The proceedings demonstrated that substantial ingenuity and innovation is under way in integrating these services, and highlighted the importance of ensuring that the emerging lessons from the field inform decisions about the next phase of U.S. AIDS policy.

By bringing together a distinguished group of speakers and experts, the conference highlighted new dimensions of the HIV/AIDS epidemic that should be addressed by the reauthorization process and distilled concrete options that the U.S. Congress and the Office of the Global AIDS Coordinator (OGAC) should act upon. CSIS was honored to have such innovative and committed individuals participate in the conference. The event provided a unique opportunity to listen and learn from their range of experiences in integrating reproductive health and HIV/AIDS services for women, and it led to a clear sense of how such integration can contribute to more effective HIV/AIDS outcomes.

This conference was the culmination of more than two years of work by Janet Fleischman for the CSIS Task Force. Fleischman traveled to Ethiopia, Kenya, South Africa, and India to identify and visit projects focusing on RH-HIV

integration, learn from the range of experiences in integrating different services, and meet with leading experts on RH-HIV integration policy and practice. In addition, she conducted extensive consultations with U.S. congressional and administration officials, HIV/AIDS organizations and service providers, public health experts, and women living with HIV/AIDS. This systematic effort to learn from actual field experiences and to bring those voices to Washington, D.C., set the stage for the conference's invaluable contribution to the discussions on PEPFAR reauthorization and U.S. policy.

The conference featured leading practitioners involved in RH-HIV integration from Kenya, South Africa, India, and the United States, with audience participation representing a wide range of key governmental and nongovernmental agencies.[1] Each country panel focused on a specific entry point for integration: Kenya on the integration of voluntary counseling and testing (VCT) and family planning (FP); South Africa on the integration of reproductive health/family planning with prevention of mother-to-child transmission (PMTCT) and antiretroviral (ARV) programs; and India on using treatment for sexually transmitted infections (STIs) as an entry point for RH and HIV services, with a focus on reaching sex workers. The final panel looked at the way forward for U.S. policy.

This conference report is designed to inform the debate as Congress and the administration consider PEPFAR's next phase. It demonstrates ways that reproductive health and HIV can be linked together to better serve the needs of clients and health care providers in a more comprehensive, cost-effective, and efficient manner. The range of integrated programs presented included PEPFAR-supported projects, which demonstrates that U.S. HIV/AIDS programs can create space for RH-HIV integration. Indeed, one valuable outcome of the conference was learning about the emerging lessons on RH-HIV integration and focusing on how they can be adapted and expanded in other settings and in additional countries. Clearly, further evolution and clarification of U.S. policy in the area of RH-HIV integration would be welcomed by implementing organizations in many countries that receive PEPFAR funding.

This report summarizes the conference's panels and presentations, and it concludes with the recommendations that emerged from the conference concerning practical, actionable steps for Congress and PEPFAR. In particular, this report recommends that U.S. policy focus on the following areas: expand PEPFAR support and dedicated funding for RH-HIV integration programs; develop guidance for PEPFAR country teams and partners on how to implement RH-HIV integration, along with appropriate tools and indicators; increase overall resources for population and family planning programs; address U.S. policy restrictions, notably the Mexico City policy and the abstinence earmark; strengthen community involvement and support comprehensive, rights-based

[1] Participants included U.S. government agencies and congressional offices, UN agencies, nongovernmental organizations (NGOs) focusing on women's rights and human rights, AIDS activists, private foundations, academics, and health practitioners, as well as NGOs working on HIV/AIDS in PEPFAR countries.

approaches; and address the need for more evidence by supporting research and ensuring horizontal dissemination of promising approaches.

This is a particularly important moment to focus policy attention on the area of RH-HIV integration. The window is now open on debate around what reauthorization should focus on and what approaches should be taken. There is broad agreement that reauthorization needs to emphasize elevating prevention and integrated approaches that link related, strategically important areas, and this is particularly relevant to reproductive health and HIV/AIDS. This kind of response will require empowering U.S. officials, partners, and implementing organizations in the field to carry forward programs and to give them greater program flexibility. The issue of sustainability is critical, as PEPFAR moves from an emergency program to a more long-term response to the AIDS crisis.

The conference also provided a forum for candid discussion about the obstacles to RH-HIV integration. One major challenge involves the enormous disparity in resources between HIV/AIDS and reproductive health/family planning programs. This creates extreme programmatic pressures in efforts to promote "wrap-around" programs. Another obstacle is the reality of competing priorities. Although President Bush called for PEPFAR to be reauthorized at a $30-billion level, this represents a slowing of growth in U.S. HIV/AIDS funding and will present challenges in addressing new program areas.

At a time when many policymakers, experts, and advocates are debating whether U.S. funding for HIV/AIDS is undermining other critical health priorities—including child survival, maternal health, and family planning—the promising approaches toward integration presented at the conference illustrate both the important overlaps between these sectors and ways that greater integration of services can help strengthen the health sector overall. The conference participants made the strong case that RH-HIV integration represents the kind of efficiency and long-term cost-effectiveness that should make it a PEPFAR priority area. The broad consensus across the country panels underscores the importance for Congress to factor in the conference's recommendations as it deliberates about what new objectives should be included in PEPFAR and how much money will be required.

With women increasingly bearing the brunt of the AIDS epidemic, especially in Africa and increasingly in India, this is a critical time to focus on new opportunities to ensure the success of prevention, care, and treatment programs. The field experiences presented in this conference report provide examples of innovative approaches that are under way and that point the way forward for U.S. AIDS policy.

Presentation by Representative Betty McCollum: Taking a Long View of Public Health

Representative Betty McCollum (D-MN), a leading voice for U.S. leadership on global health as well as on HIV/AIDS and women's health,[2] opened the conference with a powerful call to action by the U.S. Congress. She stressed the Congress's responsibility to ensure that "sound science, good policymaking, and the necessary political will are combined to make investments to defeat disease, prevent needless suffering, and promote healthy individuals."

McCollum stated her belief that healthy families make healthy communities and countries, which in turn make for a more secure world; accordingly, health should be at core of our international development, combined with food security, water, education, and economic development. This is a way to build stable countries and to advance democracy. Child survival and maternal and reproductive health should form the foundation for a global platform.

McCollum acknowledged that this approach will face stiff competition for resources and that the health of women and children is rarely a priority for policymakers.[3] She stressed that the United States will need to make investments and plan wisely—to take a long view of global health. Outcomes should not only be based on quantity, but on actual improvements in the quality of life for poor families. This requires greater flexibility in how PEPFAR funds can be spent and in ensuring that professionals in the field help to determine the appropriate interventions to achieve the best results.

The reauthorization of PEPFAR presents significant moral obligations. As McCollum put it, "it's a lifetime commitment to the person we start on ARVs, not a five-year program." And this leads to concerns about U.S. policy, especially the need to inject "less ideology and more reality in PEPFAR" by using the best scientific information available to determine a reality-based approach to prevention. What follows from this is that the abstinence earmark should be removed, as should any impediments to working with sex workers. We need to educate people about safe sex and dirty needles. As McCollum put it: "We need to deal with it; we cannot hide from it."

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[2] Representative Betty McCollum has been a particular champion in the United States for education and health care. As a member of the Appropriations Subcommittee on the State Department and Foreign Operations, McCollum is working to promote effective U.S. leadership in confronting the global AIDS pandemic while supporting investments that reduce extreme poverty and hunger and improve the status and health of women and children around the world. McCollum is a cofounder of the Congressional Global Health Caucus. For more information, see http://www.mccollum.house.gov/index.asp?Type=B_BASIC&SEC={75763EB0-3018-458A-AC14-F212BF0F31CC}.

[3] McCollum has responded to these challenges by introducing three pieces of legislation: (1) HR 1225, focusing on family planning and maternal health, and cosponsored by pro-life republicans who recognize the needs for family planning; (2) HR 2266, regarding the U.S. commitment to global child survival; and (3) HR 3175, focusing on protecting girls by preventing child marriage—by delaying marriage, delay child birth; by being in school, delay onset of sexual activity.

Lives are being saved with PEPFAR, but U.S. funding for maternal survival, child health, and family planning remains essential. The United States has to focus on creating sustainability. PEPFAR reauthorization is very important, but this does not mean that the United States can cut other crucial investments in the lives of women and their families, such as family planning and motherhood programs.

McCollum closed by stressing the importance of this conference in convening these implementers and experts and the need for specific recommendations that can be incorporated into the reauthorization process.

Kenya: Integrating Voluntary Counseling and Testing with Family Planning

Dr. Marsden Solomon, Regional Medical Adviser, Family Health International (FHI), Kenya

Dr. Marsden Solomon from Family Health International (FHI) in Kenya described their work in bringing family planning into VCT. Their rationale for integrating these services flows from the common needs and concerns of both VCT and family planning clients; in particular, both groups are sexually active and in their reproductive years, both are at risk of HIV infection or might be infected, and if the clients have an interest in preventing unintended pregnancies, both need access to contraceptives and need to know how HIV affects contraceptive options.

The benefits of family planning for HIV/AIDS prevention are well documented. Adding family planning to PMTCT helps achieve HIV/AIDS goals by reducing the number of unintended pregnancies leading to children born with HIV, as well as the number of child deaths. Even moderate decreases in unintended pregnancies to HIV-positive women will reduce as many HIV-positive births as PMTCT programs.

In Kenya, FHI is assisting the Ministry of Health in integrating family planning into VCT. The program began with an assessment in 2002 showing that integrating the two services is feasible and acceptable by clients and service providers. FHI is now conducting operations research to find out what issues surface in service provision and focusing on how to scale up.

The most important challenges that FHI has encountered involve the lack of ownership of the integration agenda by provincial and district managers and the shortage of human resources and commodities (including contraceptives). The absence of family planning indicators in the VCT program presents a major challenge, since the importance of family planning in VCT programs is not being captured. Finally, inadequate coordination between the RH and HIV programs presents barriers to integration, given the parallel nature of the respective programs and inadequate funding for scale-up.

Many lessons have emerged from FHI's work. First, advocacy is needed at all levels in order to help bring the relevant people on board, from the policy level to

the service provision level. Second, FHI found that supportive delivery guidelines and leadership from the Ministry of Health are essential ingredients for quality and sustainability. This is particularly true given the limited coordination that exists between RH and HIV services. Third, FHI noted the importance of ensuring commodity security, notably HIV-testing kits and contraceptive commodities.

PEPFAR's contribution to RH-HIV integration is a critical factor in Kenya. PEPFAR has supported pilot projects that integrate family planning and VCT services, including family planning into comprehensive care centers (CCC) and PMTCT. This effort is being scaled up within the AIDS Population and Health Integrated Assistance (APHIA II) program. Yet challenges remain with PEPFAR funding, especially concerning unclear guidelines on how PEPFAR funds can be used for integration. Still, PEPFAR presents many opportunities for RH-HIV integration, and the APHIA II program has shown that favorable PEPFAR guidelines are emerging to support integration.

Moving forward, Dr. Solomon noted that PEPFAR can support integration in a number of ways. In particular, he stressed that PEPFAR should encourage and support recipients to make prevention of unintended pregnancies among HIV-positive women central to HIV-prevention strategies. In addition, PEPFAR should support scale-up of effective family planning/HIV models with PEPFAR money. Finally, PEPFAR should include family planning indicators as measures of program success—what gets measured gets done.

Dr. Solomon concluded that contraception should be a core part of HIV prevention, care, and treatment. He stressed that prevention of unintended pregnancies among HIV-positive women is cost effective and contributes to HIV goals. FHI's work has shown that it is feasible to integrate reproductive health into HIV programs. PEPFAR should make greater investments in RH-HIV integration to enhance the public health impact of its programs.

Dr. Saiqa Mullick, Senior Associate, Population Council

Integration of HIV Prevention and Testing into Family Planning Services: Lessons from Kenya

Dr. Saiqa Mullick from the Population Council discussed their findings on integrating counseling and testing into family planning clinics. The rationale for integrating services was that STIs and HIV are common in clients at family planning clinics, yet FP providers often miss opportunities to integrate information about other services; that FP services in Kenya offer an opportunity to reach a large number of sexually active women; that repeated visits offer the opportunity for follow-up; and that reducing unwanted pregnancies in HIV-positive women is a key PMTCT strategy.

Kenya has experienced a rapid rollout of vertical HIV services, but the country is still struggling to improve uptake in HIV services. Women in Kenya are less likely than men to have heard of VCT in Kenya (48 percent) and are less likely to have used a condom at last sexual encounter (24 percent). VCT is offered

during pregnancy through PMTCT programs and through stand-alone centers. Kenya has a relatively high contraceptive prevalence rate (40 percent) and high utilization of public-sector family planning services. In fact, family planning services are well established in Kenya, with some 58 percent of women obtaining their contraceptives from the public sector. Most of these women are on hormonal contraceptives—injectables and oral—which do not provide protection from HIV. Kenya also has a high proportion of women reporting unwanted pregnancy (20 percent). STIs and HIV are common among family planning clients, but services providers often miss opportunities to integrate information about other services.

The policy environment in Kenya is conducive to integration. In addition to the National Reproductive Health Strategy and the National Health Sector Strategic Plan, the recent draft strategy for integration of VCT and family planning services defines integration as: "the incorporation of some or all components of family planning into existing VCT services and vice versa."

In response to this situation, the Population Council study looked at the acceptability, feasibility, effect, and cost of integrating HIV prevention and VCT information and services into family planning services. They developed a model of integration that educates family planning clients about VCT and offers them counseling and testing as part of routine family planning visits (testing model). At the same time, the program developed another model that educates FP clients about VCT and refers them for testing to vertical services (referral model). The study set out to describe feasibility, acceptability, provider perspectives, and effects on family planning.

The project chose two sites: one in Nyeri, which had low VCT availability, was the testing model; the second site was in Thika, with about 16 VCT sites, was the referral model. In both sites, the project strengthened the family planning services, based on the balanced counseling strategy (BCS), which was modified to include information on HIV and STI prevention, dual protection, and VCT awareness. The integration of these other issues constituted a "BCS plus" approach, with HIV risk, routine offer of VCT, and dual-protection information provided during all consultations.

At the same time, the project worked on sensitization of national, provincial, and district teams, which was found to be a critical, though time-consuming, effort. This involved reviewing and developing training materials and job aides, in collaboration with the Department of Health, strengthening routine data collection for family planning and VCT, providing supervision and support for service providers, and strengthening basic supplies and commodities—HIV test kits and contraceptive supplies and training of health providers conducted by Ministry of Health staff.

Among the family planning clients at risk of HIV and STIs, the project found that 51 percent did not know their HIV status, 24 percent said their partners had been tested, 37 percent said they planned to have more children (indicating that they will engage in unprotected sex), 4 percent used a condom last month, 24 percent had ever used a condom, 96 percent were using a hormonal contraceptive, 2 percent were using a condom with a hormonal method.

An important element of the project was to develop indicators of quality of care, including counseling on STI and HIV prevention, dual protection, VCT, family planning method, client-provider rapport, and client behavior change. All the scores improved in a statistically significant way, but the greatest improvement was for the VCT counseling, which improved from three- to four-fold in both models.

The Population Council drew a number of conclusions from this project. To begin with, it found that integration of HIV prevention and provider-initiated testing into family planning is acceptable to both clients and providers and is feasible even in contexts of staff shortages. They found that the use of the "BCS plus" tools facilitated integration. The quality of family planning services did not decline in either model; in fact, the project found significant improvements. On the government side, the departments involved have proved to be interested in integration and have requested assistance in scaling up these interventions.

Moving forward, the integration models will continue to evolve and will need to address status-related issues, such as how to use the family planning opportunity to ensure that the women get the services and information they need. In particular, VCT will need to be coupled with effective post-test care. It was clear that flexibility around implementation is needed, but providers should be prepared to respond to clients' reproductive health and HIV needs. If reproductive health services are to serve as an effective foundation for integrated services, the national government and international donors will need to make great investments in the reproductive health system, including addressing issues such as stock-outs. Finally, further operations research is necessary to evaluate the models as clients' needs and programs evolve and to monitor the impact on HIV-positive and negative clients.

Many challenges lie ahead for integrating family planning and VCT. It is unfortunate that the reduction of unwanted pregnancies in HIV-positive women has received little attention as a PMTCT strategy, even in contexts where HIV prevalence and rate of unwanted pregnancy is high, as in Kenya and South Africa. There are limited PEPFAR resources available for interventions based in family planning services, despite the huge potential to reach large numbers of women. Another challenge involves the annual cycle of funding, which limits research on documenting behavior change over a longer time period. Finally, ongoing problems of staff shortages, weakness of routine data collection, and vertical programs require special efforts for joint implementation, supervision, and training.

Buck Buckingham, PEPFAR Coordinator, Kenya

Buck Buckingham presented the PEPFAR context in Kenya, where U.S. HIV/AIDS funding has risen exponentially in the past couple of years—from $5 million in 1998 to an expected $500 million in 2008, making it the second-largest PEPFAR budget on the continent. Over the same time period, however, family planning and population funding has seen only minimal increases of about 3 percent.

This is set against a sobering background. For many years, Kenya was rightly seen as a reproductive health and family planning success story, linked in part to the work of the U.S. Agency for International Development (USAID). But the 2003 Kenyan Demographic and Health Survey (DHS) was a wake-up call; it showed that total fertility rates and under-five mortality rates had increased between 1998 and 2003. In the period from 1998 to 2008, family planning/reproductive health funding from the United States went up by just $2 million, an increase of just over 3 percent per year. Compare that to the figures for HIV and AIDS in Kenya, as noted above: $5 million in 1998; $500 million in 2008. This vast increase in funding is a great opportunity, but it also confers on the U.S. PEFPAR program a responsibility to use the resources as creatively as possible.

Buckingham went on to describe the AIDS Population and Health Integrated Assistance (APHIA) II Project in Kenya, involving seven provincial-level awards for facility-based services. What makes APHIA II distinct is that it combines HIV/AIDS, child survival, and population funds, with some TB and malaria funding, and is designed to maximize facility-level synergy and to minimize duplication of administrative structures and costs.[4]

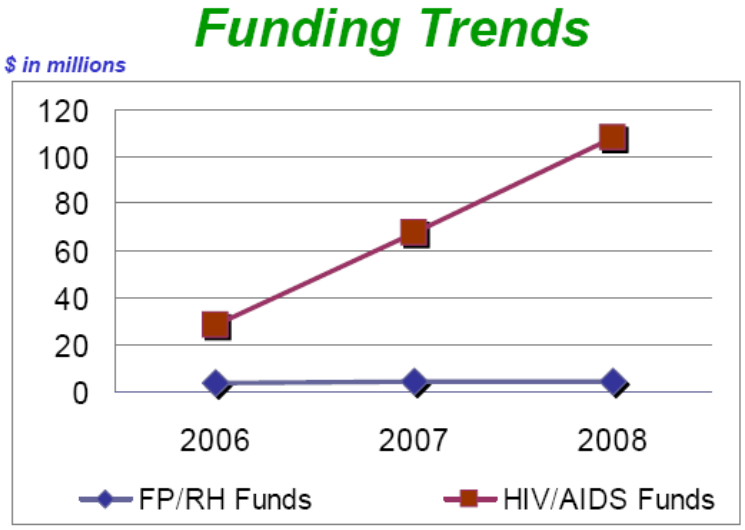
The seven provincial-level awards are managed by EngenderHealth, Pathfinder, FHI, JHPIEGO, and PATH. Each one of these organizations in turn works with a consortium that includes indigenous, faith-based, community-based organizations, and other international partners.

After its first year, the status of APHIA is as follows: the total funding in 2006 was $29.5 million ($3.8 million FP/RH funding; $24.9 million PEPFAR). In 2007, the FP/RH funding increased to $4.7 million, but the HIV funding shot up astronomically to $62.7 million. The ratios of funding tell the trend within the APHIA programs: in the first year, the ratio of FP/RH to HIV funding was 1 to 6.6; it then doubled to 1 to 13.3; and it has almost doubled again to 1 to 24 in 2008. If all U.S. HIV funding in Kenya is included, then the reproductive health and family planning money is effectively flat lined. In 2006, it was at the $3.8 million; in 2007, it went to $4.7 million; and in 2008, many are hoping to at least maintain that level.

Lessons have been learned in the scale-up of APHIA. Even with these funding challenges, PEPFAR in Kenya has found that integrating funding streams and services has allowed the program to go from two provinces to national coverage, even when population funds do not increase. Nevertheless, many challenges remain in promoting wrap-around programs as the number of sites expand, especially where other U.S. government agencies are more dominant than USAID, such as the Department of Health and Human Services (HHS), the Centers for Disease Control (CDC), and the Department of Defense (DOD). One

[4] Before APHIA, the United States had a project called AMKENI (Awakening, in KiSwahili). Due to funding limitations, AMKENI only worked in two provinces (Coast and Western). At the start, it was funded entirely with FP/RH funds; in its last year, three-quarters of its funding was from FP/RH and one-quarter from PEFPAR. AMKENI reached 98 facilities in those two provinces in its five-year program.

of the important take-away messages is that PEPFAR must invest far greater resources in measuring what its programs are doing.



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As APHIA has moved to more provinces and sites, commodity security has become a challenge, especially when much of family planning inventory is covered by other donors. APHIA targeted a four-fold increase (380) in RH service delivery points, but actually reached 883. Still, the challenge of commodity security is evident; 717 of the 883 sites reported family planning stock-outs. Despite the challenges, APHIA has shown that, with virtually no increase in family planning money, the project has been able to move ahead with the creative and effective integration of resources and program integration.

South Africa: Integrating PMTCT and ART with Reproductive Health

Dr. Vivian Black, Leader Maternal Health, HIV Management Cluster, Reproductive Health Research Unit (RHRU), University of Witwatersrand

Dr. Vivian Black presented the work of RHRU on integrating ARV clinics into antenatal clinics in Johannesburg. The context of South Africa is challenging: over 5 million people are infected with HIV, and most are of reproductive age and are women. Of particular concern is that over 75 percent do not know they are infected; they only test when they fall sick, which makes treatment and care much more difficult. There is a significant treatment gap for adults; currently, 640,000 need highly active antiretroviral therapy (HAART), but only 300,000 are on

HAART. Despite the great achievements in treatment access, thanks in part to PEPFAR, a large shortfall of people needing treatment remains, and these people will die. For next 10 years, more people will need antiretroviral therapy (ART) every year.

In South Africa, the HIV-prevalence rate among pregnant women is about 29 percent, and the transmission rate about 20 percent, leading to some 63,000 infants being infected in 2006. RHRU contends that PMTCT can be used to fight HIV more broadly. Like family planning clinics, PMTCT programs have a captive audience; that is, women in the health system who are still largely healthy. If health care providers can use that opportunity to find out their HIV status, those who are HIV positive can be staged and initiated on ART while in the health system. Moreover, there is an opportunity to extend the reach of the health services to their other children who might be HIV infected, as well as to their partners who might not have been tested and who might need care and treatment. By treating women adequately and correctly, pediatric HIV and infant and child mortality can be effectively reduced. In order words, one way to address the treatment gap is by strengthening PMTCT programs.

This requires changing the mindset of health workers so they assess female patients in the following ways. Does this woman have HIV, and if not, is she at risk? If she is at risk, how do we prevent her from getting infected? Once that's been established, does this woman want to become pregnant or is she currently pregnant, and if so, what do we do about that, which raises issues of fertility counseling, contraception, and emergency contraception. If she is HIV positive, is she on ART, does she need to be on ART, and if not, how do we maintain her in the system so she gets ART at the appropriate time? If she wants to become pregnant, how do we ensure that the pregnancy happens in the best possible environment, so that if she is HIV positive, the baby will be negative and the partner is included; and if she does not want to become pregnant, is she on contraception? If she is using barrier methods only, does she know how to access emergency contraception (EC)?

In terms of the pediatric population, they tend not to have a chronic illness but rather a rapidly progressing disease. Most of these children acquired HIV via mother-to-child transmission. Accordingly, if we can improve PMTCT coverage, we can close the pediatric treatment gap rapidly.

In 2004, RHRU started an integrated ART clinic in an antenatal clinic (ANC). The project started treating women who qualified for ART in the ANC itself and has expanded to three sites. In Johannesburg Hospital, the program has initiated over 850 women on ART. The women have experienced few ARV side effects and have registered good adherence. Three-quarters of those tested had virtually undetectable viral load at delivery. The program has reduced transmission rate to 4.3 percent, and while RHRU wishes it was even lower, it is significantly lower than the national average. For those women who have been on ART for more than seven weeks, the transmission rate is down to 0.3 percent. This points to the importance of reaching women early enough so they can be initiated on ART as soon as it is appropriate.

When RHRU started the program, one of challenges was the lack of postnatal care in South Africa, which meant that there was no opportunity for follow-up. In response, in October 2005, RHRU started a postnatal clinic designed especially to support women on ART and to ensure adherence. This is part of an effort to provide comprehensive care for these women—to encourage family planning, partner involvement (although this has not been very successful yet, with only about 2 percent of partners coming in), and to conduct cervical smears to detect cervical cancer. Of concern is that just under 50 percent of the cervical smears show an abnormality.

An ongoing problem is the lack of health care providers able to deliver services, which relates to the broader problem of capacity and overall care in South Africa. For example, in the past, when doctors performed cervical smears, the turn-around time for results was two weeks; now, it can take six weeks. This speaks to the problem of weak laboratory capacity to support reproductive health services.

Integration is important for many reasons, not least of which is that even free health services cost the patient money. Duplicative services increase costs for both the patient and the health services, and inconvenience impacts patient's compliance. When patients are referred elsewhere for services, that patient is often lost. It is therefore essential to provide as many services as possible while the patient is in the health clinic.

To better understand the obstacles women face, Dr. Black described the patient's journey through the system. To begin with, pregnant patients need to make an ANC appointment, and 94 percent attend at least one ANC visit. But in order to control the numbers of patients, some clinics do not accept women until 28 weeks gestation, and these delays often mean that the woman may miss out on HIV care.

This situation makes it all the more important that the first ANC visit is as comprehensive as possible. However, VCT uptake remains problematic, ranging from 5 to 80 percent, depending on the clinic. Clinic flow can be part of the problem. For example, in a clinic with 5 percent VCT uptake, a woman has to be highly motivated to have an HIV test. She may arrive at the clinic at 7:00 a.m. and might not get tested until afternoon.

To better understand this, RHRU conducted a survey about the barriers women face in accessing VCT. Not surprisingly, issues such as stigma, fear, and denial were prominent, but so was partner involvement. As Dr. Black explained: "Too often, a woman comes into the health care services when she is pregnant, she learns she is HIV positive, and then she goes home with the disease—and we expect her to disclose. But in our environment, the person with the knowledge of the disease is responsible for it—so it's her fault, it's her disease, she's brought it into the family. She's then blamed for the disease. This impacts her ability to cope with her pregnancy and disease."

In order to stage a pregnant woman identified as HIV infected, the health care provider orders a CD4 cell count the same day. This is useful in clinics where it

works, but in some primary health care clinics a woman has to be referred elsewhere for a CD4 test, and this can take four weeks. She then returns to the original clinic for the results, and if the count is low, she is referred back for ARVs. Too often, by this point she has already delivered and has not even received a single dose of neverapine. “So the woman at highest risk of transmission gets the worst care,” Dr. Black noted. Integration of services, conversely, would enable the system to do away with the onerous referral mechanisms and provide comprehensive care.

An important part of postnatal follow-up involves adherence support, including support for infant feeding choices. This is a time to support the woman, to try to encourage partner involvement, to discuss contraception, and to conduct infant testing. Postnatal follow-up allows the health care providers to pick up on missed opportunities: if a woman only presented during labor and was not diagnosed, this is a chance to offer an HIV test and to provide appropriate care and staging. For those women who want another child, this is the chance to ensure pre-conception care and adequate treatment.

In summary, the barriers to PMTCT uptake include: access to health systems, poor HIV-testing uptake, no follow-up of women with unknown HIV status, poor ongoing support for HIV-infected women, referral for staging, referral for HAART, systems in labor and postpartum for taking neverapine in labor and after labor, follow-up of HIV exposed infants, and postnatal follow-up.

For the way forward, Dr. Black emphasized the need to improve PMTCT services to care for HIV-infected women and to shift the focus from preventing HIV infection in children to caring for HIV-infected women. “If we look after mom comprehensively, the women will embrace the system if it is for her.” In addition, this approach will lead to improvements in maternal and pediatric health, decreases in pediatric HIV, increases in HIV awareness in communities, and reductions in the HIV treatment gap. This calls for integrating reproductive health into PMTCT, including pre-conception management, family planning, and postnatal care.

Regarding its evolving relationship with PEPFAR, Dr. Black noted the changing emphasis from numbers to quality, since the health system will not retain patients if it does not provide quality care. She suggested that PEPFAR continue to embrace innovation ideas and, where successful, rapidly implement them at larger scale. While PEPFAR’s stringent reporting requirements are difficult, they have strengthened RHRU’s organizational structures. PEPFAR could build on these reporting requirements for PMTCT and reproductive health indicators and reporting strategies.

Promise Mthembu, Global Advocacy Officer, International Community of Women Living with AIDS (ICW)

Ms. Promise Mthembu focused on the importance of addressing the sexual and reproductive health (SRH) and rights of women living with HIV/AIDS within the

context of the AIDS response. As an organization of women living with HIV, ICW has said for years that HIV is an SRH issue as much as SRH is an HIV issue.

Mthembu noted that South Africa often boasts that it has the most comprehensive HIV/AIDS strategies, and yet the new national AIDS strategy does not seek to comprehensively integrate HIV/AIDS with SRH and rights, although it does mention the importance of pap smears. Too often, South Africa falls back on popular excuses for adequately integrating HIV and SRH, such as lack of funding, staff training, and staff commitment.

PMTCT is increasingly integrated into HIV/AIDS services in South Africa. While this integration is essential, Mthembu pointed out that this approach tends to turn HIV-positive women into reproductive machines and neglects the issues faced by HIV-positive women who do not wish to have children or who are not of reproductive age. This underscores the importance of integrating SRH and rights into PMTCT services.

Women's vulnerability to HIV/AIDS often occurs in the context of sexual and reproductive health, which is why women living with HIV have been raising issues of sexual and reproductive health and rights as one of their main concerns for many years. Seen from this perspective, certain questions arise about HIV/AIDS services, including whether medical visits during pregnancy are the best time for HIV testing. Women living with HIV are often subjected to denials of services and denials of rights. If they fall pregnant, they are viewed as irresponsible human beings. In addition, the lack of access to services, including diagnosis and treatment for STIs, and the emphasis on access to ARV treatment in PEPFAR programs should not come at the cost of providing pap smears.

The problems that women living with HIV/AIDS experience are often linked to stigma and discrimination. In some instances, problems are also driven by the popular HIV-prevention discourse, such as the admonition to use a condom at all times, even though women cannot always negotiate condom use. This highlights the need to balance prevention messages and to link them to the realities that women face.

Mthembu and ICW support new interventions that would make linkages between the areas of SRH and HIV/AIDS, but she raised a series of questions to consider when looking at integration. To begin with, it is important to focus on priority areas and specific indicators. Next is the issue of accountability: if the two services are put together, then which is accountable? Mthembu stressed the importance of understanding the "core business" of the services and organizations that we seek to integrate. For example, family planning is viewed by some as population control rather than as HIV prevention and care. Similarly, how do we integrate the critical social issues, such as violence against women, treatment literacy, and women's rights? Integration must include a human rights perspective and focus on improving rights, not contributing to any further limitation of rights. Most integration is geared to health care settings, but HIV-positive women often see health care settings as "centers of powerlessness." How can integration help transform these power relations such that a woman living with HIV can make her own health care decisions, not simply those imposed by the service provider.

Gender-based violence (GBV) is particularly important, since the way that HIV infection contributes to vulnerability to GBV has implications for integration. For example, once a woman has HIV, it often becomes difficult for her to access GBV services, since people have lost sympathy for her. When a woman is offered an HIV test before being given post-exposure prophylaxis (PEP), and the woman says she is already HIV infected, the negative attitudes that she encounters from service providers present barriers to accessing other SRH services.

These challenges are especially difficult since, from the ICW perspective, the HIV/AIDS field is still characterized by gender insensitivity, and it is unclear whether integration will be able to address these deficiencies. This raises fears that ignoring the importance of rights in the integration effort might limit the success of the whole effort. The compelling argument for integration should be that it would improve women's rights.

Mthembu stressed that PEFPAR and other HIV and AIDS funding instruments are important because they demonstrate the commitment of policymakers to address HIV and AIDS as an emergency, particularly in the developing world. Mthembu commended PEPFAR for improving access to treatment, but she also underscored the missed opportunities on SRH. PEPFAR has tended to sideline sexual and reproductive health and rights in addressing HIV and AIDS. She made the following recommendations for PEPFAR's future programming:

- Support the integration of sexual and reproductive health and rights in HIV prevention, care, and support at the health sector and the social level. This integration should include services for gender-based violence and rape and support for training and social mobilization on the SRH and rights of women.
- Integration should include a women's rights training component, as well as supporting access to legal services for women. This can help ensure that the health system itself is transformed to better adhere to rights.
- Ensure that SRH-related treatment (such as pap smears and treatments, treatment and prevention of STIs, breast screening and treatment) are integrated into the HIV treatment package.
- Ensure that interventions are meaningful to women with HIV. Some women may access contraceptives, but more information is necessary about which contraceptives work best for women with HIV and which work best with those on ARV. We must focus on interventions that are not only useful but that are appropriate for women with living with HIV/AIDS.

Kevin Osborne, Senior HIV/AIDS Adviser, International Planned Parenthood Federation (IPPF)

Mother- and Child-Centered Care: Getting it Right

There has been extensive political commitment to the issue of linking SRH and HIV integration.[5] The opportunities and benefits for linking SRH and HIV are clear, especially in terms of scale-up, more effective treatment, increasing access to quality maternal health services, strengthening health systems, community and partner engagement, reducing stigma, and expanding entry points. However, most programs have neglected some of the most cost-effective approaches to reducing the proportion of infants living with HIV, such as preventing primary HIV infection among women of childbearing age and avoiding unintended pregnancy among women living with HIV who do not currently wish to become pregnant.

A Framework for Priority Linkages

IPPF is focusing on mother- and child-centered care. Despite the policy restrictions and funding cuts imposed by the Mexico City Policy, known by many as the "global gag rule," IPPF has continued to support comprehensive sexual and reproductive health services around the world. In 2006, IPPF supported 55,911 service delivery points including 5,733 clinics, 38,646,556 total SRH services, and 4,736,399 mother and child services.

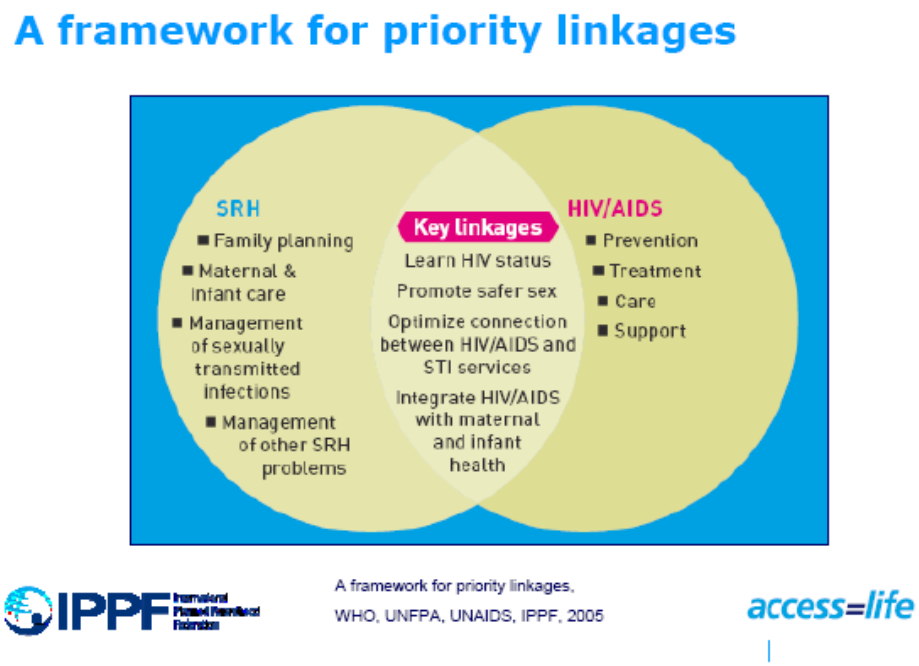
In South Africa, there is a clear tension between policy and practice on integration. On the one hand, South Africa has been an exemplary example in Africa; on the other hand, the country has developed vertical and unlinked strategies for SRH and HIV, too often plagued by territorialism and a problematic political commitment to HIV and AIDS. In addition, there is a lack of integrated approaches to manage the broader structural issues, such as the SRH and HIV needs of youth, and issues such as gender-based violence.

Progress on integration has also been stymied by policy restrictions, especially the U.S. gag rule. In Kenya, the effect of the gag rule has been dramatic, causing 9,000 people to lose access to health care including pap smears and postabortion care and a reduction in family planning training for nurses and the SRH capacity in the country.

IPPF has been developing a variety of SRH/HIV models of care within an SRH setting. In late 2005, IPPF introduced VCT, PMTCT, and ART and began training staff in HIV-related skills. In 2005, IPPF established a pharmaco-vigilance system in four sites within the IPPF Member Association in Kenya,

[5] These include the following: the Millennium Development Goals 4, 5, and 6, (2000); the UNGASS Declaration of Commitment (2001); the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (2004); the New York Call to Commitment: Linking HIV/AIDS and SRH (2004); the UNAIDS Policy Position Paper: Intensifying HIV Prevention (2005); the World Summit Outcome (2005); the Abuja Call to Action: Towards an HIV-Free & AIDS-Free Generation (2005); the UNGASS Review Political Declaration on HIV/AIDS (2006); and the Maputo Declaration (2006).

Family Health Options Kenya (FHOK). These sites have now been accredited by the government of Kenya as official ARV sites within an SRH setting.



Low global coverage of PMTCT is a reminder of the fact that despite knowing what to do, we—as a global community—very seldom actually do it. It is especially true with regard to prongs 1 and 2 of the WHO PMTCT approach where problems have arisen: (1) primary prevention; and (2) the prevention of unintended pregnancies in women living with HIV. Some of the key barriers include insufficient staff and awareness of the importance of giving post-test counseling to HIV-negative women, poor partner involvement in ANC and low levels of partner testing, and the lack of follow-up. The issue of staff capacity and attitudes is particularly important, including the negative attitudes of health workers around the rights of people living with HIV.

Policy barriers are another important factor to be addressed. In particular, lack of tools and indicators for monitoring and evaluation of SRH-HIV integration and gaps in the evidence base have proved to be barriers. In addition, vertical funding streams for SRH and HIV contribute to the poor linkages between family planning and HIV programs.

To address the evidence gap on RH-HIV integration, IPPF (together with UNFPA and WHO) is working in partnership with the Cochrane Collaboration to highlight those areas where more research and advocacy is urgently needed. This review is in progress but preliminary data indicates that too often studies on linked interventions are not designed appropriately, and few studies have

compared linked interventions to separate, unlinked SRH or HIV interventions. Programs appear to be moving ahead of published research toward addressing integration of counseling and referral services and some integration of care and treatment with other services. Although programs are moving in the direction of linking care and treatment for both SRH and HIV, there is insufficient evidence to determine the efficacy of these integrated services. Rigorous evaluations are urgently needed to inform both policymakers and program planners and to identify the best strategies for linking SRH and HIV services. Together, researchers and programmers need to define a clearer set of priorities for the research agenda.

India: Integrating STI Treatment with HIV/AIDS Services

Dr. Bitra George, Deputy Country Director, Family Health International (FHI), India

Why SRH-HIV Linkages Are Critical for India

With a population of 1.1 billion and high population growth rate, SRH-HIV linkages are critical. The family planning program has been active for 50 years. However, the national HIV/AIDS program is relatively new in India, initiated with the establishment of the National AIDS Control Organization (NACO) in 1992. In 2006, the latest estimates of people living with HIV/AIDS in India was revised following findings of a new Demographic and Health Survey for India as well as an integrated assessment of sex worker populations in six high-prevalence states. The revised estimates indicate that national adult HIV prevalence in India is approximately 0.36 percent (previously 0.9 percent), which corresponds to an estimated 2 million to 3.1 million people living with HIV/AIDS (PLHA) in the country. There are an estimated 100,000 PLWHA, including around 8,000 children, on ARV drugs.

Integration of SRH and HIV is especially critical in a concentrated epidemic as in India, where 86 percent of transmission is through the sexual route, and where youth between the ages of 10 and 24 are at risk of STIs and HIV and have high rates of unwanted pregnancy. Indeed, the National Family Health Survey (NFHS) in 2007 showed low levels of HIV awareness among women—only 17 percent of women had comprehensive knowledge of HIV/AIDS, although 61 percent had heard of it. However, these statistics mask substantial variation in rural-urban populations. Of women who had ever heard of HIV/AIDS, it is higher among urban (83.2) than rural (50 percent).

The NFHS shows high levels of awareness on family planning methods, but low utilization, especially among rural women. A legacy of the forced sterilization campaigns in the 1970s is that most women—some 37 percent—use female sterilization as their family planning method. This has increased since NFHS 2 (1998–1999). Accordingly, family planning in India is driven by female sterilization, which is totally different from the African context. In India, the

unmet need for family planning is 13 percent, with unmet need for spacing methods (6.3 percent) and unmet need for limiting methods (6.8 percent).

The government of India uses the term "convergence," as opposed to "integration," which reflects bringing family planning and HIV/AIDS services together at various levels. The government established a joint working group that identified the areas where convergence can happen, including STI management, condom promotion, VCT, prevention of parent-to-child transmission, behavior change communication, blood safety and training. This is a clear indication that the policy environment is favorable, but implementation remains a challenge. At the national policy level, the National Rural Health Mission framework calls for greater cross-sectoral convergence. This has translated to the goals of the third phase of the National AIDS Control Program (NACP-III) and the second phase of the Reproductive and Child Health Program, which outline the need for greater integration of SRH-HIV linkages.

USAID funds HIV activities in the four southern states in India and reproductive health programs in northern states. At the programmatic level, integration remains a challenge. To translate integration at the policy level into action, there is a need for emphasizing SRH-HIV linkages in program implementation plans, including PEPFAR's country operational plans (COPs) and program strategic approaches.

FHI in India through its diverse portfolio of research and implementation projects has attempted to bridge the gap. FHI aims to integrate family planning into all of its HIV/AIDS programs, and an important focus is on integrating family planning and HIV services for sex workers, using STI clinics as the entry point for integration.

The Context: Integrated FP/HIV Services for Sex Workers

The Aastha and STI Capacity Building Projects are part of the India AIDS Initiative (Avahan) of the Bill and Melinda Gates Foundation. The Aastha Project focuses on reducing the incidence of HIV and STI among sex workers and their partners in Mumbai and Thane Districts of Maharashtra. Services include strategic behavior communication, condom provision, and STI services. The STI services are provided through 17 static clinics, 38 satellite clinics, and 300 monthly health camps.

The Aastha Project can point to some significant accomplishments. The project has provided 58,000 sex workers with STI/HIV services, has conducted 107,415 counseling sessions to address safe sex practices, and has performed pregnancy tests and hemoglobin tests for more than 3,500 sex workers. Every month, some 34,000 sex workers visit the STI clinic, and some 20,000 sex workers have been tested for syphilis.

FHI learned some important lessons in providing integrated family planning/HIV services. An important element of the Gates Foundation's funding is its flexibility: 10 percent of the funds are kept aside for any specific needs of the sex workers, which is how FHI managed to add RH services. FHI has found

that integration can be initiated with minimal additional funding (10 percent discretionary funds) and that integration of family planning did not impose additional demands on the infrastructure. Training of staff in family planning counseling skills was essential in order to provide a range of options for sex workers. Nevertheless, a structured evaluation is still required to measure the effectiveness of the approach.

Challenges remain in integrating family planning and HIV programs. First, some sex workers do not recognize the need for FP services, since many use abortion as their family planning method, and there are many misconceptions among sex workers about various family planning methods. A second challenge is the poor quality of public family planning services, including the shortage of family planning commodities, and the stigmatizing attitude of health care providers in government family planning clinics. It has proved to be difficult to link with government family planning programs to provide onsite contraceptive choices at the Avahan STI clinic. Finally, it is challenging to promote and provide family planning services without compromising the focus on and quality of STI/HIV-prevention services.

Based on these experiences, Dr. George made several recommendations for global policymakers and donors related to integration.

- Development of guidelines, standards, and tools (job aides for health care providers in STI clinics on family planning) for operationalization of integration of FP and HIV services.
- Training and continuous mentoring of clinic supervisors and staff in HIV services to ensure quality FP services. Ensure integrated pre-service and in-service training of health care providers including integrated supervision.
- Integrating one service at a time rather than integrating all FP services might be more practical—a phased approach. In the future, pap smear, postabortion care, maternal and child health.
- Formalize coordination between FP and HIV services—role definitions.
- Develop systems to monitor the process of integration, including reporting on specific integration indicators and monitoring of quality of services provided.
- Dedicated funding for FP/HIV integrated programs, especially PEPFAR funds.
- Changes required in the funding mechanisms that are currently supporting vertical FP/SRH and HIV programs.
- Funding required in preventing unintended pregnancies among HIV-positive women to reduce new infant HIV infection.
- Structural changes in health systems to accommodate integration—with shared objectives, resources, and infrastructures.
- Strengthen procurement and supply chain management of commodities to prevent stock-outs.

- Develop and scale up models for involvement of the private sector in providing integrated services, including public-private partnerships and social franchising.
- Strengthen community advocacy efforts for quality integrated services.
- Address stigma and discrimination that limit people's access to integrated services, especially sex workers.
- Need for more evidence, best-practice documentation, and scientific evaluations on effective methods, approaches, and models of integrations.
- Address gender equality and women's continued vulnerability to negotiate safer sex and other FP choices.

Amita Dhanu, Senior Project Manager, Family Planning Association (FPA), India

FPA India, an accredited member of the International Planned Parenthood Federation, was established in 1949 and is committed to promoting sexual and reproductive health and supporting the right to reproductive choices, including family planning. Since the early 1990s, FPA India has also been working to reduce the spread and impact of STIs and HIV/AIDS.

The Aastha Project is run by FPA India, with technical assistance from FHI, and is funded by the Bill and Melinda Gates Foundation. The project aims to reduce the incidence of STIs and HIV among sex workers and their partners. The context of the Aastha Project is the situation of sex work in Mumbai. Out of a population of 20 million, there are 65,000 identified sex workers operating in 21 hotspots. The HIV prevalence among sex workers in Maharashtra is 23 percent. The sex workers function in a range of settings, including brothels, bars, street-based locations, and home-based locations. As is often the case, condom use with regular partners is quite low. These sex workers are subject to violence and police harassment and are largely uncovered by the public health system.

The Aastha Project promotes community engagement and strategic behavior change communication (SBC), led by the peer-to-peer model. It promotes and distributes condoms and works to provide information on the prevention and treatment of STIs and services for reproductive health. The package of STI prevention and treatment services includes asymptomatic treatment, monthly screenings, and partner treatment.

However, the project realized that the needs of the sex workers went beyond the STI package, which led them to develop an integrated service package. This package includes STI services, but it also provides general health services for sex workers, their partners, and their children; services for reproductive health issues (counseling on menstrual hygiene, safer sex, and contraception; urine pregnancy tests; and hemoglobin estimation); referrals for antenatal care and advanced RH needs, such as medical termination of pregnancy; and referrals for HIV testing, care, and support, as well as for TB diagnosis and treatment.

An important aspect of the Aastha Project is its emphasis on community mobilization. The peer educators are active sex workers who work as site managers, responsible for about 50 other sex workers. More specialized assistance is provided by sex workers who are active members of the Project Advisory Group, the Clinic Advisory Committee, the Task Force Committees (that help sex workers in need), and the Core Group for Legal Education. Through these mechanisms, the project conducts advocacy for women's rights, protection of human rights, and violence prevention. The Aastha *gats* are small, self-help groups of sex workers that work to mobilize sex workers to access clinic services, help them in opening bank accounts, etc. The project also works to sensitize police on HIV and violence prevention.

There is considerable value added by the Aastha strategies for the sex workers. The service delivery model combines clinic and outreach, based on the number and density of sex workers and the times and locations that work best for them. The drop-in center-cum-clinic helps sex workers to access services in a safe space, backed up with clinical services. The drop-in centers (DICs) also provide opportunities for income-generating activities, literacy classes, and activities for the children. The sex workers act as peer counselors and peer nurses to help address the sex workers' issues in a holistic and nonjudgmental fashion. At times, the peer counselors accompany the sex workers when they are referred elsewhere for services.

Over the past three years, the Aastha Project can point to a number of achievements. Over 25,000 sex workers are registered with the project, and 18,565 sex workers have accessed clinical services at least once. On average, 9,900 sex workers access Aastha services every month, and 5,000 sex workers access clinical services every month. As a result of these services, symptomatic visits have declined from 43 percent in September 2006 to 11 percent in September 2007. Over 7 million condoms have been distributed.

In conclusion, Ms. Dhanu made the following recommendations/observations:

- Recognize and meet the felt needs of sex workers rather than focusing purely on STIs.
- Community involvement and capacity building is crucial.
- While condom promotion is vital, other contraceptive choices must also be given.
- Capacity building of service providers is crucial.
- Training for counselors should include reproductive health and STI/HIV-prevention objectives.
- Vertical SRH care or STI/HIV/AIDS-prevention and treatment programs should be restructured by: integrating some services, one by one; adding and strengthening others; expanding services to include new population groups; and strengthening referral links.

Dr. Amitrajit Saha, Associate Director SRH, PATH India

Dr. Amitrajit Saha noted the global evidence that populations at risk of HIV and unintended pregnancies—such as young people, sex workers, and people living with HIV—are not able to access the SRH and HIV services they need. This is the case in India as well, where family planning, maternal and child health, STI services, and HIV services are all provided as separate services and often target different populations. Although previous research has shown the need for converging HIV and SRH services, PATH conducted an assessment to investigate the demand for convergence among populations at risk of HIV and unintended pregnancy in India, as well as the attitudes of service providers and policymakers. The findings have implications for program implementation, for strengthening capacity, for policy, and for further research.

The government of India has recognized the need for converging or linking SRH and HIV services in the Reproductive and Child Health program (RCH II), in the National AIDS Programme launched in 2007 (NACP III), and in the National Rural Health Mission (NRHM). While the policy environment is favorable, state governments lack the evidence required to make informed decisions about what options will work best in different settings. In response to this situation, PATH worked with state governments, nongovernmental organizations (NGOs), and local communities in Bihar, Andhra Pradesh, Maharashtra, and Uttar Pradesh to identify options and challenges for HIV-SRH convergence.

Findings from the assessment showed that STIs were widespread among all groups, indicating that they all would benefit from increased access to HIV and SRH services. Sex workers had the most difficulties relating to pregnancy and childbirth and also the least access to government SRH services at district hospitals, community health centers, and primary health care centers. Findings also show that men rarely use government services for management of STIs and that sexually active young men and women need information and access to services for HIV prevention. Young men and women knew the least about existing HIV and SRH services; young people in higher-prevalence states noted the need for access to HIV testing more than those in lower-prevalence states. Stigma experienced at mainstream government SRH services was the main barrier to access for sex workers, positive people, and young men. Sex workers and positive people also require more privacy and better confidentiality at these services.

The majority of suggestions for convergence involved government services and more government convergence options in lower-prevalence states. Positive people saw government HIV services such as ART and VCT centers as less stigmatizing than government SRH services. As a result, positive people and sex workers did not suggest full integration of HIV and SRH services but had very specific suggestions for what should be converged and where, including adding family planning and STI services to vertical government services such as ART and VCT. Sex workers and positive people would like to use mainstream

government services for surgical abortion, MCH, and PPTCT (PMTCT)—but only if staff attitudes and social stigma are addressed.

Service providers' awareness and understanding of convergence "policy" was mixed, but managers and frontline workers were generally receptive to the notion of convergence. Some service providers worried that women from the general population would boycott antenatal services and/or that the quality of services would be compromised by increasing access to sex workers and positive people. Some private providers thought they would lose business by being overly identified with HIV and sex workers. Frontline workers raised concerns about increased workload. Training needs identified by service providers included stigma reduction; counseling; universal precautions; strategies for working with populations at risk; HIV prevention, care, and treatment; and referrals. In contrast to SRH providers whose main concern was improving staff attitudes and behavior toward people at risk, HIV service providers expressed the need to improve their SRH skills to be able to provide a wider basket of services to their clients. Service providers also felt there was an important role for NGOs in demand generation, mobilization, advocacy, reaching out to vulnerable populations, and providing support and training.

Most people who participated in the assessment were enthusiastic about the idea of convergence and many practical suggestions were made. Rather than advocating full integration of all HIV and SRH services, suggestions for convergence from groups at risk in the community were pragmatic, based on their own experience of service utilization and what would work for them in their own context. The assessment showed that HIV providers are attitudinally more ready for convergence. It may therefore be more feasible initially to initiate convergence of SRH services within existing HIV services.

Female sex workers are both key to HIV epidemic dynamics in India and to the response, yet the assessment shows that their HIV and SRH service needs are not being met adequately by the public sector. There is an urgent need to train health workers in addressing their needs and to develop strategies to reduce stigma at public health facilities. Similarly, the SRH needs of positive women are not being adequately met by the public sector. Family planning and STI services need to be provided from existing HIV services like VCT and ART centers.

The assessment showed that health services do not generally provide services or space to address the needs and concerns of young sexually active men and women. "Young people–friendly" services need to be provided at mainstream government facilities, and more opportunities to access condoms and HIV-prevention communications and referrals need to be given to young women at the sub-center level.

There are important challenges to and implications of HIV-SRH integration in India. First, it is necessary to build the evidence and to demonstrate cost effectiveness. Second, communities must be involved (particularly "most-at-risk" marginalized communities) in the design, ownership, and advocacy for integration, and multiple stakeholders must also be involved. Lessons learned must be disseminated in order to advocate for change with key stakeholders.

Finally, successful pilot projects must be scaled up to increase access for people most at need.

Dr. Saha made the following recommendations for USAID and PEPFAR:

- Explore the possibilities of integrating reproductive health and HIV initiatives already supported by USAID/PEPFAR in India.
- Support the expansion of PPTCT coverage and the strengthening of linkages with RH and family planning activities.
- Support the evaluation of promising demonstration projects on HIV-SRH integration.
- Support the expansion of comprehensive prevention approaches to address gender-based barriers to service access.

Moving Forward: U.S. Policy and PEPFAR Reauthorization

Dr. Tom Kenyon, Principal Deputy Coordinator and Chief Medical Officer, Office of the Global AIDS Coordinator (OGAC)

Dr. Tom Kenyon spoke from the perspective of PEPFAR about how best to address issues of integration. He stressed that the key is to improve access, and RH-HIV integration may or may not be the best option in a given setting. The position of OGAC is to empower the PEPFAR country teams in collaboration with the host country to design the best strategy to improve access, based on local realities and guidelines.

This means that we need to talk about both sexual health and reproductive health. PEPFAR addresses sexual health through the "ABC" approach and its enabling elements, including gender discrimination. Reproductive health, on the other hand, is the purview of USAID's Office of Population and Reproductive Health. While there are many linkages and synergies between the two, there are important distinctions.

Dr. Kenyon stressed that many of the issues about how to improve services do not need to wait for PEPFAR reauthorization. For example, for the first time in the 2008 country operational plans (COPS), a tick box was included to indicate whether or not an activity was linked with reproductive health care. This will help PEPFAR to monitor progress in this area moving forward.

PEPFAR is committing to creating linkages wherever possible, and it works with other U.S. government programs to ensure appropriate linkages and to strengthen overall health systems—including family planning, as well as TB and malaria, immunization, orphans and vulnerable children (OVC) programs that are broader than HIV, education, gender, food and nutrition, livelihoods, and supply chain management. In malaria, for example, by using the supply chain and community-based services created by PEPFAR, the United States has helped to reduce the cost of bed net delivery to a household in Zambia by 75 percent. For OVCs, the United States can help them get an education, either directly through

PEPFAR or through the African Education Initiative, to provide scholarships and strengthen life skills and prevention curricula in schools. Education, especially for girls, is a powerful HIV-prevention instrument and helps to prevent unintended pregnancy and to delay sexual debut.

The PEPFAR country teams emphasize knowing the epidemic, including the drivers and the magnitude. This is done alongside their family planning colleagues, and issues such as contraceptive prevalence rates and rates of unintended pregnancies can be learned through co-surveillance systems, monitoring systems, and population-based surveys that can improve the ability to conduct joint planning. The goal is to use data to guide decisionmaking and planning.

Developing an infrastructure in which to provide HIV prevention, care, and treatment can help improve the delivery of family planning services. As of September 2006, PEPFAR had supported counseling and testing for more than 18 million persons, 71 percent of whom are women. Recognizing the importance of reaching women through existing family planning centers, PEPFAR supports the addition of counseling and testing into these settings.

One of the greatest inroads we have made is in access to HIV/AIDS treatment. As of March 2007, PEPFAR had supported treatment for 1.1 million people, 61 percent of whom are women. Treatment access has created a powerful incentive for testing, and people living with HIV/AIDS can receive ongoing and comprehensive care that previously did not exist. Prior to treatment, episodic care was the norm, and ongoing services, such as family planning, for people living with HIV/AIDS did not happen on a large scale or in a systematic manner. This is therefore a major contribution that PEPFAR is making to the problem of unintended pregnancy in HIV-infected women. We are helping them to know their status and creating an environment in which to engage them in longer-term care, such as family planning.

From 2004 to 2006, PEPFAR supported PMTCT services for women during 6 million pregnancies and, as such, has created a strong platform to not only improve the antenatal and postnatal health systems for women, but also to improve access to other interventions. But in spite of the progress being made, this only represents 24 percent of the pregnant women living with HIV and their infants in need of these services. The issue of expanding PMTCT access remains an urgent issue to address.

In addition to primary HIV prevention, ARV drugs for HIV-positive pregnant women and their children, and comprehensive care for HIV-positive women, PEPFAR also supports voluntary family planning for HIV-positive women to prevent unintended pregnancy.

The U.S. government has distinct HIV/AIDS and family planning programs and resource streams. As the Kenya program showed, the United States works to ensure wrap-arounds between its HIV/AIDS programs and voluntary family planning programs, which are primarily supported by USAID. The wrap-arounds can work in two ways: first, PEPFAR funds can be used to support integration of

HIV/AIDS programs into voluntary family planning programs. On the other hand, USAID can integrate voluntary family planning into the HIV/AIDS programs supported by PEPFAR funds.

HIV funding also indirectly benefits family planning programs by assisting health systems overall. A recent FHI study in Rwanda showed how the addition of HIV services to primary health care centers contributed to the increase in the use of non-HIV services, including maternal and reproductive health, prenatal health, and general health overall, as well as a 50 percent increase in the number of family planning clients.

Currently, the only commodities that can prevent both unintended pregnancies and HIV transmission are male and female condoms. Since 2004, the United States has procured 1.7 billion condoms around the world, making the United States by far the largest supplier of condoms in the world, more than all other donors combined. The USAID Office of Population and RH supports the procurement of other contraceptive methods, making it the largest bilateral donor of international resources for voluntary family planning and reproductive health support, accounting for some 40 to 50 percent of all international resources for this issue.

Country Examples

- In Rwanda, PEPFAR places great emphasis on quality PMTCT services, tracking women after they leave antenatal services through pediatric diagnosis and follow up. Broad-based promotion of family planning, using USAID's child survival and health funding, has led to significant increases in acceptance of family planning on a national scale. USAID is working with PEPFAR to ensure that quality family planning programs supported by USAID are made available to PMTCT clients supported by PEPFAR.
- In Uganda, PEPFAR supports the Ministry of Health and the national PMTCT Phase II strategy. The PEPFAR-supported Uphold Project has both HIV and family planning funding and helps implement this strategy. The focus is on consolidation of services, increasing PMTCT uptake, improving male involvement, partner reduction, strengthening family planning programs, and improving comprehensive care for HIV-positive women, their partners, and their exposed children. In addition, the USAID Acquire Project supports family planning needs for HIV-positive women at a PEPFAR supported ART center. In less than one year, 450 clients received family planning support. This highlights the importance of identifying and strengthening the operational processes needed for linkages, such as training, supervision, monitoring, community mobilization, and advocacy for family planning and HIV.

In terms of future directions, PEPFAR will seek to strengthen efforts to ensure coordination and appropriate linkages with other programs, including voluntary family planning programs. PEPFAR will continue to track key wrap-around activities, as is now being done to track linkages with reproductive health in FY 2008. PEPFAR will pay close attention to the issues of discordant couples and

prevention for PLWA, as well as to wrap around support for family planning. Recognizing that women are disproportionately infected and affected, PEPFAR will focus increased attention on the particular health issues for women living with HIV and related gender issues. Continued efforts are needed to ensure that women receive accurate information about their HIV care and treatment options, as well as on how HIV treatment may affect current contraceptive use or intentions. PEPFAR will expand efforts to maintain an effective health workforce to deliver HIV/AIDS and other essential care, including family planning.

Dr. Kenyon closed by stating that women are bearing the brunt of the epidemic and that we must all support women to prevent new HIV infections and respond compassionately to women living with HIV.

Dr. Geeta Rao Gupta, President, International Center for Research on Women (ICRW)

Dr. Geeta Rao Gupta highlighted the valuable opportunity offered by PEPFAR reauthorization to enhance the effectiveness of PEPFAR. One important way to do this is to integrate RH and HIV services for women. While this is not an easy task, it must be done because it will ensure that PEPFAR is able to meet its goals overall, to improve the quality of its programs, and most importantly, to meet needs of women and girls. Dr. Rao Gupta emphasized that the needs of women and girls are comprehensive, not vertically arranged.

It is particularly important that PEPFAR pay attention to sexual and reproductive health needs of women living with HIV, through testing sites, PMTCT, and treatment programs.

Dr. Rao Gupta relayed the experience of a positive woman who had visited ICRW. She had been extremely sick, but after she started on ART, she was healthy and well again. In explaining what it had been like before treatment, she referred to herself and others like her as “the living dead,” having been essentially taken for dead by their families and communities. As a result of treatment, they are now living again. As Dr. Rao Gupta described: “And when you’re living again, you want to resume a healthy sexual life, have children, and family, and a sense of community. But she said that no one is really thinking about us, about what lies ahead for us, and what are needs are.”

So with this woman in mind, Dr. Rao Gupta stressed that the integration of RH and HIV services is “an ethical imperative,” due to the success of PEPFAR’s treatment programs. Moreover, integration is also pragmatic, since the two services are linked through sex. Integration is also achievable, as evidenced by the case studies presented at this conference. While there are certainly costs associated with integration, it is also cost effective. As Representative Betty McCollum emphasized earlier, we need to take a long-term view; integrating RH and HIV services will prevent unwanted pregnancies, reduce the cost of PMTCT, and ultimately reduce the number of children orphaned or in need of care due to AIDS.

Dr. Rao Gupta commended the committed people within OGAC and in the PEPFAR country teams who are doing important work, despite the U.S. policy restrictions. While it is impressive how much is happening through PEPFAR, we need to find ways to use the evidence coming from these programs to share with other country teams to ensure that this takes root in other PEPFAR focus and non-focus countries.

Dr. Rao Gupta then presented a "to do" list, which includes elements for PEPFAR reauthorization and others for PEPFAR to implement right away.

- Operationalizing RH-HIV integration requires guidelines. OGAC should proactively communicate with PEPFAR country teams, providing written instructions and guidance on RH-HIV integration and signaling the importance of moving forward with RH-HIV integration and providing the necessary information about how to do it.
- Develop country-specific strategies and strengthen the links between PMTCT and MCH and RH.
- Invest in strengthening the capacity of service providers and ensure they are trained to address the fertility desires of HIV-positive women.
- Strengthen RH programs to serve as expanded entry points for HIV/AIDS services and address the family planning commodity shortages that hamper the functioning of family planning programs.
- Ensure that ARV treatment protocols include family planning.
- Allow and encourage the staff working in PEPFAR country programs to make the case for value of RH-HIV integration, drawing on the growing body of evidence to present to policymakers to get congressional support.
- Prioritize integrated programs to reach young people, especially young women and girls, both married and unmarried.
- Increase resources for population and family planning programs. In order for wrap-around RH-HIV programs to be effective, the levels of funding for RH and family planning cannot continue to be diminished leaving the programs weakened.
- Expand opportunities for horizontal dissemination of lessons learned on RH-HIV integration. With so many PEPFAR programs, RH-HIV integration work is often scattered, ad hoc, and dependent on the commitment of particular people. PEPFAR must develop mechanisms to make the RH-HIV integration work systematic, based on a supportive policy context, in order to implement the lessons learned on a larger scale across countries. The success of RH-HIV integration will depend on how PEPFAR will operationalize it, invest in operational research, determine what is needed to provide quality services, and ensure that policy and legislative context is supportive.

Discussion

In the discussion period, participants raised a number of questions about how PEPFAR can do more that just a tick box to encourage RH-HIV integration, since family planning has a direct impact on HIV, and how it can prioritize comprehensive rights-based approaches. Participants acknowledged that PEPFAR has made important progress in addressing the family planning needs of women with HIV, but it is still seen largely as the domain of USAID. Yet mounting evidence shows the contribution of family planning to HIV prevention. Beyond a tick box, participants encouraged PEPFAR to develop dedicated family planning indictors within ART programs, measuring the number of ART clients on family planning methods.

In response, Dr. Kenyon agreed that integration ought to be an issue of access and quality, not just ticking the box. But he suggested that PEPFAR should leave it up to the ingenuity of country teams and partners to determine the best delivery model. OGAC can set parameters, but it does not want to dictate that country teams must integrate, especially since that might harm family planning services.

In summary, Dr. Kenyon returned to the basics—that PEPFAR is a program for HIV prevention, care, and treatment, and he does not anticipate that this basic mandate will change. Nevertheless, he recognized that prevention means a lot of other issues have to be addressed in societies and that people living with HIV/AIDS have many needs. He said that PEPFAR hopes to meet those needs. But if PEPFAR spreads itself too thin and becomes a TB or malaria or family planning program, then lives will be lost. “We have many competing priorities and appreciate that family planning has an integral place in HIV management, but PEPFAR is unlikely to become a family planning organization. We would dilute our expertise. Family planning is not the expertise of PEPFAR,” Dr. Kenyon emphasized.

Other key issues that were raised by the audience included the importance of addressing gender-based violence as part of an integrated approach, the need to listen to women and to work with communities, and the need to strengthen health systems to handle HIV/AIDS, especially reproductive health. Finally, there was discussion about the importance of new U.S. AIDS legislation to mandate certain priorities and to push for integration in some PEPFAR programs.

Conclusion: U.S. Policy Options for RH-HIV Integration

The innovation and richness of the field experiences from Kenya, South Africa, and India presented at the CSIS conference offer great promise for moving forward with RH-HIV integration. The valuable evidence that is emerging from these programs demonstrates that a new threshold has been crossed, exposing a critical, new dimension of the response to the HIV/AIDS crisis. With the reauthorization of PEPFAR in 2008, a new U.S. administration in 2009, and OGAC’s ongoing choices about implementing existing policy, the United States has an unprecedented opportunity to apply these lessons in order to strengthen

U.S. AIDS strategy. Accordingly, the policy options for RH-HIV integration deserve the immediate attention of U.S. policymakers.

Based on the presentations and discussion at the CSIS conference, the policy options for making RH-HIV integration a priority in PEPFAR fall into the six main categories listed below. Taken together, they represent the best opportunities for PEPFAR to move ahead with integration in a way that is both effective and sustainable.

1. Expand support and dedicate funding for integrated reproductive health–HIV/AIDS programs and support the scale-up of effective, integrated FP-HIV models.
   - Integrate RH into PMTCT program, from pre-conception management, family planning, and postnatal care. Develop country-specific strategies to strengthen the links between PMTCT and MCH and RH.
   - Direct PEPFAR programs to make prevention of unintended pregnancies for women living with HIV central to prevention strategies.
   - Increase integration of reproductive health/family planning with VCT programs.
   - Invest in strengthening the capacity of service providers, and ensure that they are trained to address the fertility desires and to provide appropriate information on contraceptive choices for HIV-positive women.
2. OGAC should provide guidance to PEPFAR country teams on implementing RH-HIV integration and develop reproductive health and family planning tools and indicators for integrated RH-HIV programs.
   - Ensure that ARV treatment protocols include family planning.
   - Include family planning indicators as measures of program success and develop tools and indicators for monitoring and evaluating RH-HIV integration; gaps in the evidence base have to be addressed.
   - Develop guidelines, standards, and tools for operationalization of integration of FP and HIV services.
   - Develop systems to monitor the process of integration and to formalize coordination between FP and HIV services, including reporting on specific integration indicators and monitoring of quality of services provided.
3. Increase resources for reproductive health and family planning programs in order to make wrap-around RH-HIV programs effective.
   - Expand resources for RH-FP programs to serve as expanded entry points for HIV/AIDS services and address the family planning commodity shortages that hamper the functioning of family planning programs.
   - Strengthen procurement and supply chain management of commodities to prevent stock-outs of family planning and HIV commodities.

4. Address policy restrictions that prevent women from accessing RH and HIV services, including the Mexico City Policy and the abstinence-until-marriage earmark.
5. Strengthen community advocacy efforts and community involvement for quality integrated services and support comprehensive and rights-based approaches that address gender equality.
    - Address key gender issues, notably the links between gender-based violence and HIV/AIDS. Integration should include a women's rights training component, as well as supporting access to legal services for women.
    - Ensure that interventions are meaningful to women living with HIV/AIDS by providing appropriate information about which contraceptives work best for women with HIV and which work best with those on ARV, and ensuring that SRH-related treatment (such as pap smears and treatments, treatment and prevention of STIs, breast screening and treatment) are integrated into the HIV treatment package.
    - Identify and address barriers that women face to accessing PMTCT services.
6. To document impact and gather more evidence, compile and distribute best practice documentation and scientific evaluations on effective methods, approaches, and models of integration.
    - Expand opportunities for horizontal dissemination of lessons learned on RH-HIV integration. PEPFAR should develop mechanisms to make the RH-HIV integration work systematic, based on a supportive policy context, in order to implement the lessons learned on a larger scale across countries.
    - Invest in operations research and evaluations—that is, the need for operations research to evaluate models as they evolve and to monitor the impact on HIV positive and negative clients.
    - Embrace innovative ideas and rapidly implement at larger scale.

About the CSIS Task Force on HIV/AIDS

The CSIS Task Force on HIV/AIDS seeks to build bipartisan consensus on critical U.S. policy initiatives and to emphasize to senior U.S. policymakers, opinion leaders, and the corporate sector the centrality of U.S. leadership in strengthening country-level capacities to enhance prevention, care, and treatment of HIV/AIDS. J. Stephen Morrison, director of the CSIS Africa Program, manages the overall project, in cooperation with the CSIS Freeman Chair in China Studies, the CSIS Russia/Eurasia Program, and the CSIS South Asia Program.

The honorary cochairs of the task force are Senator Russell Feingold (D-Wis.) and Senator John E. Sununu (R-N.H.). Former senator William H. Frist remains an active partner of the task force. The CSIS Task Force on HIV/AIDS is funded principally by the Bill and Melinda Gates Foundation, with project support and input from the Henry J. Kaiser Family Foundation, the David and Lucile Packard Foundation, and Merck and Co. The task force outlines strategic choices that lie ahead for the United States in fighting the global HIV/AIDS pandemic and comprises a core network of experts drawn from Congress, the administration, public health groups, the corporate sector, activists, and others. This panel helps to shape the direction and scope of the task force and disseminate findings to a broader U.S. audience.

Now in its seventh year, the task force's principal focus is on two critical issues: first, raising the profile and improving the effectiveness of U.S. support to global prevention efforts and facilitating a bipartisan discussion of global HIV prevention policy; and second, examining how U.S. leadership can facilitate the sustainability of HIV/AIDS programs, both in terms of resource flows and in situating HIV/AIDS responses within a broader strategy to address gaps in gender equity, health infrastructure, human capacity, and international collaboration on global health. The task force continues to engage on the emerging dynamics of the epidemic in Russia, China, and India with recent delegation visits in mid-2007.