Integrating the Fields of Sexual and Reproductive Health and HIV/AIDS

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EXECUTIVE SUMMARY

The global AIDS epidemic continues to expand in many countries in sub-Saharan Africa, Eastern Europe, and Asia. In Africa, the impact of many deaths during the last twenty years is seriously affecting development and will be felt for generations. Women and girls are now disproportionately affected. While Africa remains the hardest hit region, Asia is experiencing a rapidly growing epidemic. The intersection of Asia's large young population and distortions in sex ratio at birth, along with the AIDS epidemic's disproportionate toll on young women, may threaten Asia's "demographic dividend" and social and economic development.

At the same time, the global AIDS response has begun to invest heavily in providing life-saving anti-retroviral (ARV) treatment to those living with AIDS and in making HIV/AIDS a treatable chronic disease. As more young people enter into lifelong ARV therapy, they have ongoing needs for sexual and reproductive health services related to healthy sexuality and family formation.

The HIV/AIDS field and the sexual and reproductive health (SRH) field must better coordinate efforts to prevent sexual transmission of HIV/AIDS, apply gender perspectives to HIV/AIDS programs, and provide sexual and reproductive health services to HIV-positive couples. Such coordination is necessary to better leverage the strengths of both fields in research and service provision in these times of weakened health systems and vertical programs. Sexual and reproductive health services include client-oriented family planning, safe abortion, maternal and child health services, treatment of sexually transmitted infections (STIs) and reproductive tract infections (RTIs), and provision of contraceptive and safe sex services and information to youth. AIDS services include HIV prevention, treatment of AIDS patients, and social and economic impact mitigation programs. Many of the efforts to link the two fields have been spearheaded by the SRH field, with less interest from most AIDS organizations. Mutual distrust and political marginalization of the SRH field have hindered better collaboration.

Several recent meetings have focused renewed attention on needed synergies between the reproductive health and AIDS fields. At the same time, the SRH field has been working to incorporate gender and SRH perspectives into the eight United Nations millennium development goals (MDGs), the new focus of development priority setting and funding. The field published several practical tools and guidance documents in 2004. These efforts are a few of many to link the two fields, from a narrow focus on creating a rationale for family planning within the AIDS field to insuring full reproductive and sexual rights of HIV-positive women within the MDG frameworks. The reviews have highlighted many critical issues, and much has been accomplished to articulate an agenda for collaboration and synergy both at the service delivery level and at policy levels.

In this report, we review major activities undertaken to link the two fields, highlight "values" that each field brings to the collaboration, and point out shortcomings and gaps in the AIDS response

that neither field has sufficiently addressed. We conclude with specific recommendations to address these gaps and to foster better synergy and effectiveness in a linked HIV and SRH response.

Strengths that each field brings to a linked response include:

Sexual and Reproductive Health Field

1. Focus on gender equity
2. Recognition of the SRH needs of unmarried young people
3. Attention to violence against women and girls
4. Attention to reproductive tract infections
5. Recognition of the special needs of young married women and girls
6. Protection and fulfillment of reproductive rights
7. Access to large numbers of women and youth
8. Application of social science research findings to program design

AIDS Field

1. Human rights perspectives, including the right to health and the principle of nondiscrimination
2. Outreach to vulnerable and marginalized groups and individuals
3. Recognition of importance of development impact, multisectoral programming, leadership, and governance
4. Implementation of continuum of care and comprehensive approaches
5. Legitimization of sexuality as a critical area of research
6. Attention to couples and communities
7. Attention to stigma and discrimination
8. Participatory principles related to promotion of the greater involvement of people living with HIV/AIDS
9. New prevention technologies for women: microbicides and vaccines

However, a number of serious constraints hinder better collaboration between the two fields. These **shortcomings or gaps** include:

1. Weakened health systems and the impact of health sector reform
2. Failure to adequately understand and address sexuality in the design of programs
3. Inattention to and/or violation of reproductive and sexual rights in the context of HIV/AIDS
4. Continuing reliance on risk group approaches to HIV prevention and missed opportunities to address the broader range of vulnerability
5. Need for better application of social science research findings on sexual behaviors that address the structural determinants of vulnerability
6. Insufficient interest and initiative from many in the AIDS field

Many of these gaps and shortcomings should be addressed at the global policy level by multilateral and bilateral donors, national and local governments, and community-based groups looking to harmonize development funding and synergies. Because private foundations are less governed than bilateral programs by politicized agendas related to sexuality and rights, especially those in the United States today, it may be easier for them to support open discussions and to generate some of

the needed evidence-based research on sexuality and rights that this paper identifies. Moreover, the flexibility of foundation grant making makes it easier to support work that crosses "stove pipe" funding categories for innovative linking demonstrations.

We offer six **recommendations for next steps**:

1. Share a version of this report with selected AIDS actors and funders and those in the SRH field working to promote links between AIDS and SRH programs, especially those working in hard-hit countries. Convene a meeting with strong representation from the AIDS field and from program implementers in the global South to ascertain interest, attitude, and perspectives on the recommended links between SRH and HIV programs outlined in this report.

2. Convene meetings on specific "gaps" (in this report or suggested by others), focusing on AIDS actors and MDG and other development agencies and actors outside the SRH field, to refine issues and define needed research. Such meetings would bring AIDS, health system, and carefully selected SRH people together to discuss the successful elements of integrated responses to HIV and SRH, including research, programs (new and scaling up), and new directions in policy. Meetings should include representation from the hard-hit countries in southern Africa. Topics might include:

    - HIV-positive people and their sexuality and reproductive desires
    - The range of human sexual behaviors and roles and sexual networking, with implications for re-envisioning HIV prevention beyond risk groups and "core transmitter groups"
    - Integrating SRH into the continuum of care for HIV chronic disease management, using lessons learned from implementing a "quality of care" approach to SRH services
    - Intersections of HIV and sex ratio at birth trends in Asia, projected demographic dividends
    - Developing methods for formulating context-specific, integrated responses within weakened health systems that take into account:
        - The stage of the epidemic
        - Resources available
        - Nature of the epidemic (injecting drug use, sexual, blood transfusion)
        - State of the health system
        - Women's status
        - Youth rights
        - Sexual and reproductive needs of infected couples

      These might result in menus of strategies. These approaches should model dynamic conceptualizations of the stage of the epidemic and sexual interactions, diversities, and multiple roles of populations targeted.

    - Links between specific health service programs (e.g., STI as a lead issue in service delivery integration of SRH and AIDS; communication about AIDS behavior change and family planning Information, Education and Communication (IEC) programs; reproductive health services added to HIV/tuberculosis or HIV/tuberculosis/malaria packages; working with pharmacists; abortion and postabortion care; referral links to SRH services for AIDS patients, etc.)

3. Support for pilot demonstration projects and research and evaluation of context-specific efforts to integrate HIV/AIDS and other services at the primary health care and local levels, including, if appropriate, SRH services and approaches. These demonstration projects, which would be undertaken within clearly articulated sexual and reproductive rights frameworks, should build on innovative work on the ground. These might include models of comprehensive SRH and AIDS services for couples and individuals over the life cycle.

4. Support for a peer-reviewed efficacy of existing HIV and SRH interventions and for commissioned studies to fill the gaps. To strengthen the case for needed links, integrated intervention packages, formulated from agreed-on methods discussed above, should be evaluated.

5. Much can be done at the global policy level to educate and influence major AIDS and development donors like the United Nations Development Programme (UNDP), Global Fund to Fight HIV/TB/Malaria, the European Union, the G8, and the International Financing Facility Initiative about the value of SRH and HIV/AIDS funding and the ways these programs can be linked.

6. Finally, in-depth studies should be conducted of "positive deviance" in the SRH field, such as in Kerala, India, which boasts high female education and social equity.

This report highlights the importance and urgency of collaboration between the fields of SRH and HIV/AIDS in the context of weakened health systems, competing development challenges, and the feminization of the AIDS epidemic. After reviewing recent efforts, highlighting positive values that each field can bring to the partnership, and analyzing gaps and shortcomings in the current response, we offer several recommendations for developing a policy, program, and research agenda that fosters greater collaboration in responding to the worsening AIDS epidemic while meeting the sexual health needs of individuals and communities worldwide. Each field can learn from the other, gain better access to populations in need of services, benefit from gender and rights perspectives articulated for each field, and better focus resources and attention on the multiple needs of individuals, families, and communities.

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Acronyms Used in This Report

ABC	"abstinence, be faithful, wear a condom" programs
AIDS	Acquired Immune Deficiency Syndrome
ARV	anti-retroviral
CCM	country coordinating mechanisms
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHANGE	Center for Health and Gender Equity
CIDA	Canadian International Development Agency
CRC	Convention on the Rights of the Child
DFID	U.K. Department for International Development
DOTS	direct observed therapy
EU	European Union
FHI	Family Health International
ICPD	International Conference on Population and Development
ICRW	International Center for Research on Women
IDU	injecting drug users
IEC	Information, Education and Communication
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
FHI	Family Health International
HIV	Human Immunodeficiency Virus
HPTN	HIV Prevention Trials Network
MCH	maternal and child health services
MDG	United Nations millennium development goals
MTCT	mother-to-child transmission
NGOs	nongovernmental organizations
PEPFAR	President's Emergency Plan for AIDS Relief program
PIWH	Pacific Institute for Women's Health
PSI	Population Services International
RTI	reproductive tract infections
SRH	sexual and reproductive health
STI	sexually transmitted infections
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VCT	voluntary counseling and testing
WEDO	Women's Environment & Development Organization
WHO	World Health Organization

I. INTRODUCTION AND BACKGROUND

The AIDS crisis continues to unfold and has assumed a dominant position in the global development agenda. Worldwide, the epidemic has increased rapidly in women, especially young girls; women now represent 48 percent of global infections. In sub-Saharan Africa, women are especially hard-hit, with 57 percent of all current infections in women and 75 percent of youth infections among girls (1). At the same time, the increasing global commitment to providing life-saving antiretroviral treatment to the world's poor is making treatment of the AIDS disease an important new objective of most countries' AIDS responses.

However, despite substantial global investment in the last decade, the epidemic continues its inexorable rise. This is especially true among socially and economically vulnerable segments of the population, with 20 million dead from AIDS, 38 million currently infected, nearly 3.1 million new infections in Africa in 2003 alone, and 14 million orphans (2). Although still most severe in sub-Saharan Africa, with 25 million people infected, the epidemic is now also gaining a foothold in Asia, with 5.1 million persons infected in India and about one million persons in China. Two-thirds of Asia's population is aged 15–24, the age group that constitutes 60 percent of new infections. In a world that will see the largest generation of teenagers in history, with 1.2 billion 10–19 year olds making their sexual debut in the coming years (3), an epidemic that is 80 percent sexually transmitted is a sobering challenge. Asia's so-called "demographic dividend" of a large young working-age population that will drive Asia's economic growth in the first part of this century (4) may be especially at risk by the emerging epidemic. Moreover, China and India are facing increasingly large disparities in sex ratio at birth. These disparities, along with the increasing numbers of Asians infected with HIV and the toll on young women, suggest that these two demographic giants may see the epidemic intersect with sex-selective abortion to create a significant shortage of girls in Asia, with the resulting social and economic consequences. In addition, the devastating development impacts of the epidemic in Africa already are being seen in some greatly affected poorer communities in Asia. Although the Asian epidemic so far is significantly different from the African epidemic in terms of transmission routes, affected groups, and potential for heterosexual spread, the current social and economic impacts of the epidemic in hard-hit Asian communities are a harbinger for other communities in the region. China and India, the two Asian countries predicted to be economic powerhouses in the coming decades, may see the cost of AIDS challenge their economic potentials.

Meanwhile, it has been more than ten years since the historic 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt. In 2004 a series of important reviews assessed global progress in achieving the goals set forth in the ICPD Platform for Action. The ICPD represented a paradigm shift in the population and development field that established both a change in the rationale for services (health and rights) and needed new programs on the ground for the world's women and youth. The shift from population control to reproductive health and rights represented a long-overdue incorporation of gender and development perspectives into health and family planning programs and helped to push forward needed work on issues of sexuality and sexual and reproductive rights. Sexual and reproductive health services include client-oriented family planning, safe abortion, maternal and child health services, treatment of sexually transmitted infections and reproductive tract infections, and contraception and safe-sex services and information for youth. Although donors promised $6.1 billion per year (one-third of what was required to

achieve the Cairo goals), with the other two-thirds to be mobilized by developing countries, by 2003 only about 50 percent, or $3.1 billion, had been given. Despite much on-the-ground progress, the reproductive health community has seen a decrease in global funding and commitment to the Cairo goals. Some (5) contend that the removal of the global crisis and threat of overpopulation, as accomplished at Cairo and confirmed by recent demographic trends, has lessened the urgency and priority for investment. Ten years after ICPD, a combination of politics and the increasing popularity of priority-setting methods in health and resulting new vertical disease (AIDS, tuberculosis, malaria, dengue) or issue-specific (vaccines) funding mechanisms have sidelined the commitments made at Cairo and moved them away from mainstream development policy focus and funding.

The continuing expansion of the AIDS epidemic and the belated recognition that substantial investment is needed to reverse trends have shifted substantial development dollars to this urgent problem. AIDS spending, which was only $300 million a year in 1996, had increased to $4.7 billion a year in 2003. This was estimated to be only half of what was needed by 2005 and a quarter of what was required by 2007. The United States alone committed $15 billion to AIDS through the President's Emergency Plan for AIDS Relief (PEPFAR) program.

The same social and economic inequities that make women and girls vulnerable to HIV infection also increase their risk for poor reproductive health outcomes, such as sexually transmitted infections, unwanted pregnancies, and death in childbirth. These "structural" determinants of risk drive risk-taking behaviors in all vulnerable groups, not just women, and require broader social and economic development solutions beyond the scope of most HIV or reproductive health programs. But despite recognition of common determinants linked to women's lesser power and decision making, including in their sexual relationships, the gaps between SRH and HIV/AIDS programs and policies and between those within the AIDS field working on sexual prevention and treatment has widened in recent years. Now that treatment is possible, many in the AIDS field have shifted attention and resources toward providing life-saving antiretroviral treatment for the poor in the global South. A greater proportion of funding for the global AIDS response is now directed at expanding treatment (Global Fund, PEPFAR, the World Health Organization's [WHO's] "3 x 5"). While resources for prevention have also increased, many in the AIDS field have shifted attention to treatment, while within the SRH field, reproductive health work on HIV/AIDS is still aimed mainly at sexual prevention of HIV in youth and married women through behavior change and, to some degree, STI services.

Neither field is adequately reaching out to men. Both fields focus their efforts on specific groups (married women and youth for the SRH field and groups with highest risk behaviors or those living with AIDS for the HIV/AIDS field) and fail to respond to the reality of people's multiple roles in life or to the web of human relationships that define people's sexual lives. While social science research on sexual behavior has added much to the understanding of these issues, these findings are insufficiently incorporated into interventions.

A complicating factor is that the reproductive health community has been politically marginalized in the United States, the largest global funder of development aid. Driven by a moral agenda, including opposition to abortion and gay marriage, politicians have come to associate the term "reproductive rights" with sexual and abortion rights (6). It has become more difficult to engage in

honest discussions about sexuality, especially the range of sexual behaviors outside conventional marriage, at many global policy tables in Washington or at U.S.-dominated global development institutions. However, several donors, especially the European Union (EU), U.K. Department for International Development (DFID), SIDA, and the Canadian International Development Agency (CIDA), have maintained their leadership and investments in funding for harm reduction and safe-sex programs and in promoting development agendas that link work on SRH and AIDS. However, for politicians from China to Texas, it is much less contentious to put AIDS dollars into saving a life with antiretroviral medications than to discuss sensitive issues like sex and drugs. The U.S. government and its funding restrictions have shifted the U.S.'s large portion of HIV/AIDS development dollars into treatment. Within prevention programs, interventions such as condom promotion and clean needle programs are under attack, and U.S. dollars increasingly are being devoted to promoting sexual abstinence among youth. Much of the SRH field's energy and efforts have been spent defending turf related to sexual and reproductive rights that seemed assured after Cairo, while other reproductive health organizations are trying to mainstream their work into the AIDS services response, at least partly to recapture development dollars.

At the same time, the AIDS field itself is changing as treatment access begins to become the reality, or at least the stated objective, even in the poorest places. With treatment, AIDS can become a chronic disease. As people live with the disease, the field must recognize that the predominantly young populations affected will want to pursue healthy and active sex lives, marry, and have children. The field must move beyond merely preventing primary infections. Likewise, the SRH field has been slow to consider these secondary prevention needs. Such a perspective is imperative given that most AIDS patients were infected between ages 15 and 24 and, if treatment is available and affordable, may live for another forty to fifty years.

Meanwhile, a "disconnect" has occurred between program creativity on the ground surrounding collaboration and the global policy debates, especially in the United States. Local initiatives, driven by on-the-ground realities, are demonstrating the possibility of finding common solutions to these interlinked sets of issues, especially in times of weakened health systems with limited human and financial resources. Innovative programs in resource-poor areas are tackling sexual behavior change and AIDS risk reduction in creative ways, even while priority-setting approaches to defining primary health care objectives divide agendas and focus limited resources on the control of specific diseases. This priority-setting movement has further sidelined reproductive health (a broad agenda that encompasses rights protection and social development) as a priority area. Although some integrated service delivery paradigms exist, they are not yet mainstream or sufficiently promoted as models for replication on a large scale.

Several organizations have focused, especially recently, on reminding the global policy community of the important links between reproductive health and response to AIDS. Much of this effort has come from reproductive health and women's organizations, the ICPD, and (to a lesser degree) the Fourth World Conference on Women, held in Beijing in 1995). Some have suggested that these efforts are an attempt to recapture funding (7). The increasingly diverse AIDS technical assistance and funding community, however, has spent less time looking at what the ICPD agenda and on-the-ground SRH infrastructures might contribute to an improved response to the AIDS epidemic, beyond a handful of specific service integration issues.

This report reviews the main efforts to date to promote such collaboration between the two fields, highlights the main values that both fields bring to a synergistic response, analyzes the gaps, and makes specific recommendations for action. The main goal of this paper is to influence both AIDS and development organizations to take advantage of important post-ICPD research and program capacities to forge a synergistic agenda for AIDS prevention, treatment, and care and reproductive health improvement for the world's poor. This agenda must also be set within a context of rights protection, a realistic understanding of the range of sexual behaviors that drive the epidemic, and an appreciation for the weakened health systems that deliver services to the world's poor. A secondary goal is to point out to mainstream SRH organizations some important lessons from the AIDS response that might strengthen their work on HIV prevention, treatment, and care.

II. ANALYSIS OF CURRENT INITIATIVES (See Appendix for detailed agency summaries)

The past year has witnessed increasing attention, mainly by SRH funders and organizations, to the needed synergies between the reproductive health and AIDS fields. The journal *Reproductive Health Matters* organized a meeting on the topic at the 2002 International AIDS Conference in Barcelona. Many of the presentations were published in the November 2003 issue of the journal. An excellent editorial by Marge Berer and article by Askew and Berer summarized the opportunities for service integration between the two fields (8, 9). Some useful tools, guidelines, and case studies have been published and disseminated during the decade since ICPD by the International Planned Parenthood Federation (IPPF), Population Council, and others (34, 35), highlighting key issues such as staff training required for institutional change (36). In 2004, however, the field saw a renewed and intensified push for fostering greater links between reproductive health and HIV/AIDS programs, and the reproductive health community organized several meetings on this topic. Here we briefly review these efforts, discussing their major objectives, outcomes, key actors, and alliances, and then identify remaining gaps.

During 2004, meetings took place in Glion, Switzerland (WHO), New York (United Nations Population Fund [UNFPA]), Bangkok (the 15th International AIDS Conference), London (the IPPF Global Roundtable on ICPD+10), and Washington, D.C. (USAID Cooperating Agencies). New networks have been formed (Global Coalition on Women and AIDS), working groups established (UNFPA/FHI/FCI/AGI and USAID), and important publications, agency guidelines, and monitoring tools produced.

In February 2004, the U.N. coordinating agency on AIDS, UNAIDS, launched a new "Global Coalition on Women and AIDS," composed of representatives of many global SRH and women's development organizations (Women's Environment & Development Organization [WEDO], the International Center for Research on Women [ICRW], UNFPA, and others). The coalition's mission focuses on preventing new infections in women and girls, providing equal access to HIV care and treatment, accelerating microbicide development, protecting women's property and inheritance rights, and reducing violence against women. World AIDS Day 2004 focused on the increasingly female face of the global epidemic.

In May 2004, WHO's Department of Reproductive Health Research, the USAID, Family Health International (FHI), and Johns Hopkins University organized a meeting in Glion, Switzerland (and

subsequent "Glion Call to Action"). Funding for the meeting was provided by the Packard, Hewlett, and Gates foundations. The primary focus of the meeting was to promote family planning in PMTC programs to prevent births of HIV-infected children. Following closely on the heels of Glion and with an overlap of actors, UNFPA organized two meetings in New York (one technical and one high-level parliamentarians) and issued the "NY Commitment," which also included discussion of the reproductive rights of HIV-positive women. UNFPA has taken a leading role within the UN system on the issue of women and AIDS. These actors reconvened in Bangkok and organized sessions at the 15th International AIDS Conference in July to advocate for synergies between the two fields. The Bangkok meeting formed three working groups: on program and policy implementation (headed by Lynn Collins of UNFPA), research needs (headed by Duff Gillespie of Johns Hopkins University and Ward Cates of FHI), and advocacy (led by UNAIDS and the Alan Guttmacher Institute). At the ICPD + 10 Global Roundtable organized by IPPF in London in late August, HIV/AIDS was a key theme, and the roundtable formulated a series of recommendations that included needed service integration raised at earlier meetings. However, the group moved beyond narrow services to explore context (e.g., weakened health systems), cultural issues and stigma, rights, sexuality, and men's involvement. In September, USAID's Office of Population convened a working group and produced guidelines for its overseas programs on integrating family planning and HIV/AIDS as well as linking family planning and PMCTC programs. A group meets twice a year to work out the mechanisms for links in its own programs, albeit within the constraints of the current moral agenda guiding U.S. policy on SRH issues (avoidance of "rights" language and promotion of "abstinence, be faithful, wear a condom" [ABC] programs emphasizing abstinence).

At the same time, the SRH field has been working to incorporate gender and SRH perspectives into the eight U.N. millennium development goals (MDG), the new focus of development priority setting and funding. Three goals have health-related components, including global halving of new infections of HIV, tuberculosis, and malaria. The absence of a specific goal concerning SRH contributed to a sidelining by the development community of the promises and commitments made at ICPD. Working groups and advocacy organizations are highlighting needed perspectives, synergies, pathways, and instrumentality of SRH programs for reaching the goals, as well as common vulnerabilities. The excellent work by many leading gender and SRH experts to incorporate gender and SRH perspectives into the goals, especially millennium development goals 5 and 6, has generated much of the demand for and specifics of the calls for better synergy between the SRH and AIDS fields.

Several practical tools and guidance documents were published in 2004, including a practical guidance tool for UNFPA country programs on the ground, focusing on HIV prevention, and a UNFPA, Ipas, International Community of Women (ICW), Pacific Institute for Women's Health (PIWH), and EngenderHealth tool aimed at monitoring the achievement of MDGs 5 and 6 with respect to the reproductive rights of HIV-infected persons. USAID has issued guidelines to its cooperating agencies with a focus on integrating family planning and HIV services, as well as on integrating family planning services with PMCT voluntary counseling and testing (VCT) programs as part of care and support for people living with HIV/AIDS. UNFPA and EngenderHealth have produced a tool on integrating HIV prevention with maternal and child health services (MCH).

These efforts during 2004 represent a range of actions, from a narrow focus on creating a rationale for family planning within the AIDS field to insuring full reproductive and sexual rights within the

MDG frameworks of HIV-positive women. These reviews highlighted many critical issues, and much has been accomplished to articulate an agenda for collaboration and synergy both at the service delivery level and with respect to needed rights protection and women's empowerment in sexual decision making. At the same time, advocacy has been increasing for women and girls' common vulnerabilities to HIV infection, the need for HIV response to focus both on sexual prevention and on treatment, and the need to expand comprehensive sexuality education (beyond abstinence promotion) and life skills programs for youth.

III. WHAT STRENGTHS DOES THE SRH FIELD BRING TO THE TABLE?

In the ten years since the ICPD, the more than 180 states that signed on to the Platform for Action have made notable progress in implementing a rights-based, client-oriented, and participatory approach to improving reproductive health, mainly for women and youth. Below we outline eight important contributions that we believe the last decade of experience in the reproductive health field can make to improve the AIDS response.

1. Gender Perspectives

The SRH field has been at the forefront of integrating principles of gender equity with efforts to ensure positive reproductive health outcomes. More than a decade ago, those working in the SRH field recognized that women's and girls' vulnerability to reproductive health problems resulted from disparities in power relations that were defined by cultural and social constructs and economic and social disadvantage. The field recognized that lack of education and access to resources were causes of this vulnerability and began to address these issues as some of the preconditions to improving reproductive health and other health problems. For example, in many parts of the world rates of TB are much higher in women than in men, because of gender differences in health seeking and initiation of treatment. A gender analysis of health seeking has been essential for the development of outreach programs in poor rural communities aimed at bringing more women into TB treatment.

Gender Perspectives in HIV/AIDS Programs: A Continuum

Geeta Rao Gupta and colleagues at ICRW developed a continuum of HIV/AIDS programs addressing gender, sexuality, and rights (10). The programs highlight a continuum of interventions that employ a gender approach to HIV/AIDS prevention, care, treatment, and impact mitigation. The continuum results from years of efforts in policymaking, program implementation, and research on gender equity and reproductive health.

At the first stage on the continuum, the main principle is to "do no harm." This stage eliminates gender stereotypes that lead to vulnerability and that limit individuals' ability to benefit from the program. For example, sex education programs must not use gender stereotypes depict and reinforce women and girls as passive sexual victims and men and boys as sexual aggressors.

The next stage along the continuum incorporates gender sensitivity into HIV/AIDS programs. This stage requires that HIV/AIDS programs recognize that the prevention, care, and treatment

needs of men and women are often different because of physiology and socially constructed gender roles. Examples of these types of interventions include:

- Development of female controlled methods,
- Integration of STI diagnosis and treatment into reproductive health services, and
- Programs that address men's vulnerability.

In the third stage of the continuum, interventions seek to transform social and cultural values about gender. These programs work with men and women to redefine gender norms and encourage healthy sexuality. Examples include programs that work with women and men to examine the impact of gender and sexuality on sexual health and programs that foster gender-equitable masculinity and femininity. Most often the focus of these interventions is on the couple rather than the individual.

Interventions in the fourth stage of the continuum address structural factors to create an enabling environment through empowerment. These interventions equalize the balance of power between men and women within an overall context of social and economic development. Examples of these interventions include programs that provide women and men:

- Access to information, education, and services;
- Access to resources and assets, sources of credit, property inheritance, and formal sector employment with equal pay for equal work;
- Access to political and social capital and leadership at community and social levels;
- Protection and fulfillment of human rights.

2. Youth

Youth outreach programs are an example of good synergy between SRH and AIDS programs. The ICPD promoted the rights of youth to sexual and reproductive health services and information, and SRH programs and policies have made special efforts to reach girls and young women through innovative pregnancy prevention programs. Many in the SRH programs have applied this approach to preventing the sexual transmission of HIV/AIDS and other STIs in youth, and many in the AIDS prevention field have applied these strategies to reaching youth with HIV prevention information and services. In addition to promoting peer education and pushing for youth participation in designing the programs aimed at them, both the SRH and the AIDS field have incorporated gender perspectives with programs aimed at challenging gender norms and working with boys and girls together. We reviewed 436 abstracts from the Bangkok AIDS meeting with the key word "reproductive health." Among them, about one-half dealt with innovative community-based youth programs using the techniques developed in the reproductive health field to provide HIV prevention education to young people. Many of these projects move beyond simple IEC approaches and work from a "youth sexual rights" framework that acknowledges youth sexual behavior, intervenes to empower girls, and reaches out to young boys and girls together and separately to change gender norms to ones that promote equality, choice, and protection.

The Stepping Stones program is an example of such an approach. The program aims to change gender norms to promote equitable masculinities through a life skills training program that involves

men and women together. It is focused on fostering a critical examination of male and female roles and promoting responsibility for actions. While HIV/AIDS risk reduction is a major objective, its impact extends to other facets of community development. The project has been implemented in Uganda and other locations (11). Gary Barker has worked with young men in Brazil to change their socialized masculine behavior and attitude in sexual relationships and its impact on violence and HIV/AIDS risk (12).

3. Sexual Violence

The SRH field has promoted the concept of gender violence as both a public health and a human rights issue. Bringing the concept of gender violence into the health sphere has helped to raise awareness and intervention by medical personnel, who are often the first point of contact for battered women. The reproductive health field has linked the issue of gender violence, both within and outside marriage, with HIV risk and prevention and treatment efforts. The increasing feminization of the AIDS epidemic, affecting mainly married women and young girls, makes the scaling up of such approaches urgent.

At the Bangkok AIDS conference in July 2004, Rachel Jewkes and colleagues in South Africa reported on their research among 1,366 women seeking prenatal care in Soweto. These women were interviewed about their experiences of emotional, physical, and sexual violence in their relationship with their current or most recent partner, and the reports showed a strong relationship between HIV infection and violence. Their recommended interventions included a greater focus on men and male relationship control (13).

4. Attention to Reproductive Tract Infections in Women

Sexually transmitted infections and reproductive tract infections in women are associated with adverse outcomes of pregnancy and also increase the chance of HIV transmission (14). Prevention and treatment of STIs has been a major focus of HIV/AIDS prevention efforts worldwide for many years. Much effort has focused on approaches to diagnosing and treating STIs in resource-poor settings that lack the laboratory capability or human resources for gold standard testing. But these approaches have proved much less effective for women, because their symptoms are not well correlated with infections and many women are asymptomatic for STIs (15). One dimension of the increasing feminization of the AIDS epidemic is the increasing number of infected married women. Because the AIDS field has not considered married women as “core transmission groups” (i.e., they are vulnerable but not likely to pass on infections), these women have been a lesser focus for limited resources. Surveys in China and India reveal high rates of untreated RTIs among rural women (16, 17), making these women more vulnerable to infection. The HIV/AIDS field in Asia has not adequately addressed RTIs among rural women and has focused instead on STI clinics serving mainly men. The reproductive health field has garnered substantial experience in developing approaches for RTI management in resource-poor settings (18). Addressing this important component of HIV vulnerability in women is important from both a health and a rights perspective, even if not from an epidemiological one.

5. Youth Marriage

The reproductive health field has highlighted a previously under-recognized problem of young married girls, often in arranged marriages to older, sexually experienced men. In fifty of the least developed countries, 38 percent of young women aged 20–24 are married before they reach 18. In Rajasthan, India, 36 percent of girls are married by age 15 (19). Many of these young women are at increased risk for adverse outcomes of pregnancies and childbearing. These young women are especially powerless, unable to negotiate either contraceptive or condom use or to influence the behavior of their husbands, and similarly are at increased risk for HIV transmission. Married women have been outside the realm of most HIV prevention efforts for youth. Approaches pioneered by the reproductive health field to reach young married women will be important tools for the AIDS field's effort to reach out to vulnerable women.

The International Women's Health Coalition has been a vocal advocate for recognizing the increased risk of HIV for these young married women and is working with partners in the predominantly Muslim north of Nigeria (Girls Power Initiative, the Adolescent Health and Information Project, and the Conscientizing Male Adolescents program) and in Pakistan, two places where child marriage is common. In both places, a national sexuality education curriculum is providing young women and boys with sexual health information. Programs in Nigeria are also providing skill building and self-esteem training for girls to find alternatives to early marriage, working with communities, schools, and parents as well.

6. Reproductive Rights

A major focus of the paradigm shift in the population and family planning field since Cairo has been the attention to protecting the reproductive rights of women and couples, to increasing contraceptive choices for women, and to insuring informed consent. These concepts have not been adequately applied in the AIDS field. Despite advances in treatment, many HIV-positive people are urged to abort pregnancies or be sterilized. Most are told not to have children for fear of passing the virus to new generations. Applying the principles of reproductive rights to HIV-positive couples desiring pregnancies should accompany the treatment access movement. A number of organizations in the reproductive health field, especially Ipas and the Center for Health and Gender Equity (CHANGE), have begun to articulate these issues (20, 21). Similarly, the idea of "choice" could be applied to HIV prevention strategies by making more HIV prevention choices available to couples at risk. "Quality of care" family planning programs are demonstrating that choice increases use.

7. Reproductive Health Services Infrastructure and Reach

The reach and large clientele of reproductive health services offers an important opportunity for AIDS prevention and treatment. Married women and some youth who are reached by existing family planning, pregnancy, and delivery services, and RTI/STI services including cervical cancer and breast cancer screening, offer a huge potential clientele for VCT, PMTC, AIDS education, and condom promotion and distribution, as well as AIDS care and treatment. In many places, the post-ICPD stress on integrated MCH, family planning, and STI services (the constellation of client-oriented services) and quality of care approaches has improved service infrastructures, client

counseling, and use of services. Taking advantage of the reach and acceptability of these infrastructures will be important.

For example, MCH programs are often the main entry point into the health system for poor women and their families. Integrating VCT and HIV prevention counseling is an important opportunity to reach women and their husbands with couples-oriented prevention methods, beyond the obvious PMTC programs that are currently the main points for integration.

The most well known example of an MCH and HIV program synergy in the AIDS field that promotes a family focus is the prevention of mother-to-child transmission (PMTCT+) strategy devised and implemented by the Columbia School of Public Health. This approach offers a badly needed focus on pregnant women in existing programs aimed at preventing HIV transmission during childbirth. The Columbia team, building on previous ICPD-related work on safe motherhood (22), has expanded traditional PMTCT programs to provide ARV treatment to the mother and the family, thus insuring the woman has access to needed treatment and the child is not orphaned.

8. Use of Social Science Analysis of Behavior

The population and family planning field has a strong history of social science research and analysis of reproductive behavior and social and structural determinants of positive and negative health outcomes. For example, research has highlighted the positive effect of formal education on reproductive health–seeking behavior and decision making in women and girls, which has in turn led to positive reproductive health outcomes. Operations research, using social science research methods that test the effectiveness of reproductive health interventions, has made a significant contribution to program design and policymaking. The Horizons Project, a USAID-funded program of the Population Council, has been applying the methods of family planning operations research to HIV/AIDS programs. Although excellent social science research has also been undertaken in the AIDS field, especially in linking poverty, social status, stigma, and other factors to vulnerability, the findings have not been sufficiently applied to intervention programs. Nor have most AIDS programs made use of the growing body of knowledge on sexuality and sexual behavior and networking. AIDS programs remain largely focused on changing individual risk factors, such as condom use and numbers of sexual partners, rather than on addressing the causes of vulnerability. Changing the social, economic, and other determinants of vulnerability requires long-term investments, whereas many programs strive for shorter term results in project populations. Without the longer term changes, however, these short-term results may not be sustainable.

WHAT STRENGTHS DOES THE AIDS FIELD BRING TO THE TABLE?

Twenty years into the global AIDS response, those responding to the epidemic have learned several important lessons. Because of the substantial development impacts caused by AIDS in hard-hit communities, the epidemic has forced a greater understanding of the role of governance in an effective response. The following eight strengths are important contributions that the AIDS field can make to the reproductive health field.

1. Human Rights Perspectives

In recent years, the AIDS field has advanced principles of human rights, including the right to health. The controversies surrounding access to expensive new ARV drugs by poor AIDS patients in the South helped push these issues to the forefront of global policy debates. Rights relevant to HIV/AIDS outlined in international human rights treaties include the right to privacy; the right to the highest attainable standard of health; the right to information, education, and services; and the right to personal security. Other rights of protection from stigma and discrimination for HIV-infected persons and their families have become–dominant themes in the AIDS field. At the 2002 International AIDS Conference in Barcelona, global women's activists and researchers came together to articulate the "Barcelona Bill of Rights" on Women and HIV/AIDS (23). In contrast, the reproductive health field has been less successful in using human rights frameworks and language as rationales for extending access to safe delivery to the world's poor, despite consensus that this "right to health" should be achieved.

2. Outreach to Marginalized Groups

While the reproductive health field has been characterized by a focus on married women and (to some extent) youth, the AIDS field has from the beginning recognized the importance of outreach to marginalized, vulnerable, and often stigmatized populations, such as commercial sex workers, injecting drug users (IDUs), and men who have sex with men (MSM). Reproductive health services have largely neglected the sexual and reproductive health needs of these populations.

3. Development Impact and Multisectoral Perspectives, Governance, and Leadership

The development effects of the AIDS epidemic have forced stakeholders to recognize that the AIDS response is an issue of governance and leadership and requires a response beyond the health sector. Articulating the role that other sectors play in the response (for example, the role of the media, or the importance of involving the police in harm reduction efforts, and of aligning commerce and public health goals for to access to generic AIDS drugs) has been important for highlighting the complex interactions and solutions required to make progress in reducing incidence and impact of the disease. Moreover, the recognition that the epidemic has intergenerational impacts on human capital, through loss of farming knowledge in poor rural families and through the loss of teachers and skilled professionals, has underscored the importance of social policies and investments in health and education for economic growth. The reproductive health field has not promoted these perspectives, which could be equally applied to such issues as the development and intergenerational impacts of maternal mortality and abortion and the need for public policy responses and government leadership.

4. Continuum of Care and Comprehensive Approach

The AIDS field has promoted the concept of "continuum of care," which could be linked to the reproductive health field's concept of "constellation of services." This concept recognizes the need for a set of linked services beyond treatment, including food support, psychosocial support, education assistance, income generation, and other needed care and support services. Combining this concept with the notion of "comprehensive response," which promotes the view that AIDS

prevention, treatment, and impact mitigation are interlinked and should be provided together, has moved the AIDS field toward a broader conceptualization of needed interventions for individuals, families, and communities. These concepts might be extended to include reproductive health and other services needed by individuals and families.

5. Research that Legitimizes Sexuality as a Topic of Research

In contrast to much of the sexual behavior research in the family planning field, which focuses on topics such as "coital frequency" and "age at sexual debut," the AIDS field has legitimized discussions of sexual identity and sexual networking (a dynamic concept). This has helped the AIDS field move beyond the hetero-centric constructs of the fertility field to better understand disease transmission dynamics as separate from reproductive behaviors. The application of qualitative methods to these studies is one of the few areas where social science research has been richly applied to the AIDS field.

6. Couples, Community Approach in Addition to Individuals

AIDS programs have recognized the need to reach couples and involve the community in HIV/AIDS programs and policymaking. This is a result of efforts to address HIV prevention among discordant couples, in which one person is HIV positive and the other is HIV negative. HIV programs are also addressing situations in which both the man and the woman are HIV positive. Many women are tested in prenatal settings and therefore are the first person in the relationship to know of their HIV status. Often these women are victims of discrimination and abuse from husbands and other family members, who blame the woman for infecting her husband and children. HIV programs seek to mitigate these effects through couple counseling and testing. In addition, efforts at the community level have aimed to combat stigma and discrimination and involve HIV-positive people in community education and HIV/AIDS programming and policymaking.

7. Stigma and Discrimination

The AIDS field has dealt directly with the impact of stigma and discrimination on the ability to implement interventions. Many of the most affected early-infected groups—IDUs, sex workers, and males who have sex with malesM—are stigmatized by society. This limits access and early public support for interventions. AIDS is a feared disease, and fear and ignorance about routes of transmission have led to discrimination of AIDS patients or their family members by teachers, parents of schoolchildren, medical workers, and others. There are few other diseases with such low probability of transmission through casual contact that have invoked such fear. Because of this, the understanding of stigma and discrimination and how to intervene to prevent or reduce it are major areas of focus in the AIDS field. Examining stigma related to RTIs, for example, might be equally applied to the SRH field. Stigma and embarrassment limit health seeking for RTIs, which are linked to HIV risk.

8. GIPA and Participation

The AIDS field recognized early on the necessity of including people who live with AIDS in the design, implementation, and governance of policies and programs. Those already infected and

affected are most knowledgeable about opportunities and challenges for prevention, treatment, and impact mitigation. Participation helps to promote, protect, and fulfill human rights. The GIPA principle, "greater involvement of people living with AIDS," has been promoted not only as a strategy for effectiveness, but also as a mechanism of accountability and legitimacy. This governing principle of participation is unusual in development and humanitarian programs.

9. New Prevention Technologies for Women

One area where both the SRH and the HIV/AIDS fields are working together and where important obvious synergies exist is in the area of new prevention technologies, especially microbicides, a female-controlled method of HIV prevention. Donors are putting large sums of money into microbicide research and advocacy. As most microbicides will use intravaginal contraceptive delivery mechanism like gels and suppositories, the parallels for acceptability research are obvious. Microbicides, such as an AIDS vaccine if it becomes available, are also likely to be only partially effective, and borrowing experience from the family planning field will be useful in understanding the many factors that affect effective use. Social science and operations research in the family planning field have provided important information for service delivery programs. AIDS vaccine, with easier delivery mechanisms, will also offer women protection that they can control, without their partner's knowledge.

The seventeen strengths noted above could be used to better link responses to AIDS and reproductive health. However, a number of failures are also important to note, as these have inhibited effectiveness in each field in addressing HIV prevention and care and general sexual health. Clarifying these gaps in perspectives and approaches may be useful for creating a greater understanding and demand for the access and tools that both the SRH and AIDS fields can bring to an integrated advocacy, research, and service approach.

IV. SUMMARY OF GAPS

In this section we focus on gaps, opportunities, and major constraints to a linked reproductive health and AIDS response. These include the need for integrated approaches within weakened health systems, providing reproductive health services to HIV-positive people, and better use of information about sexual behavior and networking in AIDS program design.

1. Weakened Health Systems and the Impact of Health Sector Reform

AIDS treatment, HIV prevention education, and SRH services all function within weakened health systems with limited human and financial resources. New priority-setting approaches (e.g., the global burden of disease analysis) to primary health care agendas have focused limited local health resources on AIDS and other major communicable diseases. Because of under-investment by global institutions and governments in overall social development, as well as fiscal decentralization, debt repayment, and mandated sector reform programs, these priority-setting approaches force unreasonable choices between essential health interventions for the world's poor. While Washington and the donors are now calling for greater investments in social development, especially health and education, and are highlighting the "global public goods" nature of these

investments on building human capital, many countries have already deconstructed and privatized their health systems. It will take decades to build or rebuild these systems, reverse the brain drain, train the needed human resources to manage and staff them, and rely on them for quality health service delivery in poor areas. A recent global study highlighted the shortage of human resources for health as the key limiting issue for rolling out AIDS treatment programs in the South (24). A powerful example of how privatization has undermined health equity can be seen in China's health system, which was the primary health care model held up at WHO's Alma Ata meeting in 1980. In 2004, after twenty years of privatization and mistaken reliance on the market, China's health system ranked 188 out of 191 in terms of fairness in health access. Stove pipe funding for nonintegrated programs does little to strengthen overall health systems or build manpower and capacity to deal with the complex interrelated health issues of the rural poor in severely resource-constrained environments.

In this context, it is crucial to take advantage of on-the-ground SRH service and outreach capacities that have been built in the decade since ICPD. In many countries, programs reaching youth with information and services, preventing maternal mortality, addressing RTIs and STIs, and building the counseling skills of health workers, can be used to reach key segments of the population, especially women and youth. These services, however, will be insufficient to reach men who have been missed by both SRH and HIV/AIDS outreach programs. Service integration must go beyond merely using existing infrastructure for SRH services, some of which may not be necessary or affordable given capacity and the severity of the epidemic. The AIDS response has been stymied by cookie-cutter applications of prevention and treatment approaches without adequate attention to context, in terms of realistic assessments of infrastructure and capacity, resource availability, political commitment, and cultural and religious norms. Useful models exist, such as the work in Haiti of building on a focal need (or in wealthier Thailand and Brazil, which have fully integrated AIDS prevention and treatment into government health insurance and service systems). The Haitian approach provided TB and ARV service to the very poor, and then built a constellation of other needed primary health care services, such as prenatal care and immunizations. Use of all services increased as a result, because the model was based on an honest assessment of need, capacities, resources, and client demand. This "4 Pillars" approach in this setting of extreme poverty and weakened health systems has improved other primary health care beyond AIDS treatment access and uptake (25). Other studies undertaken by mainstream AIDS organizations that demonstrate the value of integration with selected SRH or other services will help to push the consensus on collaboration further.

The AIDS field's focus on a "continuum of care" recognizes a range of needed services, both medical and non-medical, for people affected by HIV/AIDS and their families. This concept has helped to broaden local responses beyond the immediate challenge of testing individuals and treating them with ARV therapy. It provides an important starting point for articulating a needs-based approach to integrating SRH into AIDS service delivery programs that takes into account local resources and capabilities.

2. Importance of Understanding Sexuality

HIV/AIDS and reproductive health programs have viewed sexuality primarily through a clinical or disease lens or through a hetero-centric frame of reference. Public health programs that address

sexuality focus on the negative consequences of sexual behavior, including STIs/HIV, unwanted pregnancies, and abortion. The concept of healthy sexuality—sex that is pleasurable, equitable, and free of coercion, infection, and unwanted pregnancy—is a fairly new concept in sex education and in HIV and SRH programs. Innovative sexual health programs for youth have been more likely to take this approach than have reproductive health programs focused on married women. Unfortunately, many programs have used the fear of AIDS as a pretext to suppress sexual expression and fulfillment, especially among youth. For example, the U.S. government has supported abstinence-only education despite data that demonstrate consequent increased vulnerability to sexual health problems including STIs/HIV and unwanted pregnancy.

Until the advent of AIDS, reproductive health programs did not adequately address sexual behavior outside the documentation of the frequency of hetero-normative sexual intercourse. AIDS has served to legitimize research on a wide variety of topics related to sex, sexual behavior, and sexuality, albeit by disciplines with very different theoretical perspectives and methodological approaches. Epidemiological research (often termed "behavioral surveillance") has quantified sexual risk behavior relevant to HIV infection. Behavioral surveillance research, employing primarily the survey as the main instrument of data collection, has focused on the sexual behavior of so-called "high-risk groups," especially female sex workers and injecting drug users. Anthropological research through use of a variety of methods (quantitative and qualitative) has more broadly documented sexual behavior, as well as sexual constructs, meanings, and dynamics that lead to vulnerability, and has put quantifiable data into relevant social contexts.

Use of the data yielded from these different theoretical and methodological approaches is important to develop comprehensive and effective programs. Yet despite the availability of high-quality social science research, most donors, programmers, and policymakers have used behavioral surveillance as the primary source of information to design and evaluate reproductive health and HIV/AIDS prevention programs. In HIV programs, for example, this reliance on epidemiological and behavioral surveillance data has led to a focus on high-risk groups rather than to programs that address sexuality and sexual vulnerability more comprehensively. For example, many HIV/AIDS programs in low-prevalence countries do not address sexual behavior outside the commercial sex context. Extra- and pre-marital sex, sometimes with same-sex partners, is often ignored, despite substantial evidence that such behavior exists. This research also often reflects cultural biases, particularly gender biases. Even in discussions on sex work, for example, the focus is on female sex workers as "vectors" of disease, and little attention is paid to the behavior and sexual networking of male clients or even of male sex workers. It is easier for programs to focus on abstinence among youth or 100 percent condom use in commercial sex (focusing on sex workers rather than clients) than to address the various determinants of healthy and risky sexual behavior in men, women, and youth. Donors, program managers, and policymakers should use the data available on sexual behavior and constructs of sexuality in different societies. In addition, more social science research is needed in other settings to explore these issues more thoroughly before programs and policies are designed.

Research does confirm that individual sexual behavior is likely to change over the life cycle and may differ from relationship to relationship, depending on the level of trust, power, and commitment perceived in those relationships (26). For example, men may be more likely to experiment with different types of sexual activities with paid and casual partners. Men are much

more likely to use condoms with sex workers than they are with casual and marital partners. Condom use in casual relationships is ambiguous, and negotiating condom use may be perceived by the partner as a sign of lack of trust and commitment. Female sex workers are much more likely to use condoms with their non-regular clients, less so with their regular clients, and rarely with their husbands or partners. Despite this evidence, few programs have addressed the contexts and meanings of, as well as the vulnerability within, different types of sexual relationships.

3. Reproductive and Sexual Rights

Many women discover they are HIV positive within reproductive health settings as a result of antenatal testing. In some cases, pregnant women are tested for HIV without their knowledge and consent. While usually this testing is done to provide the best care and treatment available, in some cases, particularly in contexts where care, support, and treatment for HIV-positive people has not yet been integrated into health care systems, testing is sometimes performed so that health care workers can take adequate measures to protect themselves from infection. With the rollout of PMCT programs, the reason for testing of pregnant women has changed to that of averting the birth of an HIV-positive child. Some organizations, including Ipas, have documented the problems surrounding the "opt out" option currently promoted by WHO and other organizations for testing during labor and delivery. Opting out of testing during labor and delivery, when effective counseling and testing are difficult or not feasible to implement, may violate the very rights that these services are trying to protect. The SRH field's emphasis on informed choice of contraceptives and informed consent for contraceptive procedures could serve as a model for guiding testing programs for pregnant women.

In addition to testing without consent, other rights abuses have occurred, including coerced abortion and sterilization of women who are HIV positive. Despite the efforts of the PMTCT+ programs, most women in PMTCT programs do not have access to antiretroviral therapy for themselves. Prevention of HIV among newborns is a critical component of a comprehensive AIDS response; however, medical ethics as well as the right to the highest attainable standard of health demand that women have the same access to drugs for treatment in their own right. This would enable them to live healthy lives with HIV for as long as possible and to care for their children.

Gender violence also contributes to HIV vulnerability. Sexual violence and coercion render women extremely vulnerable to psychological trauma, unwanted pregnancy, and HIV infection. Violence and the fear of violence and abandonment also prevent women from negotiating safer sex. A review of the literature on the interaction among violence, risky sexual behavior, and reproductive health by Heise, Ellsberg, et al. in 1999 (27) indicates that sexual violence in a woman's past is associated with higher-risk sexual behavior. A study in India reported that men who reported extramarital sex and experience of an STI were more likely to report that they had abused their wives (28). Maman and colleagues found that women testing positive for HIV in a VCT clinic in Tanzania were ten times more likely than HIV-negative women in the same clinic to report having experienced violence (29). While the ABC programs have been the central theme of many HIV prevention programs, in violent situations especially, women have no control over their behavior of their partner(s), including when to have sex and whether or not he uses a condom with her or with his other partners. While sensitive research and small-scale programs have begun to address this issue, the links between violence and HIV must be explored further, and more must be done to implement

primary prevention, care support, and impact mitigation programs that integrate gender and rights perspectives.

Individuals with access to AIDS therapy are and will be living longer reproductive and sexual lives as positive people. It is therefore critical that programs and policies adapt to meet the growing reproductive and sexual health needs and rights of positive people. Comprehensive sexual and reproductive health programs should aim to provide positive women and men with counseling and services that promote their right to healthy, safe, and pleasurable sexuality, their right to choose whether to have children, and the means to have them without transmitting the virus.

4. Missed Opportunities in HIV/AIDS and Reproductive and Sexual Health

Both HIV/AIDS and reproductive health programs target specific subpopulations for services and outreach, such as adolescents, married women of reproductive age, sex workers, and injecting drug users. SRH programs target married women and youth, and HIV/AIDS programs target different populations based on the stage of the epidemic, most commonly beginning with sex workers, injecting drug users, and men who have sex with men. The targeted approach, however, does not address the full range of sexual and reproductive health concerns or the needs and rights of individuals in different roles or aspects of their lives, and consequently leads to many missed opportunities. This section illustrates only a few examples. (See Table 1 for a more complete overview of gaps.)

There are many benefits of targeted approaches to HIV prevention. Harm reduction efforts quickly bring education and immediate access to preventive means (condoms, needles, and syringes) to those known to engage in high-risk behavior. Such programs are often the only services provided to those who are the most marginalized and difficult to reach. These programs also can serve as entry points for other important services, including drug rehabilitation. When resources are limited, targeted approaches focus scarce resources on the most vulnerable. Harm reduction efforts have succeeded in reducing the incidence and prevalence of HIV in specific subpopulations, for example, among sex workers in Thailand and injecting drug users in Australia, Europe, and some parts of Asia.

Yet national AIDS programs that focus exclusively on high-risk populations also miss important opportunities and may lead to unintended negative consequences. First, these programs can create a false sense of security in those who do not identify as being members of a high-risk group. Second, they place the responsibility for prevention on already marginalized populations whose behavior is often illegal. The result of this association of AIDS with illegal and immoral behavior can be blame, stigma, and discrimination against high-risk groups and people living with HIV. Because these programs are focused almost exclusively on prevention within the sex work context (with the onus on female sex workers rather than on clients) or between drug users, they often fail to address the multidimensional individual identities and behavior. Figure 1 illustrates a dynamic view of HIV risk behaviors that takes into account people's multiple roles in life and illustrates the problem of focusing exclusively on high-risk populations. For example, targeted programs do not often address sexual transmission in sex workers' relationships with their intimate partners. With drug users, the focus is often on ensuring that the target population (usually male drug users) has access to safe needles, and little attention is paid to their sexual vulnerability or to the drug use and sexual

vulnerability of female injectors (30). Similarly, programs seeking to prevent sexual transmission among men who have sex with other men often do not address these men's sexual relationships with women. In many societies, these men lead dual, often hidden, sexual lives, un-reached by any education or outreach for HIV prevention. Very few health services that address men's sexual health needs, other than STI services, are available for men who have sex with other men, and the majority of health care providers are not trained to recognize signs of anal STIs in men (or women).

Targeted programs that address HIV prevention, care, and treatment within an overall reproductive and sexual health framework may be more effective both at HIV prevention and at improving the overall health status of high-risk populations. For example, sex workers are also often mothers or married women in need of family planning, safe abortion, maternal and child health services, and RTI diagnosis and prevention. Yet their access to health care and child health services is extremely limited because of the stigma associated with sex work, financial constraints, and the fact that many sex workers are migrants without legal access to many of these services. Programs that meet these diverse needs understand that women are the focus of concern in their own right, rather than merely as a means of preventing infection in others.

While women and adolescents have been the focus of reproductive health programs, there has been and continues to be a dearth of sexual health services for men. In fact, until AIDS, men's sexual health had been almost completely ignored except within STI clinics, pharmacies, and urology departments of major hospitals. Some reproductive health and HIV communications programs have promoted "male responsibility" in protecting women from unwanted pregnancy and HIV, but few have focused on men's vulnerability and sexual behaviors. Research has indicated that men and women are influenced by sexual constructs and gender norms particular to their own social contexts, leaving men vulnerable to risky behavior and infection with HIV or other STIs. Yet men, unlike married women, have little or no access to reproductive and sexual health services. While programs are increasingly including adolescent boys, mainstream AIDS and SRH organizations have been slow to address the sexual health needs of adult men. Recent research (31) has highlighted the lack of attention to men's sexual health needs and rights (including the desire of HIV-positive men to have children), yet these continue to remain largely unaddressed in programming on the ground.

People living with HIV could benefit from comprehensive reproductive and sexual health services that focus on client needs. To date, most attention to the reproductive health of positive people has focused on preventing positive births, an important part of a comprehensive response. Many of these programs also promote sexual abstinence for positive people and, where this is not possible, counsel positive people to use condoms and other forms of contraception. Preventing positive births and unwanted pregnancies is extremely important, yet many positive people wish to live active and healthy sexual lives and have children, an important aspect of identity in many cultures around the world.

Worldwide, and particularly in sub-Saharan Africa, AIDS programmers and policymakers soon learned that they could no longer ignore the context in which most unprotected sex takes place: casual and marital relationships in which condom use is uncommon, uncomfortable, and often shameful and taboo. Many AIDS and SRH program managers believe married women are at low risk for HIV/STI infection because of their reported low levels of infidelity. Women may not be a

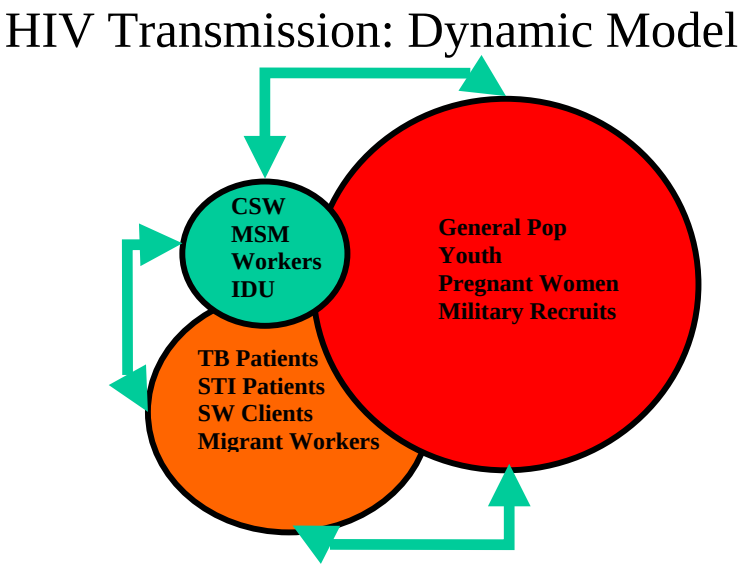
high priority in HIV prevention programs because even if they do become infected, they are not considered significant public health threats as major transmitters of HIV. Yet a significant amount of data indicates that married women are vulnerable to HIV. Because condom use in marital relationships is rare, women are vulnerable to HIV and other STIs through unprotected sex with their spouses, who are more likely to have had pre- and extra-marital sexual experiences.

Some of the literature on the gender aspects of the HIV epidemic portrays women as victims with little or no agency. Women, except for sex workers, are seen as "good," while men are sometimes portrayed as perpetrators who must take responsibility for their behavior. An exclusive focus on HIV prevention among high-risk groups can perpetuate gender norms that promote naiveté in "good" women and girls about sex and condoms or other preventive measures, yet ignore women's pleasure, power, and responsibility. This focus can also send a message that accepts risky behavior by men but denies men's vulnerability. Despite the evidence of risk, however, few HIV programs adequately address the needs of married women *until after they become infected*, become pregnant, and are subsequently tested for HIV. Only then are women targets for PMTCT and family planning to avert positive births or for prevention education if they are part of a discordant couple. Fortunately, more and more women are also being treated, thanks to innovative programs such as PMTCT+ in which women have access to treatment for themselves.

Targeted interventions are important components to HIV prevention in any setting. Yet they should be part of a larger comprehensive response that addresses vulnerability outside the context of commercial sex and injecting drug use, as well as the larger social and structural determinants of vulnerability. Addressing sexual transmission outside commercial sex requires a sensitive understanding of the sexual behavior dynamics occurring in a particular context and high-level political will to implement programs that may challenge cultural norms and values.

The integration of reproductive and sexual health into HIV prevention, care, treatment, and impact mitigation programs would promote a client-centered approach to health and well being. Currently, very few programs offer a full range of sexual and reproductive health services that meets the needs of individuals and couples in their different roles and sexual relationships. Few providers are trained to deal with sexuality and a range of sexual health issues. A comprehensive sexual health approach could address the sexual health needs of men, women, and adolescents.

Figure 1



5. Need for Better Research and Application of Research Findings

The expansion of research approaches from both the AIDS and the SRH fields may help promote better understandings of common vulnerabilities and successful service approaches. Applying research findings from one field to the other may strengthen programs for both.

Demographers working on AIDS have focused mainly on modeling the trajectory of the epidemic in terms of overall deaths and the economic impacts. Recent work to develop an Asia Epidemic Model (East West Center) has helped to refine commonly used African parameters for application in Asia. Asia's demography is very different from Africa's where the epidemic is currently centered, and further refinements in projection models are needed to make these analyses fit the realities of Asia. For example, little work is being done to highlight the potential intersections of the worsening sex ratios at birth in China and India and the potential impact on the age structure and the projected "demographic dividends" for these two countries. These types of analyses could provide important evidence for the devastating future economic and social impacts of the AIDS epidemic in Asia.

Moreover, the AIDS field is plagued by accusations that it lacks high-quality evidence on the efficacy of many of the promoted interventions, especially those for preventing sexual transmission. On the one hand, many of these accusations are driven by moral positions (e.g., that condoms fail to prevent HIV/AIDS). On the other hand, the urgency of the AIDS response has promoted pragmatic approaches on the ground. Much of the existing evidence has been evaluated without incorporating rights perspectives (e.g., poor understanding of the way in which rights protection supports the use of interventions like VCT) or an assessment of how multisectoral programs support intervention efforts, such as police and health collaborations for harm reduction.

The AIDS field also urgently needs to apply knowledge derived from social science research. This includes research on sexuality and sexual behavior, the growing understanding of the structural determinants of risk and vulnerability that drive individual risk-taking, new methods for evaluating

rights protection and health outcomes for understanding complex and interrelated systems of human behavior and motivation, and governance and non-health influences on the effectiveness of interventions.

6. Insufficient Interest and Initiative from the AIDS Field

So far, most of the work on integrating reproductive health and AIDS has been undertaken by ICPD actors and women's activist organizations. Key actors in the AIDS community and the larger development field have shown less interest. A recent article (32) charges that because mainstream AIDS organizations and HIV-infected people were consistently left out of the ICPD process and reviews, a lingering distrust exists between the two communities as does a sense that recent calls for integration are little more than attempts to regain funding levels as development priorities shift. The author highlights the missed opportunities of the last ten years and places blame squarely on the ICPD actors. The author also suggests that the AIDS response was weakened because of donors' desire to incorporate AIDS funding into SRH streams post-Cairo, which contributed to the epidemic's increase.

Many in the SRH field acknowledge that reproductive health organizations were reluctant to jump on the HIV/AIDS bandwagon a decade ago, because of the focus of the AIDS field at that time on high-risk groups and because they feared stigmatizing the field and risking newly won gains. While the AIDS field focused, and continues to focus, on these groups for prevention, the SRH field failed to see that many in these groups were potential clients for SRH services that would both prevent HIV and ensure their reproductive and sexual health.

These missteps and mistrust may be hard to overcome if both fields continue to believe that their clients are different. The challenge for the two fields will be (as clearly articulated at the London ICPD+10 Roundtable) to build consensus for joint frameworks that can use important infrastructures and human resources built since Cairo for working with youth, and on topics of sexuality, service quality, and so forth. The focus of some key actors in the SRH field on primary prevention of HIV in youth, in married women, and from HIV-infected women to their babies, while important, is only part of what needs to be done. Those paradigms often portray the issues of risk simplistically, with men as perpetrators and women as victims and focus activities primarily on women to educate and empower them to practice safe sex. Youth programs, while more active in reaching out to boys and young men and addressing gender norms, still focus on primary prevention. The AIDS field's focus on testing and ARV treatment for AIDS patients, while critical for the humanitarian response, has shifted resources and attention away from matters of sexuality and risk outside these groups and made the contributions of the reproductive health field of less interest.

Although the AIDS field has begun to advocate for a comprehensive response to the disease that includes prevention, treatment, and impact mitigation and the mutually reinforcing synergies of each of these (33), sharp divisions still exist among the three in terms of the actors, funding, and conceptualizations of the work. For example, while the HIV prevention actors view VCT as a critical opportunity for prevention counseling to those who test negative, those more focused on treatment see VCT mainly as a means of AIDS patient identification. Even within the AIDS field links must be further articulated to move beyond prevention as simply starting and maintaining

ARV therapy, to a viewing prevention for HIV couples and individuals who are living with a chronic disease and pursuing their lives. The United States, Western Europe, and Brazil offer substantial experience on this issue—places where many people have been on therapy for nearly a decade and grown from youth to adulthood, with all its expectations and changes.

V. STRATEGIES FOR MOVING FORWARD

This paper has identified several gaps and needs. Many of these must be addressed at the global policy level and taken up by multilateral and bilateral donors, national and local governments, and community-based groups hoping to harmonize development funding and take advantage of synergies.

Because private foundations are less governed by politicized agendas related to sexuality and rights than are bilateral programs, especially those in the United States today, they may more easily support open discussions and generate needed evidence-based research on sexuality and rights that we have identified above. Moreover, the flexibility of foundation grant making makes it easier to support work that crosses "stove pipe" funding categories.

Our recommendations for next steps include:

1. Share a version of this report with selected AIDS actors and funders (UNAIDS, Global Fund, 3 x 5 program at WHO, PEPFAR, Gates Foundation, etc.) and those in the SRH field working to promote links between AIDS and SRH programs. Convene a meeting with strong representation from the AIDS field and from program implementers in the South to ascertain interest, attitude, and perspectives on the recommended links between SRH and HIV programs outlined in this report.

2. Convene meetings on specific topics identified as "gaps" (in this report or suggested by others) focusing on AIDS actors and MDG and other development agencies and actors) to refine issues and define needed research. Such meetings would bring AIDS, health system, and some carefully selected SRH people together to discuss the successful elements of integrated responses to HIV and SRH, including research, programs (new and scaling up), and new directions in policy. Meetings should include representation from countries hard-hit by AIDS. Topics might include:

    - HIV-positive people and their sexuality and reproductive desires
    - The range of human sexual behaviors, roles, and sexual networking, with implications for re-envisioning HIV prevention beyond risk groups and "core transmitter groups"
    - Integrating SRH into the continuum of care for HIV chronic disease management, using lessons learned from implementing a "quality of care" approach to SRH services
    - Intersections of HIV and sex ratio at birth trends in Asia, projected demographic dividends
    - Developing methods for formulating context-specific, integrated responses within weakened health systems that take into account:
        - The stage of the epidemic
        - Resources available

- Nature of the epidemic (IDU, sexual, blood transfusion)
- State of the health system
- Women's status
- Youth rights
- Sexual and reproductive needs of infected couple

These might result in menus of strategies. These approaches should model dynamic conceptualizations of the stage of the epidemic and sexual interactions, diversities, and multiple roles of the populations targeted.

- Links between specific health service program (e.g., STIs as a lead issue in service delivery integration of SRH and AIDS; communication about AIDS behavior change and family planning IEC; reproductive health services added to HIV/TB or HIV/TB/malaria packages; working with pharmacists; abortion and post-abortion care; referral links to SRH services for AIDS patients, etc.)

- The range of human sexual behaviors, and roles, and sexual networking, with implications for re-visioning HIV prevention beyond risk groups and "core transmitter groups"

- HIV-positive people and their sexuality and reproductive desires

- Intersections of HIV and, sex ratio at birth trends in Asia, projected demographic dividends

3. Support for pilot demonstration projects and research and evaluation of efforts to integrate HIV/AIDS and other services at the primary health care and local levels, including, if appropriate, SRH services and approaches. These demonstration projects, which would be undertaken within clearly articulated sexual and reproductive rights frameworks, should build on innovative work on the ground. These might include models of comprehensive SRH and AIDS services for couples and individuals over the life cycle. Support also should be provided to study successful scaling-up of effective programs that integrate SRH and HIV/AIDS.

4. Support for a peer-reviewed efficacy of existing HIV and SRH interventions and for commissioned studies to fill the gaps. These interventions are often evaluated in isolation of one another. To strengthen the case for needed links, integrated intervention packages, formulated from agreed-on methods discussed above, should be evaluated.

5. Much can be done at the global policy level to educate and influence major AIDS and development donors like the UNDP, Global Fund to Fight HIV/TB/Malaria, the European Union, the G8, and the International Financing Facility Initiative about the value of linking SRH and HIV/AIDS funding and programs and strategies for doing so. For the Global Fund, this might involve providing support to country coordinating mechanisms (CCMs) or Global Fund Board member organizations that are already concerned about these issues, as well as groups like ICASO and GNP+. For the European Union and many European nongovernmental organizations (NGOs), targeted support for joint efforts would potentially help foster more synergy and less competition for funds. The G8, currently chaired by the United Kingdom, which also holds the European Union presidency, is pushing for an International Financing Facility for development aid. Ensuring that linked SRH and HIV/AIDS programs are on these

agendas will be important. Likewise, ensuring that the linkage issue is on the agenda of groups working on HIV and human rights will be important for promoting practical work on rights protection and regulatory and approval processes for diagnostics in both fields, especially for new prevention technologies. Linked planning and evaluation of projects at country levels could be promoted by including joint goals and objectives into Poverty Reduction Strategy Papers and U.N. Country Assistance Frameworks.

6. Finally, in-depth studies of situations of "positive deviance" in the SRH field, such as Kerala, India, should be undertaken with the goal of elucidating the factors responsible for success in SRH outcomes. Counter intuitively, Kerala, a place of high female education and social equity, is beginning to experience an increased AIDS epidemic among women. On the one hand, HIV risk may be greater for women with higher social status because of later marriage and more independence in sexual decision making. On the other hand, it may also be that the AIDS response has been undertaken without the input of women's groups and has not used the SRH infrastructure and the on-the-ground application of gender equity approaches. The AIDS interventions targeting high-risk groups of sex workers and IDUs, often the first focus of interventions in newly emerging epidemics, may be failing to take advantage of women's capacity for self-protection and sexual negotiation or to fully appreciate the complexity of sexual networking.

VI. CONCLUSION

This report has highlighted the importance and urgency of collaboration between the fields of SRH and HIV/AIDS in the context of weakened health systems, competing development challenges, and the feminization of the AIDS epidemic. After reviewing recent efforts, highlighting strengths that each field can bring to the partnership, and analyzing gaps and shortcomings in the current response, we offer a number of recommendations for developing a policy, program, and research agenda that fosters greater collaboration for responding to the worsening AIDS epidemic while meeting the sexual health needs of individuals and communities worldwide. Each field can learn from the other in important areas, monopolize access to populations in need of services, benefit from gender and rights perspectives articulated for each field, and better focus resources and attention on the multiple needs of individuals, families, and communities.

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INDIVIDUALS INTERVIEWED (phone or in-person interview)

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Adrienne Germain – International Women’s Health Coalition
Marge Berer – Reproductive Health Matters
Naomi Rutenberg – Horizons Population Council
Lynn Collins – UNFPA
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APPENDIX

Review of Organizations, Actors, and Their Priority Programs

(Note: this list may be incomplete. CHANGE, PATH, AGI, and Marie Stopes International were not reviewed because of lack of time or information. We apologize for any omissions and welcome additional information and corrections.)

1. UNAIDS and Global Coalition of Women and AIDS (a UNAIDS Initiative)

The United Nations Programme on HIV/AIDS (UNAIDS) is the United Nations coordinating agency on issues related to HIV/AIDS. The organization focuses on advocacy and policy for HIV/AIDS prevention, care, and treatment. It highlights the need to focus on the vulnerability of women and girls in programs on the ground run by UN agencies and NGOs.

UNAIDS advocates for compliance with the UN Guidelines on HIV and Human Rights, which state that women should have the right to choose whether or not to carry pregnancies to term. "Laws should also be enacted to ensure women's reproductive and sexual rights, including the right of independent access to reproductive and STI health information and services and means of contraception, including safe and legal abortion and the freedom to choose among these, the right to determine the number and spacing of children, the right to demand safer sex practices and the right to legal protection from sexual violence, outside and inside marriage, including legal provisions for marital rape."

UNAIDS also advocates for integration of HIV prevention, care, and treatment into existing reproductive health services. The rationale put forward for such integration includes:

- A ready infrastructure of existing services that address the reproductive health needs of millions of women at risk
- Clinical and community-based distribution systems that offer opportunities to reach these women
- The fact that many women use contraception, most pregnant women seek at least one antenatal visit, and a significant number of women make at least one postnatal visit
- New approaches post-ICPD that have moved beyond a narrow focus on fertility control to include STI diagnosis and treatment, to acknowledge and address sexual and reproductive health needs of adolescents, and to reach out to men—all of which have relevance for HIV prevention
- Stepping up prevention: HIV counseling and testing, condom promotion, and the management of STIs and contraceptive services as HIV prevention
- To reach treatment goals of the "3 x 5" initiative, there is a need to expand service sites where HIV counseling and testing are offered
- Many women may be more receptive to HIV counseling and testing within reproductive health service sites versus HIV testing centers
- Encouraging couples to use condoms even when the woman chooses to use another form of contraception

- Pregnancy prevention as HIV prevention: avoidance of HIV-positive babies through access to PMTCT
- Voluntary contraceptive services to help positive women prevent unwanted pregnancies

UNAIDS points out that between 2000 and 2015, the number of women of reproductive age (15–49) is expected to grow by 17 percent worldwide and by 22 percent in developing regions. UNAIDS predicts a serious shortfall in meeting the growing demand for family planning services. Service providers will need access to additional resources. UNAIDS advocates for addressing sexuality and sexual behavior rather than focusing on abstinence education.

UNAIDS also notes a number of challenges to integration:

- Men are not likely to be reached through reproductive health services, and therefore other means must be found to reach them.
- There is a greater need to integrate in countries where prevalence is high.
- In low-prevalence countries more impact may be achieved by addressing particularly vulnerable populations.
- HIV services to date have ignored integrating family planning programs (POLICY study).
- Rarely do HIV services address the need to integrate reproductive health services. HIV services should either provide RH services themselves or refer to appropriate providers.
- PMTCT programs need to provide contraceptive services to prevent future births of positive children.
- HIV-positive people will have continuing reproductive and sexual health needs, including the desire to have children. As treatment becomes more available, this will become an even greater need.

UNAIDS has developed guidelines for "integration of HIV/AIDS components into gender-based health programs" that cover the following steps: (1) establish staff for the HIV component, (2) conduct needs assessments, (3) obtain community input and involvement, (4) train program staff, (5) integrate HIV/AIDS-specific activities with routine program activities, and (6) monitor and evaluate.

World AIDS Day 2004 (December 1) focused on the increasing female face of the global epidemic.

Global Coalition on Women and AIDS

In February 2004, UNAIDS launched a new "Global Coalition on Women and AIDS" composed of representatives of many global SRH and women's development organizations (e.g., WEDO, ICRW, and UNFPA).

The goal of the Global Coalition on Women and AIDS is to "support and energize programs that mitigate the impact of AIDS on girls and women worldwide." The Coalition focuses on:

- Preventing HIV infection among adolescent girls, focusing particularly on improved access to reproductive health care;
- Reducing violence against women;
- Protecting the property and inheritance rights of women and girls;

- Ensuring equal access to care, treatment, and support for women and girls;
- Improving community-based care with a special focus on women and girls;
- Improving access to female-controlled prevention technologies including the female condom and microbicides; and
- Supporting ongoing efforts toward universal education for girls.

The Global Coalition emphasizes the need to provide diagnosis and treatment for STIs. It also notes evidence from Cote D'Ivoire and India indicating that integrating VCT into sexual and reproductive health services reduces stigma associated with AIDS and increases the use of other health services. The Coalition advocates for the use of microbicides (contraceptive as well as non-contraceptive) that protect women from infection and are a method women can control themselves.

The Global Coalition was active during the 15th International AIDS Conference in Bangkok, Thailand, in July 2004 and organized numerous sessions, workshops, and press briefings on women and AIDS. The Coalition gave all meeting participants a guide to the meeting's sessions on women and AIDS.

UNAIDS and the Global Coalition on Women and AIDS play mainly an advocacy role. However, there is little evidence yet that this has resulted in any scaling up in programming on these issues at the country level.

2. World Health Organization
Department of Reproductive Health Research (RHR)
Department of Gender and Health
Glion Meeting

A number of divisions at the World Health Organization have undertaken work related to integrating SRH and HIV/AIDS, although most recent efforts have been spearheaded by the Division of RHR, with participation by other departments.

The WHO/RHR recently issued a strategy paper for its work, which includes paragraphs 18–22 dealing with RTIs and STIs, including HIV. This paper highlights the importance of HIV prevention in women through RTI and STI testing and counseling and notes the importance of incorporating HIV prevention for youth and women into SRH programs and services, within the sexual and reproductive health and rights framework set out at ICPD.

Prior to this effort by WHO/RHR, it should be noted that WHO's Department of Gender and Women's Health and Family and Community Health organized an "Expert Consultation on Integrating Gender into HIV/AIDS Programmes" in June 2002. An excellent background paper was prepared for this meeting by Geeta Rao Gupta and others from ICRW. This paper sat squarely in the HIV/AIDS field and analyzed the structural determinants of poverty and gender inequalities, sociocultural gender norms, and sexual power relationships that drive the epidemic in women and girls. It called for programmatic efforts aimed mostly at incorporating a gender lens into HIV programming and focusing on transformative interventions that empower women and girls, providing them with assets and the social capital required to protect themselves. Examples are provided, including the Healthy Highways project aimed at truck drivers in India, the Sonagachi

project in India that empowered sex workers to prevent HIV/AIDS in Calcutta, and the Stepping Stones curriculum used in Uganda and other places that provided life skills training for women and girls.

Glion Meeting and Call to Action, May 3–5, 2004

In May 2004, WHO/RHR organized a major meeting on linking SRH and HIV/AIDS. The principal actors for this meeting were WHO, USAID, Family Health International, and the Packard, Hewlett, and Gates Foundations. The meeting and call to action focused on one potential synergy between reproductive health and HIV/AIDS services: the integration of family planning into services for the prevention of mother-to-child transmission of HIV. A background paper was prepared for the meeting by John Stover of Futures Group, showing the cost benefit of preventing births of HIV-infected babies to HIV-positive women by providing family planning counseling and services to increase contraceptive use. Family Health International prepared a background comprehensive literature review of family planning, HIV prevention, and care service integration. Other background papers provided further cost benefit analyses and modeling of the impact.

The Glion Call to Action on HIV/AIDS in Women and Children was issued, calling for better links between reproductive health and HIV/AIDS prevention and care, specifically between family planning and PMTCT. The call to action very clearly states the ICPD consensus regarding women's rights to decide freely on matters related to their sexuality. The four-point approach called for in the Glion statement includes:

1. Primary prevention of HIV infection in women
2. Preventing unintended pregnancies in HIV-infected women
3. Preventing mother to child transmission of HIV
4. Providing care, treatment, and support to HIV-infected women and their families identified through PMTC or VCT services

The meeting noted the "structural forces" that drive both epidemics, but recommendations focused narrowly on service integration requirements. At the Glion meeting, the U.S. government refused to sign the call to action. It protested the use of the term "rights," which implied entitlement, and requested the language be watered down. In the end the U.S. did not sign, despite the watered-down language. The only other person not to sign was a well-known reproductive health advocate, who protested the watered-down language on rights.

The major actor for the Glion meeting was RHR, although representatives from the Division of HIV/AIDS and Gender and Women's Health were included. As noted by one person involved in the work, UNAIDS was definitely not driving this effort, although the organization was supportive.

3. UNFPA and New York Meeting: "Linking HIV/AIDS with SRH"

In the last several years, UNFPA has become increasingly more vocal in advocating for better links between SRH and HIV/AIDS, and has taken an active role in the UNAID-sponsored Global Coalition on Women and AIDS. UNFPA has published a series of "programme briefs" on eight HIV prevention areas within the UNFPA mandate. These areas are as follows:

- Preventing HIV infections in pregnant women

- Preventing HIV infections in young people
- Addressing gender perspectives in HIV prevention
- Voluntary counseling and testing for HIV prevention
- Condom programming for HIV prevention
- HIV prevention in humanitarian settings
- Programming for prevention in various stages of an HIV/AIDS epidemic
- Applying population and development strategies to enhance HIV prevention programming

Each brief reviews the issue and the rationale for prevention, what has been learned to date, and what UNFPA can do. UNFPA has also produced a "Strategic Guidance on HIV Prevention" document directed at its field staff around the world. It calls on the organization to focus its HIV prevention work in three core areas: prevention in young people, comprehensive condom programming, and prevention in pregnant women within an environment of gender equality and equity. These issues are also highlighted in UNFPA's 2004 report, "State of the World Population 2004: The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty."

In June 2004 UNFPA organized a technical meeting in New York (with UNAIDS and Family Care International) to follow up on the Glion meeting recommendations, and then a high-level global consultation at the Rockefeller Foundation on June 7, 2004, "Linking HIV/AIDS with Sexual and Reproductive Health." The later meeting involved health ministers, parliamentarians, ambassadors, leaders of UN agencies, donors, community and NGO leaders, young people, and groups representing HIV-positive women. The meeting aimed to promote necessary links between the provision of reproductive health information and services to all people reached by HIV/AIDS programs and the provision of HIV/AIDS information and services to all people reached by reproductive health programs. The meeting argued that such an approach is critical to success in achieving MDGs and will be more relevant and cost effective.

The "Commitment to Action" formulated at that meeting was more comprehensive than that issued at the Glion meeting; it addressed the larger arena of women's empowerment, reproductive rights, and reproductive health beyond family planning programs, such as safe motherhood and abortion. It called for high-level government, multilateral, and bilateral efforts to link work in both fields at the policy dialogue and programmatic levels. It addressed issues of youth, commodity supply, health system capacity, the MDGs, and global funding mechanisms like the Global Fund to Fight AIDS, TB, and Malaria. However, the declaration was quite weak in terms of programmatic issues, and the participants were mainly high-level government officials (e.g., State Councilor from China) without a specific programmatic brief, as well as high officials from UN Agencies and foundations. The NY Commitment was focused largely on prevention of HIV and did not encompass the "comprehensive approach" to prevention, treatment, and impact mitigation, which is now the most commonly accepted paradigm for the AIDS response.

A background paper prepared for this meeting by Marge Berer (editor of *Reproductive Health Matters*) and Jeff O'Malley was *not* distributed. That paper examined common vulnerability frameworks and proposed specific service integrations beyond family planning, particularly highlighting requirements to prevent the sexual transmission of HIV through safer sexual practices, especially for youth. It called for action to strengthen health systems to support services for both HIV and RH.

Several working groups formed following the Glion meeting, UNFPA meeting, and Bangkok AIDS conference to carry forward the work on linking RH and HIV/AIDS. UNFPA has taken the lead in several areas, including on a tool for rights protection (with ICRW, EngenderHealth, PIWH, and CHANGE), and is the lead agency for a working group on programmatic activities to link the two fields (see below), chaired by Lynn Collins. Nafis Sadik, former Executive Director of UNFPA, is now a special Envoy of the United Nations Secretary-General for HIV/AIDS in Asia and the Pacific.

UNFPA worked with IPPF to develop and publish guidelines for integrating VCT services into reproductive health care settings. The guidelines highlight examples from UNFPA programs. UNFPA in Haiti is merging VCT services with efforts to prevent mother-to-child transmission (MTCT). Some of these centers are including ARV treatment for pregnant women. In Zambia and Zimbabwe, UNFPA is supporting the expansion of reproductive health centers and MTCT sites to offer HIV counseling to male partners of pregnant women. UNFPA has also worked with EngenderHealth to develop a tool for linking HIV prevention and maternal and child health programs.

Skeptics have suggested that UNFPA is now belatedly placing the HIV/AIDS issue front and center as a means to reinvent itself following years of political marginalization by the U.S. government because of the ICPD agenda and its involvement in China. Because there is no explicit MDG for reproductive health, but there is one for HIV/AIDS, UNFPA is seeking to take more of a leadership role within the UN system on the HIV issue. Given UNFPA's central role in family planning programs and work with youth, there is much that UNFPA can offer on the issue. But given the agency's marginalization in recent years, it is unlikely that mainstream AIDS organizations will form close alliances with the agency for fear of alienating the U.S. government and risking access to PEPFAR funds. It may be that Marge Berer's background paper was not distributed at the June New York meeting precisely because of her strong advocacy for rights issues and the position she represented at the Glion meeting, and fear that it might further alienate the U.S. For these reasons and also because of UNFPA's focus on prevention alone, it does not appear that UNFPA will be able to succeed as a lead agency for the "centralizing" of needed perspectives on sexual and reproductive health and rights into the mainstream AIDS agenda.

4. International Center for Research on Women

The International Center for Research on Women (ICRW) is a research and advocacy organization focused on health, education, and empowerment of women and girls. In the AIDS field, ICRW currently works on the impact of stigma, empowerment of adolescents to protect themselves from HIV, improved access to prevention methods that women can control, and how HIV/AIDS affects property rights and food security.

In the 1990s ICRW initiated the Women and AIDS Research Program to identify the economic, social, and cultural factors that influence women's vulnerability to HIV. The program focuses on women, girls and boys, sexuality, and gender. As a result of the research, ICRW recommended, among other things, greater accessibility to STI services and their integration into family planning and maternal and child health services and the inclusion of education aimed at women and girls to

increase knowledge of their reproductive systems.

More recent projects focus on adolescent reproductive health and sexuality, including multisite intervention research to develop adolescent sexual and reproductive health in India; a study on gender, power, and susceptibility to STIs/HIV in India; developing gender-sensitive strategies to reduce young women's and girls' vulnerability to HIV in India, Burkina Faso, and Botswana; participatory approaches to youth reproductive health in Nepal; and research on adolescent migration in Thailand. ICRW is also conducting studies on the association of property rights and women's vulnerability to HIV and on the relationship between women's lack of power and their susceptibility to STIs/HIV in Bangalore, India. The latter will lead to interventions on the use of barrier methods and "improving gender-power relationships for women."

Geeta Rao Gupta and colleagues from ICRW prepared an excellent background paper for WHO's Department of Gender and Women's Health called "Integrating Gender into HIV/AIDS Programs."

5. International Women's Health Coalition (IWHC)

IWHC has been a leading advocacy organization working at the global policy level to preserve the gains achieved at ICPD. IWHC's programs on the ground in Nigeria, Pakistan, Brazil, and other countries have supported comprehensive sexuality education for adolescents and young adults, access to contraceptive services and safe abortion, and protection of sexual rights. IWHC works to empower women and address gender inequality that puts women at sexual risk of HIV. HIV projects currently are in Nigeria (a community life project and the Girl Power Initiative), Cameroon (support for the Society for Women and AIDS in Africa), and Peru (peer education at a site with high levels of sex tourism).

Adrienne Germain, president of IWHC, has helped push the boundaries of the discussion on HIV/AIDS prevention by highlighting a number of areas of concern and needed action for women outside core risk groups. These include child brides married to older, sexually experienced men, transactional sex between young girls and older men, violence and sexual coercion both inside and outside marriage, and taboos against discussing sex with girls. She calls for better integration of funding for reproductive health and HIV services and a focus on comprehensive sexuality education that goes beyond simple safe-sex education. She also advocates building skills and providing social support for establishing equitable and consensual relationships free of violence. The Girl Power Initiative in Nigeria works with girls, parents, community leaders, school principals, and teachers to build girls' power and self-esteem and reduce the risks of early marriage. The program has led to a pioneering program for young men, the Conscientizing Male Adolescents program, which educates boys and young men to understand gender inequality and to combat it in their own lives.

6. EngenderHealth

EngenderHealth's work in HIV focuses on:

- Reaching men to shift gender norms and reduce HIV transmission and gender-based violence
- Introducing quality improvement tools for VCT and integrating family planning into VCT services

- MCTC programs
- Working with providers to sensitize them to the needs of HIV-positive patients and the impact of stigma on delivery of quality services
- Training antenatal care providers to address HIV prevention for pregnant women
- Training providers to integrate HIV/STI and dual protection into family planning counseling
- Syphilis screening and VCT in antenatal care
- Training in syndromic management of STIs and counseling
- Technical standards for managing STIs and RTIs
- Multisectoral strategies for HIV/AIDS
- Outreach and drop-in centers for sex workers
- Involving religious leaders in HIV/AIDS prevention and care
- Research on microbicide acceptability barriers

EngenderHealth is conducting male involvement activities in India to address social norms that put men and women at risk of HIV. They are collaborating with local groups who work with young men to explore and change traditional notions of masculinity. In turn, these young men then work as peer advisors.

EngenderHealth has also pushed for more HIV prevention through family planning services, including expanding VCT at family planning sites; moving toward an expanded definition of ABC to include treatment, delaying sexual debut, and adding family planning services; providing family planning services to prevent maternal-to-child transmission of HIV; and adding family planning counseling to VCT services.

EngenderHealth worked with Ipas, UNFPA, and the Pacific Institute for Women's Health to develop a tool (described below) for protecting the reproductive rights of HIV-infected women. This tool is an important contribution to the discussion in that it identifies critical areas of rights protection that have been threatened by narrower service integration approaches, such as the right of HIV-infected women to bear children. This tool demonstrates the important role that SRH organizations can play in the AIDS response. The rights discussions in the post-ICPD period have carved out important and sophisticated constituencies for rights protection for women and sexual minorities and linked them to international human rights frameworks. The highly medicalized AIDS response will benefit from these well-developed perspectives. The Barcelona Bill of Rights was adopted at the 14th International AIDS Conference in Barcelona, Spain, in 2002, aimed at clearly articulating the human rights protections crucial for the AIDS response.

7. Ipas

Ipas is a reproductive health service delivery, research, and advocacy organization whose founding mission and continuing work is focused on advocacy for and services to insure access to safe abortions and post-abortion care. The Ipas advocacy mission is (from a statement presented to the UN Commission on the Status of Women):

- Overall protection of the human rights of women and girls (the Convention on the Elimination of All Forms of Discrimination Against Women [CEDAW] and the Convention on the Rights of the Child [CRC]).
- Human rights violations including rape, forced pregnancy, and sexual slavery put women

and girls at greater risk of HIV/AIDS.
- Special attention to the needs and rights of refugees and internally displaced women and girls.
- Involvement of women and girls in decision making related to HIV/AIDS policies and programs.
- Economic empowerment: gender-based analyses and impact assessment of laws, agreements, and budgets.
- Access to education and information about HIV/AIDS through a broad sexual and reproductive health framework, because risk factors associated with HIV also place women and girls at higher risk for violence, unwanted pregnancies, and abortions.
- Gender inequality and discrimination.
- Media responsibility in promoting gender stereotypes.
- Research subjected to gender analysis, gender, and age disaggregation.
- Freedom of choice regarding sexual and reproductive health for women and girls.
- Eradication of stigma against women and girls "exposed to high risks of violence, marginalization, abandonment and suffering as a result of their association with or contraction of HIV/AIDS."
- Access to affordable treatment, nondiscriminatory health services, and counseling.

Using this statement as a starting point, Ipas, ICW, the Pacific Institute for Women's Health, and CHANGE developed a tool to address the following areas:

- Involvement of HIV-positive women in policymaking and program implementation
- Fertility control that meets HIV-positive women's needs
- Research on ARV therapy in relation to fertility

This tool examines the MDGs, specifically, the two that relate to HIV-positive women: MDG 5, which aims to improve maternal health (by reducing the maternal mortality ratio by 75 percent), and MDG 6, which aims to halt and begin to reverse the spread of HIV/AIDS. The tool provides a practical approach for formulating policies and programs to address the inequalities and gender-biased cultural norms faced by women and girls. This document addresses VCT, sexual assault, contraception, termination of pregnancy, assisted reproduction, foster care and adoption, and antiretroviral therapy and fertility. It also includes a set of benchmarks, questions for data collection, and guidelines for how these can help establish a baseline regarding neglected areas of HIV-positive women's reproductive health.

Ipas has also conducted research on women living with HIV/AIDS, including research on issues women face in preventing or dealing with unwanted pregnancies. Ipas has also documented situations of women with HIV/AIDS encountering stigma and discrimination in the health sector when they seek reproductive health care. They have shown that before ARV therapy availability women were often pressured to have abortions or undergo sterilizations, and that many providers still think that women should not become pregnant if HIV-positive.

Other issues raised by Ipas in their work include problems related to VCT for women in labor and delivery. Most women in sub-Saharan Africa do not seek or receive prenatal care until the second or third trimester, too late for an early pregnancy termination. VCT is also not a component of most antenatal care programs. Organizations recommend counseling during pregnancy and postpartum.

When testing is done during labor and delivery, the rights of women to "opt out" are minimized. Effective counseling in such conditions is extremely limited. Therefore, the same ethical standards of testing applied to other people are not followed in the case of women in labor. Ipas has highlighted the lack of confidentiality in such situations. They have also noted problems with false positive results from rapid tests, as well as unknown effects of ARV therapy in woman and children when results turn out to be false negative.

Ipas also advocates for VCT and treatment of women outside the context of PMTCT programs and antenatal settings. While there are often requirements to offer VCT to pregnant women, there are no such requirements for women having abortions or post-abortion care. Education and VCT should be made available to all women.

Ipas has called attention to the need to promote contraception other than condoms for HIV-positive women, noting that other methods have lower failure rates. They have raised awareness of the need for appropriate contraceptive methods for positive women—methods that don't adversely affect the efficacy of ARV, for example. There is little information in family planning clinics on method contraindications, disadvantages, and side effects in relation to HIV. Ipas has also noted that HIV-positive women have limited access to family planning in the postpartum period.

Ipas points out important gaps related to addressing fertility options for HIV-positive women and the need for greater emphasis on human and reproductive rights. With respect to measures to deal with unwanted pregnancies, Ipas notes that providers lack information on emergency contraception and safe, legal abortion services. Emergency contraception should be more widely available; for instance, in some areas it is obtainable only during normal workday hours at public facilities. Knowledge of emergency contraception is very low among women. Ipas points out that 19 of 46 million abortions each year were unsafe according to WHO, with most of these in developing countries and resulting in both long-term and short-term complications. There has been no research to date on the effects of unsafe abortions in HIV-positive women. Positive women may experience greater risks to their health from complications such as infections, sepsis, and hemorrhage. There is a need for international support from NGOs and international experts on positive women's legal access to abortion. The fear of losing U.S. government funding may prevent international NGOs from addressing abortion via information and services for positive women. Abortion services are often not available even in countries where it is legal, with services available only in tertiary hospitals rather than in community-level clinics.

Ipas has also raised the issue of foster and adoptive care by people living with HIV, calling for the right to adopt if one is HIV positive—an important but often restricted right. Ipas has highlighted the need for involvement of positive people in developing policies on HIV testing during antenatal care, labor, and delivery. Policies should be implemented to ensure that HIV-positive women are not forced into abortion or sterilization.

In the area of adolescent reproductive and sexual health, Ipas' advocacy relates to incorporating safe abortion services into the work of partners focused on HIV/AIDS—for example, the AIDS Society of the Philippines. Ipas researchers have published articles and made presentations at meetings that highlight the vulnerability of youth to both HIV/AIDS and abortion.

Although focused mostly on service delivery, Ipas does advocate on larger policy issues. Most recently, Ipas has become very involved in the reproductive health and rights of HIV-positive women. Ipas goes beyond service delivery when talking of rights and adoptive policies. There are gaps in Ipas' work in this area, however, including counseling in clinical settings for positive women regarding how to lead healthy and positive sexual lives.

8. Population Council Horizons Project

The Population Council has been conducting operations research on HIV/AIDS through the Horizons Project. The Horizons Project designs, implements, and evaluates innovative field-based service delivery strategies in the HIV/AIDS field. The program applies the operations research methods developed in the family planning and SRH field to HIV interventions and policies including prevention, care and support, and service delivery. Nearly one-third of the Population Council's research budget is devoted to research on HIV/AIDS, mainly through the Horizons Project. However, the AIDS research activities are somewhat separated from other initiatives at the Council, given that the funding from USAID's Office of Health is a separate funding stream and set of actors from those providing funding for much of the Council's other programs in population, family planning, and reproductive health. The Horizons Project collaborates with ICRW, the International HIV/AIDS Alliance and PATH, Tulane University, Family Health International, and Johns Hopkins University.

Naomi Rutenberg of the Horizons Project recently presented data from sub-Saharan Africa at the American Public Health Association's annual meeting, noting gaps in service integration between SRH and HIV counseling and prevention services and highlighting needed areas of coordination related to dual protection promotion, need for new technologies and options for women, STI services, and VCT. She presented data showing that when services are integrated, this increases HIV counseling reach, condom distribution, and STI detection and management. She also highlighted the motivations for and realities of the desire for children by HIV-positive women and noted the need for clearer guidelines on which contraceptive methods should or should not be used by HIV-positive women. Naomi felt that there needs to be more support for empirical work on the demand side for contraceptive services by HIV women and how HIV prevention and care strategies actually work for women. She highlighted the work of Cindy de Saloman in Chennai, India, in examining how to provide HIV care for women.

Horizons has funded a number of innovative research programs and is helping to provide evidence in a field where many policy declarations about needed interventions are not evidence-based, according to Rutenberg. Horizons supports Gary Barker's GEMS project in Brazil, where research is influencing gender norms of young men in the areas of STI self-reporting and condom use, violence, reproductive decision making, and child care. The program is being replicated in India. Through Horizons, the Engender program is evaluating life skills education programs in Thailand, South Africa, and Mexico that show that teachers' comfort level with the material being taught is more important than the actual content. Other research is showing intentions around childbearing by HIV-infected women in Kenya, Zambia, and looking at operational issues of integrating PMCT into FP, FP into VCT, and VCT into FP.

9. International Planned Parenthood Initiative: Global Roundtable, HIV Theme

The International Planned Parenthood Federation organized a Global Roundtable on ICPD+10 from August 30 to September 3, 2004, in London entitled "Countdown 2015, Sexual and Reproductive Health and Rights for All." This was one of the main meetings of donors and international RHR organizations from 109 countries to review the commitments and progress of ICPD and outline strategies to move forward. The Declaration that was issued was entitled "Health & Hope, Rights & Responsibilities." A key theme of the meeting was HIV/AIDS, and an excellent background paper and other materials were prepared by a working group on HIV/AIDS consisting of many of the groups listed in this summary. The HIV Theme, entitled "HIV/AIDS Meeting All Needs," focused on three issues:

1. Mainstreaming HIV/AIDS into sexual and reproductive health and rights (SRHR),
2. Structural and cultural factors influencing vulnerability and stigma, and
3. Gaps in prevention and new technologies and approaches such as ABC.

The roundtable put forward recommendations for both policy and programs related to mainstreaming SRHR into HIV services and vice versa (issue 1) and highlighted challenges related to capacity development, common language, maximizing entry points, reaching and serving the most vulnerable, and combined advocacy resources. Recommendations included setting up a SRHR and HIV/AIDS Forum convened by UNAIDS, development of common country-level frameworks and policy bodies at the national and regional level, acting on programmatic links especially related to adolescent SRHR education programs, development of a global consensus framework for action by governments and implementing agencies focused on integration and under what circumstances this should be done, and establishing global coherence across all global declarations, targets, and initiatives. For issue 2, culture and gender, identified challenges included addressing regional vulnerability, recognizing positive people as sexual beings, meaningful participation of people living with AIDS in program development and implementation, male involvement and need for services, synergistically fostering an enabling environment for combined advocacy for marginalized groups, and building social capital and solidarity among these groups. Recommendations included better articulation of HIV/AIDS core functions, SRH services for men, acknowledgement and protection of the rights of HIV-positive people, stigma-free centers, and access to and resources for female barrier methods. Issue 3, new developments along the care continuum, examined ARV treatment scale-up possibilities and where synergies with SRHR should be fostered in the context of weak health systems. Challenges identified included better articulation of common goals, especially when services must be prioritized due to lack of funding in poor areas; the need for integrated prevention building on the substantial achievements of the SRHR community post-Cairo; emphasis of the critical role of NGO and civil society participation in the HIV/AIDS response; practical partnerships especially where infrastructure is limited; and joint resource tracking. Recommendations include joint advocacy for investments in existing structural capacity already set up by the SRHR community to serve the HIV/AIDS response, improved performance tracking, clear monitoring and evaluation of integrated initiatives, microbicide advocacy, and recognition and endorsement of condoms for prevention of HIV and insuring their supply.

International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR)

IPPF/WHR published an easy-to-use "STI/HIV Integration Checklist" in 2002 for use by SRH organizations to explore if and to what degree gender-sensitive STI/HIV prevention strategies have been integrated into SRH programs on the organizational, programmatic, and service-delivery levels. A self-assessment module for organizations on integrating STI/HIV/AIDS services into SRH programs was published in 2000, as well as a poster on HIV rights designed to inform SRH clinic clients of their rights related to HIV/AIDS. An early issue of the Population Council's publication, *QUALITY*, highlighted IPPF/WHR's experience in Latin America and the Caribbean in integrating HIV/STI prevention into family planning services in three different regional projects.

10. Family Health International (FHI)

FHI is a U.S. NGO that has been a major technical assistance organization for HIV/AIDS work for many years. It has also been an important actor in the family planning service delivery field (its original mission) since it was founded. FHI has been a major contractor for USAID's HIV work internationally and works closely with USAID on AIDS policy and programs. Projects linking HIV/AIDS and SRH include "Impact for HIV/AIDS prevention care and treatment" and reproductive health programs focused on youth and women. The key focus for these projects is FP/HIV service integration work (highlighted in a recent issue of *Network*, the FHI newsletter).

FHI has conducted research and interventions on existing integrated services in HIV/AIDS and SRH, especially related to dual protection and integration of VCT into family planning, mostly in Africa. Most projects focus on communication, training, and education and much less on VCT, PMTCT, and policy formulation. Projects also focus on general populations rather than specific "high-risk" groups. FHI's youth projects work 50/50 with in- and out-of-school youth. Dual protection projects promote condoms as a dual preventer of STI/HIV and unwanted pregnancy. Fewer projects promote other dual protection strategies such as condoms and another contraception, mutual monogamy, or abstinence. Very few female condoms are distributed through FHI's programs.

Population Services International (PSI) works with FHI on a number of integration projects (50 percent of integrated projects). The PSI activities integrate HIV into family planning services, and most projects are carried out in the community (see Pruyn and Cuca 2002).

FHI's "Advance Africa" project aims to integrate family planning and HIV interventions. This project focuses on dual protection—protection from infection and unwanted pregnancy, VCT (opportunity for counseling on family planning and provision of contraceptives for comprehensive protection), PMTCT (including family planning counseling, counseling and information on how sero-status affects childbearing and child survival), and people living with HIV/AIDS ("access to comprehensive family planning services in order to make fully informed reproductive health decisions").

FHI is also working on testing vaginal microbicides for HIV prevention in Africa, Asia, Latin America, and the United States. FHI has helped develop, coordinate, and implement numerous clinical research trials of microbicidal products to test their safety, acceptability, and efficacy in preventing HIV and other STIs. FHI manages the Microbicide Science Working Group of the HIV Prevention Trials Network (HPTN), an international network of researchers established in 1999 and

dedicated to the development and evaluation of non-vaccine methods of HIV prevention. FHI conducted research on nonoxynol-9 and found that it did not protect from infection.

FHI's "YouthNet" project addresses both HIV and reproductive health in young people ages 10–24 years old. "YouthNet conducts research, disseminates information, improves services, and strengthens policies and programs related to the reproductive health and HIV/AIDS-prevention needs and rights of young people around the world." The project provides integrated HIV and reproductive health education for youth.

Family Health International participated in research in Uganda that demonstrated that an inexpensive drug, nevirapine, could effectively reduce HIV transmission between infected pregnant women and their infants.

In Kenya, FHI has shown the feasibility of integrating family planning into VCT services. They recommend the following components in such integrated services:

1. Assessment of pregnancy and STI risks,
2. Provision of information and counseling on contraceptive methods, and
3. Referral of methods that are unavailable at the VCT centers.

Four levels of services are provided:

Level 1: Condoms and pills
Level 2: Condoms, pills, and injectables
Level 3: CPI and IUD
Level 4: A full range of contraceptives

They recommend that all facilities have available at least Level 1 services, progressing to Level 4 in the future.

Perceived barriers to service integration include:

1. Funding through different mechanisms
2. Service providers thinking they would be overburdened

FHI has also undertaken research on hormonal contraception and HIV, focusing on the effect of hormonal use and HIV acquisition, transmission, and disease progression.

Family Health International has clearly been at the forefront of work integrating HIV and SRH services. However, the focus has been somewhat narrow, with an emphasis on family planning rather than comprehensive reproductive health. Moreover, the aim of preventing pregnancy in HIV-positive women has omitted needed work on the sexual and reproductive needs and desires of HIV-positive women and couples. Gaps remain in FHI's gender analysis of its approach and in attention to sexual health and sexual and reproductive rights. FHI research and programs do not focus on positive people having families and healthy sexual lives. The overall message appears to be to avert pregnancy in positive women.

11. Partners in Health

Partners in Health, an NGO based at Harvard Medical School's Department of Social Medicine focusing on AIDS treatment, prevention, and care, has been working since the late 1980s in Haiti to provide HIV prevention, treatment, and care to people who are among the world's poorest. Led by Paul Farmer, Joai Murkegee, and others, this program sits squarely in the mainstream AIDS field and has been much publicized as the example of how to provide complicated antiretroviral medication to AIDS patients using a community-based network of non-health personnel to support treatment adherence. The program was based on an existing TB program to provide ARV treatment to poor people in rural areas of Haiti, building on the approach of direct observed therapy (DOTS) for TB treatment adherence. The lessons from the Haiti experiment are that in places where resources are weak and poverty and inequity are the main drivers of the epidemic, it is essential to integrate AIDS services into primary health care and use the funding and training to strengthen overall health systems and services, while relying on communities who care for their members to sustain and support the programs.

Partners in Health states that its mission is to "bring the benefits of modern medical science to those most in need of them and to serve as an antidote to despair…Its mission is both medical and moral based on solidarity rather than charity alone." The organization recently published a "Guide to Community Based Treatment of HIV/AIDS in Resource Poor Settings" summarizing what it has learned. A basic conclusion of the program is that integrating HIV prevention and care improves the overall quality of primary health care, and this has been demonstrated in Haiti. Examining the central question of whether focusing on HIV siphons resources away from other health priorities, Partners in Health have shown that focusing on "4 Pillars" (prenatal care and women's health, especially MCTC; screening and treatment of TB; screening and treatment of STIs; and HIV prevention and care, including ARV provision) results in a strengthened quality of the overall primary health care response. They show that the chief barriers to scaling up promising interventions have been patient poverty and the poor quality of general health infrastructure, and that funding and service integration is essential for overall health access for the poor. In Haiti, this meant there was a mechanism to introduce thirty new essential drugs, improving people's willingness to come forward for HIV testing and counseling once treatment was available. This led to identification of TB- and HIV-infected persons, bringing them into treatment, and preventing MCTC. A poorly used clinic where few came for VCT has been transformed into a busy prevention and treatment hub. Patient visits—and thus HIV and TB case detection and treatment—increased, prenatal care visits and PMCT increased, vaccine administration increased for children who accompanied their mothers, and staff morale was high, as was community support.

12. 15th International Conference on AIDS, Bangkok, Thailand, July 2004

Following the Glion and UNFPA meetings, the Global Coalition on Women and AIDS organized numerous oral sessions and symposia at the Bangkok AIDS conference. A brochure was available to 17,000 interested meeting participants noting all the oral sessions dealing with women and AIDS, although these meetings did not play a prominent role in the overall conference and were not particularly highlighted by the new media or the Bangkok daily reports. Kofi Annan, who gave the opening session's keynote address, did highlight the growing gender disparity in the AIDS epidemic and the structural determinants causing it, providing a strong message on the need to focus attention

on programs that reach women and girls. The theme of World AIDS Day 2004 was Women and Girls.

The Bangkok meeting included many presentations on women and AIDS. There were 436 poster and oral presentations with "reproductive health" as a keyword. A review of the abstracts of these presentations reveals that most focused on youth outreach for HIV education and safe-sex behavior, but many dealt with rights of HIV-positive women as well as the need for innovative understandings of sexual behavior and risk taking. The abstracts paint a very rich picture of the excellent, on-the-ground, work taking place.

At the Bangkok meeting, the key actors from the Glion and UNFPA meetings decided to form three working groups to further the recommendations from the "Glion Call to Action" and "NY Commitment." One working group was to deal with research gaps, another to deal with advocacy, and the third (led by UNFPA) to deal with programming. The UNFPA-led group has been the most organized, with several teleconferences already completed aimed at mapping out what needs to be done. Key actors include the drivers and key participants of the Glion and UNFPA meetings (WHO, FHI, Hewlett, Gates, IPPF, UNFPA, ICW, Family Care International, and the Global Coalition on Women and AIDS). The group is trying to develop case studies and concrete tools based on an evidence-based review. A number of persons have begun to suggest, however, that there is little empirical evidence to support recommendations. Some outputs and efforts underway include an IPPF/UNFPA collaboration on developing a tool for integrating VCT into SRH programs.

Populations	Table 1 - Matrix: Clientele Access to Public and Private HIV and Reproductive Health Services: Developing Countries*													
							HIV Prevention							
	Maternal Health	Family Planning (including sterilization)	Abortion	Infertility	RTI	STI	Condoms	N/S	PE	PMTCT	VCT	HIV Care and Support	HIV Treatment	Sexuality Counseling
MWRA	X	X	x	X	X	x				X	x	X	x	
Married adolescents	x	x	x	x	x	x				X	x	X	x	
Unmarried adolescents		x	Private clinics			Private clinics and pharmacies	X		X		x	x	x	x
Hetero men		x				Private clinics and pharmacies	x				x	X	X	
Sex workers			Private clinics			Private clinics and pharmacies	X		X		x			
IDU men						Private clinics and pharmacies	X	X	X		x			
IDU women						Private clinics and pharmacies	X	x	x		x			
Male clients of sex workers						Private clinics and pharmacies	X		x		x			
MSM						Private clinics and pharmacies	X		X		x			
Migrant workers			Private clinics			Private clinics and pharmacies	X		X		x			
HIV+ women	X	X	X			X/ Private clinics and pharmacies	X/FP			X	X	X	X	
HIV+ men		X				x/ Private clinics and pharmacies	X/FP				X	X	X	

* This matrix describes access to different HIV and reproductive health services by different groups of clientele. Public health services are denoted by X=always/often and x=sometimes/rarely. Private health services are noted.