Integrating Sexual and Reproductive Health Services with HIV and AIDS.

Raphael Rogans-Watson ***(Medsin Stop AIDS Campaign National Coordinator)***

The first session that I attended on the second day of the Women Deliver Conference was run by some of the growing body of advocates and evidence-based projects that are calling for greater integration between Sexual and Reproductive Health (SRH) and HIV/AIDS responses. Though many people in the field have been asking for this for some time, the research in this area (and the volume of the voices) is growing, and experts in both fields (who often have experience in both HIV and SRH) are starting to see the many benefits of working together.

An excellent presentation from Lynn Collins, HIV/AIDS Technical Advisor for the UN Population Fund (UNFPA), outlined some of the benefits that have been shown to come out of HIV/SRH linkage. These included:

- **Increased uptake of both services**
- **Decreased stigma** (brought about by normalising HIV into the SRH system)
- **Increased coverage of marginalised groups** (HIV services generally have had greater success in reaching marginalised groups such as men who have sex with men, commercial sex workers, and injecting drug users: this expertise and access can be transferred to the SRH field)
- **Easier access to people living with HIV/AIDS** who may otherwise not be included in any part of the health system
- **Optimising the connection between HIV and sexually transmitted infections (STIs);** an important aspect since one increases the likelihood and vulnerability to the other
- **Integrating tests and treatment for HIV and STIs** into the same setting
- **Acknowledging the links between gender-based violence and HIV,** and being able to address these in the regular health service for women.
- **Opportunities to integrate HIV with maternal and infant care**
- **Increased quality of care,** because patients are not compartmentalised into different illnesses or social problems; they are treated holistically as the 'whole human'
- **Enhanced efficiency and effectiveness –** not only important because it allows health systems to improve and develop, but this is also an essential aspect that is needed in order to attract donors

The rest of the presentations were centred around the Global Fund to Fight AIDS, TB and Malaria (GFATM), and how its vast sums of money could be utilised to increase and enhance the HIV/SRH link. The GFATM, formed in 2002, has traditionally been very weak in its funding of SRH, but considering that it now provides 27% of total funding for HIV globally, this source of capital cannot be ignored. Furthermore, there are many 'entry points' for civil society (i.e. NGOs and advocacy groups): from positions on the board, to the Country Coordinating Mechanisms (CCMs – these are the national bodies

that put forward the proposals) and even the Principle Recipients; those who receive the money, 19% of which are NGOs.

The Global Fund cannot be the only one to take the blame for its minimal funding of SRH, explained Fiona Pettitt, Consultant on Women's Issues, Stigma and Discrimination and member of International Community of Women living with HIV/AIDS (ICW). There is already some flexibility within the Fund, which allows it to accept SRH proposals as long as positive outcomes are demonstrated for one of its 3 diseases. Understandably, any proposal must be shown to produce positive results, and many of those on the panel today are working tirelessly to ensure that the monitoring and evaluation methods for GFATM recipients include SRH, gender, family planning, and stigma indicators in future rounds. Another barrier to obtaining funds has been the low quality of CCM proposals that include SRH, which unfortunately have not generally been aimed at benefiting all women, whether they are HIV positive or negative. The panellists highlighted the need to help national teams that lead the proposals. Felicity Daly from Interact Worldwide described how her organisation, along with 5 others, had developed an Advocacy Action Plan with 6 countries (Cambodia, Ethiopia, Madagascar, Malawi, Mongolia and Pakistan) at a summit last December, and had been providing technical assistance to these countries in order to help them develop sound proposals with a focus on SRH.

Altantsetseg Batsukh, from the Mongolian National AIDS Foundation, described the process following the December 2006 *Advocacy Summit on Integration of SRH with HIV/AIDS*, by which they had formed a network of national and local NGOs to identify gaps in the service and produce a coherent proposal that focussed on 2 key areas: Health Systems Strengthening, and Integration of SRH and HIV/AIDS. They had since managed to achieve the following:

- Link outreach services and peer education with SRH education for commercial sex workers
- Integrate STI treatment and counselling into HIV voluntary counselling and testing (VCT) services
- Build capacity of partners who implement the services
- Focus on promoting condoms for dual protection (Batsukh explained that condoms were commonly accepted in Mongolia for HIV/AIDS prevention, but not for family planning)
- Improve referral systems (integration does not necessarily have to involve treating everything in the same centre. By increasing linkages, for example by using antenatal services as an entry point for SRH/HIV services, the health system and quality of care can be easily improved)

So what challenges are still faced by civil society and those hoping to make SRH/HIV linkage proposals to the GFHTM? Well, a greater understanding of GFATM policies and rules would help make proposals more focussed, and a better knowledge of the many ways civil society can be involved with the Fund is needed. We urgently need greater dialogue between NGOs on a local, national and international level (a huge topic that is perhaps one of greatest challenges in the current development discourse). Additionally,

more in depth research is needed into the benefits of integrating SRH and HIV services, both for the proposals and for advocacy purposes.

Finally, as with everything in this world of multi-billion dollar donors, the cost-effectiveness of SRH/HIV integration must be proven. Lynn Collins and the UNFPA are working on this as we speak, and her initial figures suggest that it can be hugely cost-effective. However, she did stress that this was by no means a magic bullet for every situation: individual cost/benefit analyses would be needed in each situation because some health systems would be better suited to this approach than others, both in an economic sense and in terms of their capacity.

Regardless of the outcome, it was impressive to see so many well-planned, highly professional and strategic approaches to this situation. Only by working within the current system, will intelligent and logical strategies to the problems faced every day by health services around the world be solved. This was an inspiring example of change happening from the ground up (with the technical help of international NGOs and UN organisations), and I left with the feeling that the international development community could perhaps learn a lot from this approach.