

Intimate links:
**A call to action on HIV/AIDS
and sexual and reproductive
health and rights**





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Call to action

'Linking HIV/AIDS and sexual and reproductive health (SRH) programmes has the potential to significantly curtail the AIDS epidemic. Furthermore, it also addresses the unmet need and rights of women and men living with HIV/AIDS to SRH Services.'

WHO et al, 2005

In the last few years there has been a groundswell of recognition internationally of the benefits to be gained from appropriately integrating and linking HIV/AIDS and sexual and reproductive health and rights (SRH&R) in policy, programmes, services and financing architecture. Key impacts could be made on intractable problems where progress has not been acceptable and

targets are not being met. These include addressing the feminisation of HIV/AIDS and improving health equity – especially for women, young people, people living with HIV and AIDS, and many other marginalised groups.

However, despite this recognition, efforts to turn rhetoric into action have been limited and stubborn institutional and financing barriers remain.

Interact Worldwide undertakes and supports advocacy, communications, service delivery and research which strengthen synergy between responses to HIV/AIDS and SRH&R. This briefing paper draws on the experiences of Interact Worldwide and its partners in Africa and Asia to present ideas on how to move forward.

Call to action

This briefing paper is an appeal to strengthen the global response to HIV/AIDS and improve sexual and reproductive health and rights, by taking systematic action to maximise synergy in response to these intimately linked issues.

Interact Worldwide calls on governments, international agencies, donors and NGOs to commit publicly to appropriate integration and linkage of HIV/AIDS policies, programmes and services with those of SRH&R in order to reduce poverty, accelerate progress towards the Millennium Development Goals (MDGs)¹, and increase the resource effectiveness of large global investments dedicated to the fight against HIV/AIDS.

Interact Worldwide calls on key actors to:

- 1 Increase global commitment and momentum** in accelerating progress towards the health MDGs and increasing effective use of resources through appropriately integrated and linked responses to HIV/AIDS and SRH&R, aligned within national frameworks.
- 2 Strengthen the evidence base** which demonstrates the benefits of appropriately integrating and linking responses to HIV/AIDS and SRH&R in terms of stigma reduction, access to services, commodities and medicines, health equity, and outcomes amongst poor, marginalised and vulnerable people.
- 3 Use existing mechanisms to maximise synergy and oppose / reduce institutional and financing barriers, especially those rooted in or supported by vertical aid architecture and conditionality.**
- 4 Establish a Global Task Force which will review legislation, policy, regulation and practice** that prevents appropriate integration and linkage between HIV/AIDS and SRH&R, or which reduces access to HIV/AIDS and SRH&R information, services, commodities and medicines, especially amongst vulnerable groups such as poor women, young people, HIV positive people and marginalised groups such as migrants, sex workers, men who have sex with men and injecting drug users.
- 5 Strengthen capacity** for planning, implementation, monitoring and evaluation of appropriately integrated and linked responses to HIV/AIDS and SRH&R which are equitable and accessible.
- 6 Promote partnership** and inter-sectoral collaboration and exchange between actors in HIV/AIDS and SRH&R.

¹ Specifically MDGs 3, 4, 5 and 6: MDG 3: promote gender equality and empower women. MDG 4: reduce child mortality. MDG 5: improve maternal health. MDG 6: combat HIV/AIDS, malaria and other diseases.

Why integrated and linked responses are vital to combating HIV/AIDS and poor SRH&R

Sex and reproduction are common factors

HIV is primarily a sexually transmitted infection (STI), with sexual transmission accounting for the majority of cases in adults. Mother-to-child transmission (MTCT) from an HIV-positive mother to her infant during pregnancy, childbirth or breastfeeding, is responsible for some 90 per cent of cases of HIV infection in children.

HIV and other STIs are also linked. The presence of an STI increases the risk of HIV transmission, and HIV/AIDS can complicate the treatment of other STIs. By treating other STIs in people with HIV/AIDS, it is possible to reduce the risk of HIV transmission significantly. Moreover, STIs, including HIV, affect reproductive health in a variety of ways. They can cause complications during pregnancy and delivery and can lead, for example, to miscarriage, stillbirth, infertility and reproductive cancers. There is evidence of the role of HIV infection in dramatically increasing maternal mortality².

Those vulnerable to HIV/AIDS are vulnerable to poor SRH&R

The common underlying factors in vulnerability to HIV/AIDS and poor SRH&R include: poverty, gender and generational inequality, and the marginalisation of vulnerable groups such as sex workers and men who have sex with men. Poor and marginalised women are at higher risk from harmful traditional beliefs and practices and more vulnerable to HIV infection, STIs, unintended pregnancy and maternal morbidity. Equally, young people experience barriers of conservatism and discrimination when trying to access information and services for both HIV/AIDS and SRH. Young people, especially women and girls, are highly vulnerable to HIV infection, the impacts of HIV/AIDS and poor SRH&R. Few poor women, young people, or other vulnerable groups

can readily access the comprehensive HIV/AIDS and SRH&R information and services they need.

Sexually active people need both HIV/AIDS and SRH services

Traditionally, HIV/AIDS, STI and reproductive health services have been provided separately, targeting different groups of people with different approaches. Yet, to separate them divorces service provision from the reality in which sexual and reproductive behaviour takes place.

HIV/AIDS and STI services have targeted high-risk groups and emphasised the use of condoms, while reproductive health services have focused on married women and promoted contraceptive methods other than condoms. This ignores the fact that

HIV/AIDS and STI services have targeted high-risk groups and emphasised the use of condoms, while reproductive health services have focused on married women and promoted contraceptive methods other than condoms. This ignores the fact that married women and other people who use reproductive health services are often at extremely high risk from HIV/AIDS and other STIs due to the sexual behaviour of their husbands and partners.

married women and other people who use reproductive health services are often at extremely high risk from HIV/AIDS and other STIs due to the sexual behaviour of their husbands and partners. Separate services also neglect the needs of high-risk groups who have the right to access SRH services as well as services related to HIV/AIDS. For example, sex workers need access to maternal and child health services, family planning, safe abortion and STI care as well as to HIV/AIDS services. Aiming HIV/AIDS services only at high-risk groups reinforces the existing stigma and discrimination around HIV/AIDS and leads to the false belief that only people from high-risk groups are at risk. By integrating or linking services where appropriate, we can help to de-stigmatise HIV/AIDS while also addressing the dual need for both types of service and care among all sectors of the population.

People living with HIV/AIDS do not receive the SRH services they need

HIV/AIDS prevention, treatment, care and support services have not routinely offered SRH care and referral, and SRH services are not designed to address the reproductive health needs or reproductive rights of people living with HIV/AIDS. Women living with HIV/AIDS are often reluctant to use reproductive health services because they fear stigma and discrimination, have concerns about confidentiality, and do not feel confident that they will be able to make free and informed choices in relation to their SRH&R.

Women living with HIV/AIDS who choose to have children need maternal care services that provide advice about safe conception and pregnancy, antenatal screening and treatment for malaria, tuberculosis →p8

² Research supported by DFID at LSHTM shows that HIV positive women are 4 times more likely to die in pregnancy and child-birth than uninfected women. www.dfid.gov.uk/pubs/files/maternal-health-progress-report.pdf

CASE STUDY 1: UGANDA

People living with HIV/AIDS do not receive the SRH services they need

The National Community of Women Living with HIV/AIDS (NACWOLA) is a national membership organisation of women, children and young people living with HIV/AIDS and Orphans and Vulnerable Children (OVC) in Uganda. NACWOLA is an AIDS Service Organisation and is also active in advocacy and awareness raising. As part of this work NACWOLA engages at the national, District and community levels to raise awareness of the SRH&R of people living with HIV/AIDS. NACWOLA has identified a number of barriers which prevent HIV positive people from accessing appropriate SRH services.

A Lack of SRH services for Young People Living with HIV/AIDS

Young HIV positive adults have specific needs regarding their sexual and reproductive health. Unfortunately they face a number of challenges which prevent them from exercising their rights to access SRH information and services, including a lack of Youth Friendly Services.

Achen Margret said 'she got an abortion and when she went to hospital, the nurses were so arrogant and unfriendly, they abused her and gave her no attention and treatment'.

In Kampala NACWOLA refers members to a specialist centre for young people, where they can access medication, treatment for opportunistic infections, counselling and support. However, though

condoms are available, very limited SRH information and care is offered and HIV positive young people are actively discouraged from engaging in sexual activity or dating. This is at odds with their rights and desires to form intimate relationships and live positively, and means that services are inappropriate to the realities of users' lives and relationships.

Stigma and Discrimination in the Education System

NACWOLA works with young people in boarding schools, and has experience of their fear of stigma. These young people very rarely disclose their HIV positive status to their teachers. Some of them thus fail to access treatment from health centres in their vicinity as permission would be required from the school for them to attend clinics. This fear of stigma and actual stigma also means that young positive people in boarding schools are not able to access other SRH services or condoms, and are therefore unable to practice positive prevention.

NACWOLA is identifying teachers from within its membership to support young people to advocate for their rights in school, and is facilitating the setting up of in-school clubs to support stigma reduction and mutual support. NACWOLA is also supporting the development of youth clubs out-of-school. However, it remains very challenging to work on the SRH&R of young HIV positive people in the Ugandan context.

SRH Needs of HIV Positive Women

NACWOLA also works on SRH&R in relation to its adult female membership and has identified a number of serious issues around the SRH needs and experiences of positive women. Women's concerns include:

- Lack of appropriate information about family planning and fertility for HIV positive women
- Lack of autonomy in decisions about use of condoms
- Lack of access to female controlled methods such as the female condom
- Poor quality care and discrimination
- Counselling that emphasises abstinence and provides little information about or access to condoms

Another area that comes out strongly is the lack of access to Prevention of Mother to Child Transmission (PMTCT). Although NACWOLA women may have information regarding PMTCT they are often too poor to access these services, particularly in rural areas where the nearest health centre may be 25-30km away. NACWOLA has supported women who have tested HIV positive, only for their spouses to refuse to accept the diagnosis or to give them money for transport. Stock outs of supplies such as testing kits is also a recurring problem.

Annet Biryetega, NACWOLA, 2006

NACWOLA and Interact work together to advance the voices of positive women and young people in Uganda, funded by DFID.



CASE STUDY 2: MALAWI

Understanding and responding to the demand-side is critical to the design of service integration and linkage

This case study draws from a qualitative study carried out among young women from four districts in Malawi between January and March 2006. The objective of the study was to identify factors affecting the demand for Voluntary Counselling and Testing (VCT) services by sexually active girls and young women, and was carried out using the Participatory Ethnographic Evaluation and Research (PEER) method.

PEER is an innovative approach to programme research, evaluation and design based on training members of the target group (peer researchers) to carry out in-depth qualitative interviews among their peers. The detailed narratives provide insight into the social, cultural and economic context in which behaviours take place and are understood by target groups. One of the most important aspects of PEER is that it stimulates a process of empowerment among the target population by giving voice to marginalised groups.

A thorough and contextualised understanding of a range of demand-side issues is needed to develop successful and equitable integrated interventions. These include and go beyond perceptions of health, health services and the HIV epidemic. In Malawi, peer researchers identified a number of key issues for the development of services. The narratives clearly describe the implications of an underlying context of poverty, disempowerment and lack of control.

Understanding health-seeking behaviour

A wider understanding of health-seeking behaviour for preventative and curative services was needed to understand demand-side issues around VCT services. In Malawi, motivating factors for women centred

on caring for children and the family rather than protecting their own health. Protecting children was a significant motivation for VCT in all the narratives, and single and married women voiced very different problems relating to access. Furthermore, they expressed very different barriers to access to VCT services than those reported around SRH services.

Concerns over privacy and confidentiality

Significant concerns were voiced over the ability of existing clinics to provide the necessary assurances about confidentiality for HIV-related services. Fears over confidentiality, while perhaps a minor issue for Reproductive and Child Health services, become central deterrents to people seeking care for HIV. Similarly, the poor quality of emotional care in many public health facilities had a more significant impact on demand for VCT than reported for antenatal care (ANC).

Additionally the group visits to clinics for ANC or family planning services, which were reported to be valuable opportunities for socialising with other women, were inconsistent with the very private nature of services for HIV. Women voiced a need for separate areas within clinics for VCT, and opportunities to access it at quiet times. In Malawi, the perceived need by women for an escort to clinics was also a significant barrier to attendance.

Power asymmetries, gender roles and decision-making

Women reported that, in some cases, they were not the primary decision-makers over their own health care. Dominant figures, such as husbands or in-laws, may not sanction visits for HIV-related services, and opportunities to visit clinics may be limited by lack of control over time and resources for transport:

“In government hospitals, the service is free; most people flock there and the

queues are long. They are failing to attend to their household chores on time. The children will return from home and not find food, because the mother has been at the hospital. Some are married to harsh husbands; if the food is not ready they will be beaten.”

The narratives reflect a reality where patriarchal relations go beyond the household and also find expression within the health system, often in relationships between female health staff and clients:

“There was this other woman who was found [to be] HIV positive and was advised by the staff not to become pregnant, but she went ahead and became pregnant. When she went back to the hospital, the staff were rude to her, so she decided not to go back to the hospital and she ended up delivering at home. Her baby later died. As we are talking, the woman is very sick.”

Understanding the social context of the epidemic

As with SRH services, planning HIV services requires a sophisticated understanding of perceptions of causality and risk. This often encompasses the simultaneous co-existence of biomedical with more traditional models of causation:

“They say HIV is dangerous and deadly; it’s a disease with no cure. It can be spread through sexual intercourse – a disease from up above and also a disease from the spirits.”

Issues around demand for HIV services may be significantly more complex than for SRH services. In Malawi, fear of infection in the context of lack of control is reported quite explicitly as a major deterrent to seeking VCT. Risk perception may therefore be inversely related to the demand for VCT, with both control and fear acting as mediating factors.

Unease about mandatory testing

The peer researchers reported that there was significant unease about perceived mandatory HIV testing during antenatal care for prevention of MTCT:



“Government hospitals are non-voluntarily testing during antenatal care; more people are visiting [private clinics] for antenatal care because they are afraid of getting tested at the government hospital...It’s different for women, because anyone who is pregnant, whether she likes or not, she has to go for a test.”

Given the unequal power relationships between health service staff and members of this target group, it is highly credible that women are not being fully counselled as to the voluntary nature of testing for MTCT, and that reduced attendance for antenatal care will be the result. With genuine concerns over confidentiality, widespread stigmatisation of people living with HIV/AIDS, and poor availability of ARVs, VCT may expose women to a number of risks without offering significant benefits.

Perception of the testing event

A striking feature of narratives around testing is the belief that a test

inevitably results in a positive diagnosis, and therefore an entry point into crisis. Stories that people tell each other create a vision of fear in the context of absence of control over risk. In the majority of cases, this leads to a failure to reach life aspirations and, often, to death:

“...they would not want to be seen, and the government hospitals have big signs and people will see you go.”

“There was this young woman who decided to go for a test. When she went there it was found that she had already started suffering from HIV/AIDS. When she was told she fainted and she died on the spot.”

A clear and consistent response is hostility and negative judgement toward those attending VCT, with a significant risk of stigmatising provider clinics:

“God is punishing them because of their bad behaviour of having careless sex; they are unfaithful

people in their families. Women who go for VCT, they are despised by their friends.”

The data generated by the PEER approach clearly demonstrate the inadequacy of supply-side-only approaches in developing appropriate and accessible services for HIV. The rich descriptions of issues around decision-making, stigma and the experience of existing health care services highlight a range of potentially mutable demand-side indicators that should form priorities for intervention. The findings suggest the importance of broad-reach community-based interventions.

Ben Rolfe, Options Consultancy Services, 2006.

This case study was drawn from a larger study: Women’s voices: Understanding V, C and T. Perspectives on access to VCT and implications for programme development (forthcoming), a PEER Study undertaken with Banja la Mtsogolo commissioned by Interact Worldwide and funded by DFID.

Why integrated and linked responses are vital to combating HIV/AIDS and poor SRH&R

continued

and anaemia. They need specialist care for obstetric emergencies, interventions to prevent MTCT and infant feeding counselling. In addition, women living with HIV/AIDS need comprehensive SRH services. HIV positive women are at increased risk of cervical and other reproductive tract cancers and need high-quality screening services. They also need advice about suitable contraceptive options, dual protection, and access to safe abortion and post-abortion care.

People prefer integrated services

It is confusing, costly and time-consuming for people to visit different facilities for HIV, STI and other SRH information and care. This is especially true for poor people: where integrated services are not available many poor people cannot get the range of basic services they need. Forcing people to visit multiple facilities increases the risk that they will receive inconsistent information, change their minds or give up before receiving appropriate or necessary information and care. Confidentiality is also critically important when dealing with any SRH or HIV/AIDS related service; this is harder to ensure when people visit a number of facilities. Moreover, when several facilities are treating the same patient, there will be duplication of efforts and inefficient use of resources. The integrated delivery of a comprehensive package of care can reduce the costs of both accessing and providing services; improve client knowledge, confidence and satisfaction; and ensure better service quality.

Integration of services can improve HIV/AIDS and SRH outcomes

SRH services can contribute significantly to HIV prevention by providing all women, including HIV positive women, with family planning methods that protect against unintended pregnancy and STIs. This includes female-controlled methods

such as the female condom, and in the near future may also include microbicide products. Among high-risk groups such as sex workers, men who have sex with men and injecting drug users, HIV prevention will be more effective when the wider SRH&R of these groups and their partners and families are addressed. There is evidence, for example, that programmes that provide comprehensive SRH services to sex workers increase condom use amongst their clients.

Further, it is well evidenced that integrating STI prevention and family planning and maternal care services increases the use of condoms. This has the potential to reduce the adverse consequences of STIs including HIV/AIDS on pregnancy and to help promote safe delivery.

Integrated or linked HIV/AIDS and SRH services can expand access and reach a wider range of people

Large scale national interventions targeting the general population on sexual health-seeking behaviour, including sexuality education and young peoples' programmes, rights and stigma and discrimination programmes, health communications interventions, and national condom strategies, should align with appropriate dual purpose messaging on HIV/AIDS and SRH&R, in order to reduce confusion, duplication or friction, and maximise impact.

Much existing infrastructure for providing SRH information and services is well suited to provide HIV/AIDS services. SRH service providers are trained to deal with confidential issues related to sexuality, so are well placed to provide the essential sensitive information and care needed for HIV/AIDS. Parallel SRH service delivery networks are also often under utilised, especially in rural areas, and may thus have the capacity to offer a 'one-stop shop' of integrated SRH and HIV/AIDS services at the community and primary

health care levels, without unduly diverting resources from their traditional service mix.

Places where Youth Friendly SRH Services are available are ideal entry points for ensuring that comprehensive HIV/AIDS information and services are accessed by young people. SRH service providers have a history of working with young people and dealing with the difficult issues of controversy, stigma and discrimination, consent, confidentiality and access that accompany the sexuality and SRH&R of young people.

In many settings, women of reproductive age may not use HIV/AIDS specific services; this may be because of stigma, lack of access or information, censor by a family member or a perception that they are not vulnerable or at risk. However, where prevalence is high, SRH services can provide an acceptable entry point for HIV/AIDS services. Family planning and maternal care services offer opportunities to provide counselling on HIV risk reduction, HIV testing and MTCT interventions, as well as referral for HIV/AIDS treatment, care and support. Where HIV prevalence is low and HIV/AIDS is highly stigmatised, SRH services may provide more acceptable and more cost-effective settings for providing HIV/AIDS information and care than stand-alone HIV/AIDS services. The same is true for STI care which has traditionally focused on high-risk urban populations and especially on men. Providing STI screening and treatment through family planning and maternal care services could reach large numbers of women and improve detection and management of STI in pregnancy, thus reducing complications and maternal mortality. This must, however, be understood in the context of the need for separate provision for men and marginalised or vulnerable groups who will not be reached effectively, if at all, by family planning and maternal care services.

What has been done so far to integrate and link SRH and HIV/AIDS services?

Synergy between SRH and HIV/AIDS can:

- Improve access to and uptake of HIV/AIDS and SRH services
- Provide people living with HIV/AIDS with better access to appropriate SRH services
- Reduce HIV-related stigma and discrimination
- Improve coverage of SRH services in marginalised and vulnerable populations
- Increase dual protection against unintended pregnancy and HIV and other STIs
- Improve motivation of service providers, and quality of care
- Enhance effectiveness and efficiency of programmes.

Source: SRH and HIV/AIDS: A framework for priority linkages. WHO et al. 2005

Integrating or linking HIV/AIDS with SRH services

Efforts have focused primarily on integrating HIV prevention, STI prevention, diagnosis and management, voluntary counselling and testing (VCT) and MTCT interventions into family planning and maternal care services.

- WHO is finalising a review of evidence related to integrating sexual health into existing reproductive health services for women, men and young people.
- USAID is working with its implementing partners on approaches to integrating HIV/AIDS services with family planning services.
- IPPF is testing integration of HIV/AIDS prevention and treatment into SRH services. For example: in Kenya, the national family planning association is providing VCT, MTCT, prevention, and antiretroviral treatment (ART) services. Reports show that this has reduced stigma associated with HIV-related

services and increased the use of all services.

- SRH agencies such as Action Canada for Population and Development and Interact Worldwide are committed to integration and linkage across their policy and programmes work.

Integrating or linking SRH services with HIV/AIDS services

Few stand-alone VCT, MTCT and ART services address the SRH needs of men, women and young people at risk of HIV, or the family planning and maternal care needs of HIV positive women. Thus documented experiences of integrating or linking SRH with HIV/AIDS services is limited, but national-level efforts in some countries could be a model for further action. In Kenya, for example, family planning is included in VCT guidelines, and the country is integrating family planning services into all counselling and testing centres. Similarly, in Uganda, the national VCT policy encourages providers to assess clients' needs for other services such as family planning, and existing MTCT policies are being revised to strengthen the family planning component. In addition:

- HIV/AIDS agencies such as the International HIV/AIDS Alliance are committed to integration and linkage in their policy and programmes work.
- Positive organisations and groups are advocating on the SRH&R of their members, including young people.
- Interact Worldwide is committed to integration and linkage in its policy and programmes work. For example: the Interact Worldwide programme in Ethiopia funded by the EC is working with eight diverse national HIV/AIDS, reproductive health and community development NGOs, to advance integrated and linked approaches to HIV/AIDS and SRH&R for young people.

Integrating services for specific population groups

Vulnerable groups such as sex workers, men who have sex with men and injecting drug users, can face significant barriers to accessing health services at all; innovative and specific participatory, advocacy and community empowerment approaches are therefore required. To date, most programmes targeting vulnerable groups have focused on HIV prevention and have not addressed their wider SRH needs and rights. This has been recognised as an important issue and a number of approaches have been piloted, for example: providing integrated HIV/AIDS and SRH services in targeted interventions with sex workers or injecting drug users and their families.

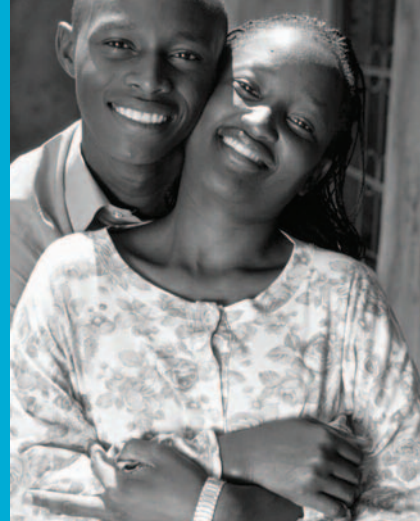
There is growing consensus on the need for specific provision of comprehensive HIV/AIDS and SRH services for men and for young people who are not well served by traditional family planning and maternal care services. To date, most attention has focused on synergy in young people's programming; in integrated counselling about dual protection, prevention of HIV and unintended pregnancy, and STI screening and treatment. Some Youth Friendly SRH Services have begun to include VCT, MTCT, ART and treatment of opportunistic infections in young people living with HIV/AIDS. In Ethiopia, Interact's partner Mekdim, which is an association of people living with HIV/AIDS and orphans and vulnerable children, has recognised need in this area:

"At Mekdim we are focusing more on integrating reproductive health and the needs of young people, especially orphans and vulnerable children. This is in response to a need within our membership and their communities. SRH is even more of a priority for positive people with the availability of ART. Our young people are agents of change."

Moges Adane, Programme Manager, Mekdim, 2006.

CASE STUDY 3: SOUTH AFRICA

Introducing the female condom into national family planning services increased acceptability and uptake



South Africa is one of the few countries in the world where the national family planning programme has played a central role in introducing the female condom. Preliminary findings suggest that promoting the female condom through family planning services has resulted in substantial uptake and sustained use, and that South Africans view the female condom as an acceptable barrier method.

The female condom was piloted initially through government family planning clinics and Planned Parenthood Association of South Africa community sites, as part of the Department of Health National Introduction of the Female Condom and Emergency Contraceptive Pills Programme. Family Health International provided technical support. The pilot programmes included training for providers, demonstration models and information leaflets, and quality assurance, supervision and record-keeping support.

Preliminary data from the first 18 months show that around 80 per cent of people who chose the female condom were also using hormonal contraceptives. This indicates a desire for dual protection. Most of the people who chose the female condom said that they used it to protect themselves from HIV and other STIs. It was found that the female condom served to complement, rather than substitute for, the male condom. A significant proportion of women also reported using male condoms, but said that the female condom allowed them to protect themselves in situations where men could not be persuaded to use a male condom. Family planning providers saw the female condom as an important addition to the range of contraceptives available, giving women more choice and a method that protects from both pregnancy and STI. The most significant barrier to integrating the female condom into clinic activities was identified as a lack of time to provide counselling on dual protection and on how to use the female condom.

Sixty-five per cent of women who participated in in-depth interviews said that it was easier to persuade their partners to use the female condom than the male condom, primarily because it represented a transfer of responsibility from the man to the woman. Only 3 per cent of men refused, while 88 per cent of women said that they were more frequently using protection since the female condom had become available.

The success of the pilot programmes is attributed to phased introduction, comprehensive training of providers, reliable supplies, and a national barrier methods task force that includes government and NGO stakeholders. The programme will be expanded to cover more than 450 sites by the end of 2006, and a study evaluating the effect of female condom distribution on the use of dual protection is currently being finalised.

Mags Beksinska, Jenni Smit, Reproductive Health and HIV Research Unit, University of Witwatersrand. May 2006.

The success of the pilot programmes is attributed to phased introduction, comprehensive training of providers, reliable supplies, and a national barrier methods task force that includes government and NGO stakeholders.

Barriers to integrating and linking HIV/AIDS and SRH&R

Before the benefits of synergy between responses to HIV/AIDS and SRH&R can be fully realised, some issues must be addressed and barriers to integration and linkage overcome.

Define a common terminology

Some organisations and frameworks refer to 'synergy', and others refer to 'integration', 'linkages' or 'mainstreaming'. These words are often used interchangeably, although they mean different things to different organisations. While language may seem a minor element, it plays an important role in defining action.

Strengthen global policy and leadership

Until the June 2006 UN General Assembly political declaration³ on HIV/AIDS, global policies and development frameworks had not encouraged synergy between HIV/AIDS and SRH&R. For example: the MDG compact separates HIV/AIDS from SRH&R. Within the UN system, responsibility for SRH&R and HIV/AIDS is shared across different agencies, and leadership on synergy has been weak. Equally, the large bilateral donors in the sector have not used their influence to take meaningful action on integration and linkage. This has hampered progress at global and national levels. In addition, HIV/AIDS and SRH actors often have different priorities and perspectives and this has contributed to failure to agree a common platform and advocacy agenda.

Increase the quantity and effectiveness of investment in HIV/AIDS and SRH&R

Donor funding for HIV/AIDS has increased significantly, and is highly identifiable due to its 'vertical' or 'stand alone' nature, but the effectiveness of some investments is open to question. The US, for example, is the largest donor to HIV/AIDS programmes in many African countries, yet the use of PEPFAR money is restricted and prevents effective, comprehensive programmes, especially in relation to HIV prevention and SRH&R. There is also concern that

resources required to support universal access to treatment by 2010 will not be forthcoming from donor or Southern governments. On the other hand, funding for SRH&R has declined in recent years, although it's hard to track as SRH is often embedded in support to the health system as a whole. The shift from programme funding to budget support and Sector-Wide Approaches (SWAp) could have adverse implications for SRH in countries where it is not prioritised in national health plans.

Enhance links between funding mechanisms for HIV/AIDS and SRH

Despite statements in support of synergy, donor action often reinforces the separation of HIV/AIDS and SRH&R efforts. Programmes are funded separately, and few donors allocate resources to support integrated approaches. Within donor agencies, HIV/AIDS and SRH&R usually sit with different country advisors, different policy teams, and different budget lines. The Global Fund, a significant source of HIV/AIDS financing, does not adequately promote synergy with SRH&R, and SRH&R organisations have had little representation on Global Fund Country Coordinating Mechanisms. Consequently, activities are not appropriately integrated and linked and large donors to the Fund, such as the UK and the US, have not yet prioritised advocacy on this issue.

Strengthen national policies and laws

National development frameworks, such as Poverty Reduction Strategies, rarely mention the synergy between HIV/AIDS and SRH&R. References to SRH&R in national HIV/AIDS policies and plans are generally confined to STIs and prevention of MTCT. Equally, reference to HIV/AIDS in national SRH policies is often limited to condoms, young people's SRH and MTCT. Crucial linkage areas

such as the SRH&R of HIV positive people, and the promotion of condoms for dual protection, are often omitted by both sets of policies. Laws on issues such as gender-based violence and inheritance rights that have implications for both HIV/AIDS and SRH are often weak, inequitable or poorly enforced.

Regulations on partner and parental permission and on mandatory and opt-out testing often limit access to services for specific populations, such as married and unmarried women, and young people.

Enhance linkage of institutional structures and programmes in HIV/AIDS and SRH&R

An autonomous HIV/AIDS coordinating body is accepted best practice under the 'three ones' approach, and reflects the need for harmonised, nationally led multi-sectoral responses. However, in many cases, the coordinating body can find itself in uneasy relationship with other mechanisms designed to enhance harmonisation and alignment, including health SWAp. SRH plans are integral to health sector plans and consequently separately coordinated and financed from the national response to HIV/AIDS. Coordination between these structures is challenging and HIV/AIDS policies, guidelines, training curricula, logistics and monitoring systems, for example, may be developed completely separately to those used in SRH. Separate institutional structures reinforce vertical programming and the lack of effective mechanisms for integration, collaboration and consultation can be a significant barrier to realising synergy between HIV/AIDS and SRH&R. National separation of institutions and financing is often mirrored at District level by separate and poorly coordinated HIV/AIDS Committees →p14

³ http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf

Despite statements in support of a synergy, donor action often reinforces the separation of HIV/AIDS and SRH&R

CASE STUDY 4: PAKISTAN

Parallel 'communities': barriers to linking SRH and HIV/AIDS

The London School of Hygiene and Tropical Medicine carried out policy research as part of the Interact Worldwide supported partnership programme entitled 'Building Up Rights Based Approaches to HIV/AIDS in Pakistan (Tameer)'.

The research identified some of the barriers to integrating HIV/AIDS and reproductive health, and potential opportunities for individuals and organisations involved in reproductive health to increase their contribution to the HIV/AIDS response⁴. The findings from this research are highly relevant to the global efforts to bring together HIV/AIDS and SRH services.

Findings

The research showed little integration between HIV/AIDS and reproductive health, either in policy documents or programmatic goals at programme or service-delivery levels. A central issue was the existence of largely separate, compartmentalised HIV/AIDS and reproductive health communities that identify with separate target populations and have different policy goals. Productive links between these two communities has been given very little policy attention whilst efforts to support strengthened engagement have been constrained by the following factors:

Contextual barriers to integration in HIV/AIDS and reproductive health networks

For the reproductive health community:

- Among reproductive health clients, there are few cases of HIV/AIDS and there is limited client demand for HIV/AIDS or STI services.
- The reproductive health community has a public health/medical approach rather than a positive sexuality and rights-based (SRH) approach. The latter is more suitable to complex issues surrounding HIV/AIDS.
- Existing service outlets are positioned for the general population, not key groups that are vulnerable to HIV/AIDS.

- There is a lack of HIV/AIDS expertise.

For those working on HIV/AIDS:

- Generally narrow, donor-driven projects that focus on condoms and safe injecting.
- Their experience as NGOs is in raising awareness, not service delivery.
- There is a limited concept of and expertise in reproductive health.
- There is an existing identification with urology or dermatology in terms of building links, as opposed to with reproductive health.
- There is a dynamic of isolation: there is resistance to seeking health care for HIV/AIDS clients, which further distances the HIV/AIDS community from the non-HIV/AIDS community.

Barriers related to the people and organisations (actors) involved:

The two sub-sectors have different actors:

- Different target groups.
- Different organisations that serve them.
- Different government actors and structures.
- Largely different donors and experts.

The reproductive health and HIV/AIDS communities have different perspectives:

- There is a lack of conceptual understanding of reproductive health in the HIV/AIDS community.
- In the reproductive health community, there is a perception of HIV/AIDS as a donor agenda that reduces support for reproductive health.
- Lack of bedding-in of the HIV/AIDS agenda in the government and non-government sectors with entrenched negative attitudes to groups especially vulnerable to HIV/AIDS.

Different NGO circles:

- Existing NGO networks are divided by issue (i.e. HIV/AIDS, drug use, reproductive health).
- There is a lack of mutual trust.
- There are differences in the size and

experience of HIV/AIDS and reproductive health NGOs, with the former mostly small and focused on specific vulnerable groups and the latter often larger and longer established.

Process-related barriers:

- Recently there has been policy profiling of HIV/AIDS rather than incremental recognition of reproductive health issues over time.
- There is a vertical response to HIV/AIDS, while the reproductive health field takes a more systems-oriented approach.
- HIV/AIDS is identified as an independent issue, separate from the reproductive health spectrum.
- There is an epidemiological approach to HIV/AIDS and a more holistic approach to reproductive health.

While there has been little change in the last two years at policy level, there has been some tangible increase in the participation of reproductive health NGOs in the HIV/AIDS response. And while few of the 350 NGOs involved in HIV/AIDS are from the reproductive health sector, there has been a change in the nature of involvement of those that are. Some reproductive health NGOs are now providing tailored HIV/AIDS services for key vulnerable groups, rather than just providing general HIV/AIDS information in reproductive health settings. This is a result of competitive outsourcing of HIV/AIDS prevention activities by the National and Provincial AIDS Control Programmes for which some reproductive health NGOs have had comparative advantage in terms of scale and management capacity.

Mobilising factors for reproductive health NGOs towards HIV/AIDS:

- Experience of reproductive health NGOs in working with young people.
- Experience of reproductive health NGOs in condom programming.
- Use of the reproductive health



community's research resources by government and donors for HIV/AIDS-related research.

- Increasing policy profiling for HIV/AIDS and increasing pressure from global partners and donors to include HIV/AIDS.
- Increased in-country resources for HIV/AIDS.
- Vacuum of specialist HIV/AIDS NGOs with the capacity to work at scale.
- Economies of scale in the more established reproductive health NGO community, with its operations infrastructure taking on new areas of work.

Potential opportunities and benefits:

- Programme management experience and trained human resources and operations infrastructure can provide absorptive capacity for the new HIV/AIDS competencies that are required.
- Capacity to negotiate government contracts.
- Experience with development and

support of community-based organisations (CBOs); potential for more extensive and meaningful partnering relationships with smaller HIV/AIDS NGOs and CBOs.

- Less stigmatisation of HIV/AIDS leads to greater normalisation of services.
- Greater leverage for access to health services for key vulnerable groups.
- Greater leverage at policy level.

Potential pitfalls:

- The lack of internalisation of the wider SRH agenda among the reproductive health community creates the potential for reduced interest in HIV/AIDS. This could lead to downscaling of funding, compartmentalisation instead of integration of HIV/AIDS, and an inadequate focus on sexual rights and the empowerment of key vulnerable groups, in favour of a medical/public health intervention.
- There is a potential for positioning services for populations at relatively low risk, and failing to

ensure adequate access for key vulnerable groups.

Shehla Zaidi and Susannah Mayhew, London School of Hygiene and Tropical Medicine, 2006.

The programme 'Building Up Rights Based Approaches to HIV/AIDS in Pakistan (Tameer)' is executed by Interact Worldwide. Implementing partners include: Pakistan National AIDS Consortium and its constituent Provincial Consortia, Shirkat Gah, the Dutch Royal Tropical Institute (KIT) and the London School of Hygiene and Tropical Medicine. The programme is funded by the European Commission, DFID and Interact Worldwide.

⁴ This research was part of a larger, in-depth, policy study of the HIV prevention scenario in Pakistan, conducted between 2004 and 2005 under the programme (forthcoming). In-depth interviews of NGOs, donors, government and experts and review of documents for the larger study have been used to inform this analysis.

Breaking down barriers to linking HIV/AIDS and SRH continued

and Health Management Teams, and a mix of integrated and vertical financing, logistics and systems. In both donors and national institutions there can be little incentive to coordinate policies, planning and programmes in some quarters.

Develop guidance and evidence to support complementary planning

Identifying when and where synergy makes sense depends on the local context, including the situation with regard to HIV/AIDS and SRH&R and the structure and organisation of health and related services. Currently there is a lack of clear guidance to assist countries in developing context-specific policies, plans and budgets which seek to maximise effective integration and linkage appropriately across the health system, between its different levels and in relation to the national response to HIV/AIDS. Likewise, there is currently limited evidence or guidance about the feasibility or relative effectiveness of different approaches to integrating and linking HIV/AIDS and SRH services and likely impacts upon access, uptake and quality of care. This evidence is essential for determining priorities and making decisions about the best use of available resources, and for ensuring that the necessary resources and support can be secured.

Strengthen health systems

In countries where health service management has been decentralised, weak District planning, logistics and monitoring capacity contributes to the lack of effective integration and linkage at service delivery level. Better resourced basic SRH services, including family planning, maternal and gynaecological care, STI services, staff, space, equipment and essential SRH commodities, would revolutionise capacity to provide comprehensive integrated services and to integrate HIV/AIDS services into routine care.

Train managers and providers to be able to provide integrated or linked services

Management of integrated and linked services is more complex than managing

vertical programmes, and consequently training and supervision is required. Unfortunately, many countries have severe human resource constraints in the health sector, and do not have enough appropriately skilled health providers and managers to ensure minimally adequate coverage. Some health workers are therefore understandably concerned that introducing a wider range of services will reduce the quality of care that they can provide. Where these human resource constraints pertain, they need to be highly prioritised in overall plans and resources for health. In addition, judgmental attitudes and discriminatory practice towards sexually active unmarried women, young people, men who have sex with men and people living with HIV/AIDS, as well as negative personal views amongst health workers about condoms, which can mitigate against effective, integrated service delivery, need to be addressed in training and monitoring.

Challenge opposition to SRH&R

Religious and political opposition to SRH&R has reduced SRH funding and programming and the scope for providing comprehensive, integrated services. The influx of PEPFAR money, whilst supporting critical scale up of VCT and ART, has had a significant distorting effect on structural coherence and best practice in the response, especially in relation to established and evidence based strategies for HIV prevention and vulnerability reduction. The US committed the largest share of HIV/AIDS funding in 2004 (\$1.6 billion; 45 %), and it looks likely that this will remain the case to 2010⁵. This money is accompanied by legislation and policies restricting its use in comprehensive prevention programmes. This includes: abstinence-only earmarking of funds; restrictions to comprehensive SRH&R work with young people; restrictions on condom promotion outside of high risk populations; and conditions placed on grantees who wish to respond to the

needs of sex workers. Conservatism at the country level, whether cultural, religious, or political, compounds this situation and needs to be addressed through participatory advocacy and alternative financing, in order to stem further erosion of development gains in HIV/AIDS and SRH&R.

Build capacity of NGOs and the private sector

NGOs, faith-based organisations and the private sector make an important contribution, but for a variety of reasons they may not integrate or link HIV/AIDS and SRH&R information and services effectively. There is high demand amongst these providers for support to building their roles in providing more comprehensive and higher quality HIV/AIDS and SRH&R information, counselling and services.

Harmonise monitoring and evaluation where appropriate

Indicators used by SRH&R programmes do not measure HIV/AIDS outcomes. Similarly, indicators used by many HIV/AIDS programmes emphasise coverage rather than impact and few consider impact on SRH outcomes. The only indicators linked to SRH in national HIV/AIDS monitoring and evaluation frameworks are the number of delivery points for MTCT and condom use. Additionally, there are no commonly agreed indicators to monitor and evaluate integration and linkage. Measuring the process and outcomes of integrated programmes and services is more complex than measuring vertical programmes and requires a range of performance indicators, including qualitative indicators which address the demand side. Approaches also need to be developed to monitor possible adverse effects, for example, the risk that inappropriate integration of HIV testing into antenatal care may reduce uptake of these services.

⁵ 'Financing the response to HIV/AIDS in low and middle income countries' July 2005, J.KATES, Kaiser Family Foundation

Recent developments and opportunities to step up action

Growing awareness of the synergy between HIV/AIDS and SRH and of common barriers to progress has resulted in the establishment of new coalitions and partnerships.

Despite the existing barriers to linking HIV/AIDS and SRH efforts, there is growing recognition of the benefits of this approach; recent developments are setting the stage for increased support. The following section highlights key developments that are opening up opportunities to advance appropriate integration and linkage of these two intimately related development sub-sectors.

Recognition that synergy is critical to achieving international development and HIV/AIDS targets, such as the MDGs

At the 2005 Millennium Summit, world leaders reaffirmed the ICPD commitment to universal access to SRH information and services by 2015. This was based on the recognition that the MDGs aimed at reducing child mortality, improving maternal health, combating HIV/AIDS and achieving gender equality will not be attained without improvements in SRH. The ICPD commitment is now to be included as a target in MDG 5.

Increased international commitment to strengthening synergy

The need to strengthen synergy between HIV/AIDS and SRH policies, programmes and services is reflected in the 2004 Glion Call to Action on Family Planning and HIV/AIDS in Women and Children. This statement focuses on the linkages between family planning and MTCT. The 2004 New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health also highlights the public health rationale for integration. It calls for greater attention to SRH within development assistance frameworks and instruments. The UNAIDS 2005 policy position paper 'Intensifying HIV Prevention', builds on the Glion and New York statements, and calls for stronger programme linkages

between HIV/AIDS and SRH. The 2006 UNGASS HIV/AIDS political declaration also firmly declared that the target of universal access to comprehensive prevention, treatment, care and support cannot be met without strengthening policy and programme linkages and coordination between HIV/AIDS, SRH, national development plans and strategies. Further, governments committed to expanding to the greatest extent possible, supported by international cooperation and partnership, their capacity to deliver comprehensive HIV/AIDS programmes in ways that strengthen existing national health and social systems, including by integrating HIV/AIDS intervention into programmes for primary health care, mother and child health, sexual and reproductive health, tuberculosis, hepatitis C and sexually transmitted infections.

Development of supporting frameworks and guidelines

Efforts to develop frameworks and guidelines to support integration and linkage have been stepped up. For example, WHO, UNFPA, UNAIDS and IPPF have produced a framework that identifies priority areas for links that could lead to significant public health benefits, and an inventory of available resources and guidance.

New coalitions and partnerships

Growing awareness of synergy between HIV/AIDS and SRH and of common barriers to progress has resulted in the establishment of new coalitions and partnerships. International agencies, donors and governments have established inter-departmental working groups and task forces, and non state actors in civil society and academics have begun to collaborate across traditional thematic and disciplinary boundaries such as health and human rights.


Call to action

This briefing paper is an appeal to strengthen the global response to HIV/AIDS and improve sexual and reproductive health and rights, by taking systematic action to maximise synergy in response to these intimately linked issues.

Interact Worldwide calls on governments, international agencies, donors and NGOs to commit publicly to appropriate integration and linkage of HIV/AIDS policies, programmes and services with those of SRH&R in order to reduce poverty, accelerate progress towards the Millennium Development Goals (MDGs), and increase the resource effectiveness of large global investments dedicated to the fight against HIV/AIDS.


Interact Worldwide calls on key actors to:

- Key
-  Southern governments

 International agencies

 Donors




















 NGOs

 Research institutions





















Action

Actors

1. Increase global commitment and momentum in accelerating progress towards the health MDGs and increasing effective use of resources through appropriately integrated and linked responses to HIV/AIDS and SRH&R, aligned within national frameworks.

Strengthen global leadership and coordination.	 
Ensure that investments in SRH&R have mainstreamed HIV/AIDS, and that investments in HIV/AIDS are appraised for appropriate inclusion of SRH&R.	   
Encourage national and international agencies to track funding allocations to SRH&R and to use their findings to mobilise resources.	   
Advocate for increased investment in integrated and linked HIV/AIDS and SRH&R programming, including strengthening the capacity of SRH providers to deliver HIV/AIDS interventions, and of HIV/AIDS programmes and services to address the SRH&R of people living with HIV/AIDS, marginalised vulnerable groups and young people.	 
Increase awareness among national policy makers of the contribution of improved SRH&R to addressing HIV/AIDS and meeting the health MDGs, and advocate for appropriate integration and linkage.	 
Advocate / support research and development in to Microbicides.	    

2. Strengthen the evidence base which demonstrates the benefits of appropriately integrating and linking responses to HIV/AIDS and SRH&R in terms of stigma reduction, access to services, commodities and medicines, health equity, and outcomes amongst poor, marginalised and vulnerable people.

Support / develop models for appropriate integration and linkage in programmes, development communications and services, and identify process and impact indicators for evaluating their effectiveness.	    
Support / conduct more evaluative research to identify: feasible, effective and cost-effective approaches to integration in specific epidemiological and health system contexts; how basic packages of information and services should be provided in different contexts for different client groups through different levels of the system.	    
Support / conduct research to improve understanding of factors that influence sexual and reproductive behaviour by vulnerable groups, HIV positive women and men, and young people.	    
Strengthen the evidence base for comprehensive approaches to HIV/AIDS and SRH in support of the challenge to religious and political opposition to sexual and reproductive rights and rights to health.	    

3. Use existing mechanisms to maximise synergy and oppose / reduce institutional and financing barriers, especially those rooted in or supported by vertical aid architecture and conditionality.

Use UN and donor HIV/AIDS harmonisation and funding mechanisms, including GFATM, to increase dialogue and coordination among multilateral and bilateral agencies working in HIV/AIDS and SRH&R.



Promote dialogue and collaboration on human rights, policy development, planning, technical approaches and implementation between national bodies responsible for delivery of HIV/AIDS and SRH&R programmes, development communications and services.



Encourage donors to support allocation of adequate resources within global funding mechanisms, national HIV/AIDS strategic plans, budget support and health / other sectoral plans, as well as within their own strategies, to ensuring comprehensive integrated and linked responses.



Identify, prioritise and meet funding and technical resource gaps in sexual and reproductive rights and health rights of marginalised and vulnerable groups.



Advocate for NGO financing mechanisms to fund integrated HIV/AIDS and SRH&R programming and services, and to support collaboration between HIV/AIDS and SRH&R organisations.



Encourage commodity security committees to take integrated systems approaches to policy, planning and programming, including procurement and distribution, in order to strengthen HIV/AIDS and SRH services.



4. Establish a Global Task Force which will review legislation, policy, regulation and practice that prevents appropriate integration and linkage between HIV/AIDS and SRH&R, or which reduces access to HIV/AIDS and SRH&R information, services, commodities and medicines, especially amongst vulnerable groups such as poor women, young people, HIV positive people and marginalised groups such as migrants, sex workers, men who have sex with men and injecting drug users.

Advocate for / support a stronger emphasis on SRH&R information and services in national HIV/AIDS policies and guidelines, and on HIV/AIDS information and services in national SRH policies and guidelines; provide appropriate policy guidance and support for collaboration between stakeholders.



Ensure that all key stakeholders are engaged in policy development and revision; enlist champions to advocate for a more integrated approach to SRH&R and HIV/AIDS.



Advocate for / support legislation to protect the SRH&R of women, young people, people living with HIV/AIDS and marginalised groups such as migrants, sex workers, men who have sex with men and injecting drug users, and for implementation of existing anti-discrimination laws.



Advocate for / support the development of policies on provision of integrated youth-friendly SRH&R and HIV/AIDS services and comprehensive services for marginalised and vulnerable groups.



Advocate for / support the development of evidence-based policies on SRH&R of HIV positive women, men and young people.



Advocate for / support the development of policies that systematically promote dual protection in family planning and HIV prevention programmes and reduce stigma attached to male and female condom use.






Advocate for reform of laws, policies and regulations that limit provision of comprehensive SRH&R and HIV/AIDS information, services and commodities, or that prevent specific population groups from accessing them, including donor conditionalities and prohibitive official and unofficial fee charging in the health system.



Advocate for policies that empower women and girls to access services and commodities, and that address gender inequity and gender-based violence.



Call to action continued

Action	Actors
5. Strengthen capacity for planning, implementation, monitoring and evaluation of appropriately integrated and linked responses to HIV/AIDS and SRH&R which are equitable and accessible.	
Clarify terminology and promote common understanding of mainstreaming, synergy, integration and linkage.	    
Support efforts to strengthen health systems, including decentralisation, planning, logistics, transport, strategic health communications and referral.	  
Support efforts to strengthen human resources, including review of roles, responsibilities, training, support and supervision of different cadres of health worker.	  
Provide guidance on planning integrated and linked services, including for people living with HIV/AIDS, marginalised and vulnerable groups, young people and men.	   
Develop practical tools to support implementation, monitoring and evaluation.	    
Ensure adequate and reliable supplies and commodities for HIV/AIDS and SRH.	  
Provide District managers in decentralised health systems with technical support to plan and implement integrated HIV/AIDS and SRH services that address local priorities.	  
Build the capacity of NGOs, including religious and community organisations, to deliver integrated and linked services through grant-making, training and technical assistance, and provide training for private sector providers of HIV/AIDS and SRH services.	  
6. Promote partnership and inter-sectoral collaboration and exchange between actors in HIV/AIDS and SRH&R.	
Increase coordination and collaboration between HIV/AIDS and SRH&R programmes and services, for example, through joint planning and staff allocation and joint development communications.	 
Support partnerships and referral between public sector, NGO, religious and private sector health service providers, in integrated District health systems.	   
Promote collaboration between community programmes, for example, HIV/AIDS home based care (HBC) and family planning programmes. Train HBC workers to provide SRH information and referrals, and train community-based family planning distributors and traditional birth attendants to promote condom use and refer clients to HIV/AIDS services.	   
Improve networking and linkages between HIV/AIDS and SRH&R NGOs.	  
Engage civil society in advocating for the SRH needs and rights of people living with HIV/AIDS, young people and vulnerable groups, and for action to tackle stigma and discrimination.	 
Build the capacity of NGOs that are represented on health sector and HIV/AIDS committees to advocate for integration and linkage; build the capacity of HIV/AIDS and SRH&R NGOs in HIV/AIDS and SRH&R policy and advocacy.	 

To sign up to support this call to action go to www.interactworldwide.org



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Interact Worldwide is an international Sexual and Reproductive Health and Rights (SRH&R) and HIV/AIDS non-governmental organisation with over 30 years' experience in supporting information, services and advocacy with civil society organisations and the most marginalised communities in Africa, Asia and Latin America.

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