

**Integration of HIV/AIDS and Sexual and Reproductive Health,  
Finding Common Ground: Risk or Reality?  
XVI International AIDS Conference  
August 16, 2006**

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**ISABELLE DE ZOYSA:** Good afternoon. Wow, it works - and welcome to this session, which is titled "Integration of HIV/AIDS and Sexual and Reproductive Health: Finding Common Ground" and subtitled "Risk or Reality." This session is part of the controversy and common ground stream of the conference but with the hope that it's more about common ground, this one, than about controversy, which some of the other sessions have been on so I think one of the themes of the session that we're going to have is finding the common ground between HIV/AIDS and sexual and reproductive health communities and concerns, which in the session just before this one where described by one participant from India as almost in separate worlds and unfortunately, that is often the case but we're going to work towards finding the common elements.

I'm just going to say a couple of words about one of the key common elements, which I think is - can be said in just one word with very few letters - sex - s-e-x, sex, sex, sex - we don't say it often enough in this conference. Recognizing that sex is at the core of any work around sexual and reproductive health and rights and is still as noted in one paper that was distributed this morning, a concern for the HIV/AIDS community, "AIDS is Still About Sex" - is the title of this particular newsletter from the Caucus of Evidence-Based Prevention recognizing that globally, the transmission of HIV

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is primarily through sexual roots and even where the roots of transmission are primarily other as in places where injecting drug use may be the dominant mode of transmission, sex is still a concern drug users also have sex and even where we're talking about other issues around care and treatment, sex is still a concern. That came out in the other session as well - do people living with HIV have sex? Well yes, they do. They do and they have sexual rights and they have a need for sexual and reproductive health services. The other common ground area is the - some of the root causes of both sexual and reproductive health and HIV/AIDS, which - things to do with poverty, gender inequality, things to do with social marginalization of people who are most vulnerable to HIV and so there's a lot to learn from each other, those of us who sort of ascribe our sort of belonging more to one or other community and so in this session, we've got some distinguished persons who have been working this area for quite a while, many, many years for most of them and who are going to be talking about some of the issues that come about in working towards the building, developing, the linkages between sexual and reproductive health programs and HIV/AIDS programs seeking to be concrete and practical, looking at what the experiences on the ground from which we can learn, which we can try and develop, and expand and work on in different settings. We're going to talk about some of the actions that need to be taken at the policy level,

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at the program level, and at the service delivery level.

We're supposed to have 5 participants in this session. There's still 1 who is missing. The gender balance is not good. The person who's missing is male so that might help. I hope they'll turn up but let me call then the first speaker, the order's a little bit different from what you've got in your program. We're going to have Dorothy Odhiambo first, followed by Nono Simelela, and then Javier Bellaug [misspelled?] from the HIV/AIDS Alliance, who's not here. Anybody who sees him, please let us know, Lynn Collins, and then Naomi Rutenberg - just to be sure you know what the order is.

So let me introduce Dorothy Odhiambo, who is probably well known to a number of you. She currently works with the International Federation for the Red Cross Regional Office in Nairobi. She's a teacher by profession and an advocate for the rights of persons living with HIV and AIDS and she's been actively engaged in AIDS activism for the past 10 years. She's passionate, I think, and that's true to say very passionate about the sexual and reproductive health rights and needs of positive people. She's a technical advisor to several networks of her persons living with HIV/AIDS and associations of persons living with HIV/AIDS in Kenya.

Dorothy, would you like to come to the podium?

**DOROTHY ODHIAMBO:** Thank you very much for that

elaborate introduction. My presentation is going to take a

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slightly different approach in that I'm going to use a story line to highlight the sexual and reproductive health needs of people living with HIV and AIDS and it's my expectation that this story line will set the pace for the discussions that will follow. My story line is basically bent [misspelled?] around the typical dilemma faced by people living with HIV and AIDS, concerning their fertility desires and sexual and reproductive health rights and needs. As persons living with HIV and AIDS, we need to affirm and strongly so that we are still alive and each living being has a right to some level of comfort, compassion, and love. Due to our HIV status, we have been condemned more often than not to a life of solitude, loneliness, and by which selection, makes it very difficult for us to live healthy and comfortable lives with HIV or AIDS. Our fertility desires including our sexual/reproductive health needs are always assumed, sometimes misconstrued or outrightly misinterpreted depending on the context in which the conversation around these issues is taking place.

As persons living with HIV and AIDS, we do have sexual and reproductive health needs and rights. We do have fertility desires that should normally be taken into consideration whether at policy level, in program designs, and in service provision especially those services that target or portends [misspelled?] to target people living with HIV and AIDS. The interesting question that normally arises has always been when

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- when they are HIV positive, what needs, why sexual and fertility desires and yet they are already living with the virus? If they had any needs as I want to presume they are and if you want to believe they're part and parcel of the rights of persons living with HIV and AIDS then they must be met and in the comprehensive manner that fulfills the entire continuum of care and needs for people both men and women living with HIV. How and when we can demand these rights and services is a question that we must address if you want to deliver.

Reports from people living with HIV and AIDS affirm that their sexual desires and needs are hardly taken into consideration by service providers. Sexual reproductive health and HIV and AIDS programs and services have often failed to take into consideration the unique needs and desires of people living with HIV and AIDS. A lot of focus has been previously placed and is still being placed on issues of maternal health especially issues around the prevention of mother to child transmission normally at the expense of the full range of sexual and reproductive health and needs of persons living with HIV and AIDS. It is difficult for me, sometimes, to even access - even as a person living with HIV and AIDS - the most basic things - access to condoms as normally it is construed that I'm not out [misspelled?] to infect other people by continuing to have sex and instead condom education, which we normally need, is always put aside. Instead of condom education and instead of

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being provided with information, people living with HIV and AIDS are normally castigated and condemned. Much of the counseling is to ensure that they stop being sexually active or even to those who are asymptomatic, the expectation that they are HIV positive and are supposed not to have sex has always taken a front line thoughts.

The big question is does HIV or AIDS make us less human than others? Besides access to treatment and to antiretroviral therapy and the drugs, we strongly believe that a positive mental outlook and enjoyment of life is an important factor in extending the lifespan of a person living with the virus. When we seek a safe, satisfactory, responsible, and a healthy sexual life, is that asking for too much? Can that be delivered against a context that is considerate and compassionate to the needs of persons living with HIV and AIDS? In order to fulfill or to express our sexual desires, we need information, we need education on safe and protective methods of having sex, yet service providers hardly think about such needs and they often concentrate their education either on abstinence or other methodologies and at best, education on condom use, which sometimes don't apply to women living in most parts of the world.

This approach, as we all know and as evidence, is now showing presents a dilemma to women because we know that they have very little control and they cannot even enforce when,

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how, and with whom to have sex. Many sexually active people living with HIV and AIDS need dual protection, yet service providers only think about the easiest way out and that is condoms and we know that condoms has had considerable failure rates in preventing pregnancy. Providers are likely to discuss contraceptives but very little information is given on the ones that are appropriate and right for people living with HIV and AIDS. We are all aware now that increased access to antiretrovirals has also led to improved quality of life of people living with HIV and AIDS resulting in a positive shift in their sexuality and fertility desires. However, we've noted that the majority of persons living with HIV and AIDS still have no access to antiretrovirals and even those who have access have to contend with antiretrovirals or treatment services that are [INAUDIBLE], noncomprehensive, and do not address fertility and sexual right health needs of people on treatment. This normally leaves persons living with HIV and AIDS in a dilemma. How can [INAUDIBLE] programs be comprehensive enough to start thinking about related issues especially those issues that touch on the sexual and reproductive health of persons living with HIV and AIDS? At what level and all points should national treatment programs consider sexual reproductive health needs of their clients? What are the benefits, if at all, is there in bringing these services to a one stop point? How and when do we insist, as

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people living with HIV and AIDS, that these services are made comprehensive enough for us not to shuttle from one point to the other looking for different services in 10 places at the same time - I mean on the same day because at the end of the day, I'm only one person, yet I'm expected to go to these different places for different services to ensure that I get all the care I need.

Is this practical? We've seen programs, for example, that make people living with HIV and AIDS and especially women, at point A - I go and pick up my antiretrovirals. At point B, I'm expected to go another distance to pick up my treatment for my opportunistic infections. At point C, I'm supposed to go and talk to a family planning service provider to see if there are services for me there. At point D, if I have a child, I have to look for services to ensure that my child is healthy and all these must take place in the same day. Surely, are we being fair when we have programs that make us shuttle like that? Many of us, sometimes, are made to withdraw from sex, sometimes not because of our diagnosis but simply because maybe you've lost a partner, you've lost your sexual desires, the fear of spreading disease and the fear of reinfection, or feeling of guilt due to the judgmental attitudes of service providers towards people living with HIV and AIDS. This makes it very difficult to pursue a safe and satisfying sexual life. Normally due to the [INAUDIBLE] nature of the programs, whether they are HIV and

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AIDS programs or they are sexual reproductive health programs and services, sexually transmitted diseases often go undiagnosed especially in people living with HIV and AIDS because it's presumed that they are not supposed to have sex and therefore, they are not supposed to be free from most of these infections, yet more often than not, we are supposed to grapple with some of these infections without much attention or much support. Now, look at the possible fertility desires, we are always discouraged against having children after diagnosis. For some reason being that we are likely to infect our offsprings. This is totally in disregard to the fact that we have very little, sometimes, very little control of our fertility and decisions whether to have children or not based always of the factors that come into play, for example, community and family pressures to get children despite one's status.

When such [misspelled?] pressures build up, women living with HIV and AIDS are often left alone to grapple with the dilemma and to make decisions with no prior information on how to prevent the transmission of the virus from mother to the child and current statistics are now showing that only 10-percent of these women especially in Sub Saharan Africa, are able to have the full knowledge and the access to ensure that they prevent transmission of the virus to their children. Where PMPCT programs have taken off, the cost is always prohibitive

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especially if there is no donor funding support and this normally shuts out many women who have the desires to have, to continue having children who are free from HIV and AIDS. Many of people living with HIV and AIDS have complained of inadequate information from service providers to enable them make informed decisions about their fertility.

The question is who do we turn to when service providers who are expected to address our needs are to provide the critical support that is needed by us [INAUDIBLE] nonjudgmental and have negative attitudes towards women living with HIV and AIDS who still desire to have children. Access to ARVs in some countries in Sub Saharan Africa is pegged on whether the woman agrees to be sterilized. This is a violation of human rights of women living with HIV and AIDS. Who do we turn to - to help us address those issues? How do you deal with service providers who insist that to access antiretrovirals or to be put on treatment, it must be after the woman is sterilized? More often than not, we are coerced into decisions and left with no option but to go with what service providers propose and what they think is best for us. On the other hand, termination of a planned pregnancy is considered illegal in so many countries. Access to safe and legal abortion is still a big issue for women living with HIV and AIDS. Emergency contraceptives is still out of reach of these women and yet, sometimes they require such services. Access to testing is

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another issue that we have to grapple with and in so many contexts in Africa, you'd find that many women in their reproductive age have no access to testing so they get pregnant and they learn about the pregnancy when they are already infected and that presents a dilemma.

Further, women living with HIV need information for safe contraceptives and information on how these contraceptives may react to other medications that they take, for example, antiretrovirals and other treatments for opportunistic infection. Looking at policy issues, we need and urgently as a priority, dialogue on how to develop and improve on policies at national level that are explicit on inclusion of sexual and reproductive health needs and rights of people living with HIV and AIDS and meaningful engagement of people living with HIV and AIDS is critical for national programs to have such policies. In conclusion, I would want to say that it's high time we start acting differently. We need committed leadership and ownership in facing the reality and adversity of our sexual and reproductive health needs. We need to close the gap between what we say and what we do. We need accountability and timelines, strict timelines from stakeholders and organizations on how, when, and from whom we demand and expect action on our sexual and reproductive health needs and this action, if at all it comes up, must include us. Thank you very much. [APPLAUSE]

**ISABELLE DE ZOYSA:** Thank you Dorothy for a very strong

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intervention. We thought it would be important to start with this part because it surely is the sexual and reproductive health needs of people living with HIV that is at the nexus of this effort to come together between these communities, these areas of work, and I think Dorothy has shown us very powerfully to what degree these needs, these rights are neglected, even denied and the demands that are made to take action to change that.

We're now going to have 2 presentations. The first that is going to focus on efforts to integrate HIV/AIDS work into existing sexual and reproductive health programs and services, which Nono will give. Nono Simelela and the second, which will focus on the converse and effort to integrate sexual and reproductive health services into HIV/AIDS programs and services.

So I have the pleasure in introducing Nono who is an obstetrician/gynecologist from South Africa. She's been working in the field of HIV/AIDS and sexual and reproductive health for many years. She is currently working in the International Planned Parenthood Federation based in London on linking sexual and reproductive health to HIV/AIDS programs. She wants me to say that she's a mother and I think all of us here feel strongly about the need to show our passion about this area, nor because it's something nebulous [misspelled?] out there but also because it's something that we feel in our very hearts, so

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Nono, please.

**NONO SIMELELA, MD:** Thank you very much Isabelle for the introduction. I'm just going to share with colleagues here and participants what we have done in IPPF to just bring to life this concept of integrating the services that are provided from SRH perspective, how we - as continuing to fight to integrate our services and try to provide comprehensive seamless care and this has been pointed out - this is just a few examples of what it can take and the fact that it's possible to actually do this. Within IPPF, a lot of people know that IPPF is predominantly a [misspelled?] fundamental SRH organization strongly focused on reproductive health issues, of commodities and adolescent sexual health and everything else that has to do with maternal and infant health, so that the introduction of a response to the HIV challenge is something that we are still grappling with. I think our recognition of the fact that access to treatment for HIV has meant that there is an increased demand for SRH services for people who are living with HIV and that is something that everybody is [INAUDIBLE] to respond to that even in the absence of HIV infection, women in developing countries are faced with cultural pressures, traditional pressures, to procreate and although we want to believe that such pressures don't exist anymore, we know that on a day to day basis, for women in Africa, this is a reality and outside of tradition and culture, there is an individual need to know

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whether or not you can have children and that when you do have that need, you can exercise that choice. Discordant relationships are a part of the fabric of our lives right now and in areas in countries where the epidemic is mature, the chances of being in a discordant relationships are very high. So we have to face that reality and deal with it in a manner that takes our responses forward. When you look at quotations like these, it really forces you, as a healthcare provider, as a policy maker, as an advocate for women's health, to respond to this challenge not by having dialogue but looking at what you can do on the ground and in collaboration with partners, likeminded organizations, we felt that it was time within IPPF to respond to these needs, to respond to the challenges. Given the limitations you can't have integration if you don't have money. People have spoken about that. So we needed to find ways in which we could be part of this discourse at an international level and see what we could do to get our donors interested in integration. So with our partners at WHO, UNFPA and UN AIDS, this framework was developed and as the framework took flesh and became something that was real, we looked at how we, within our programs in IPPF, could put a life and make this a reality. We knew that we had to respond to the fact that people living with HIV are not a homogeneous group. In this conference, we've heard about vulnerable populations, men who have sex with men, injecting drug users, sex workers, and all of these people have

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a right. All of us have a right however we want to identify ourselves and we needed to respond to that as an institution. We had to look at issues of introducing antiretrovirals into our programs and that did not come easy. It came at a cost but today, we look back and we feel proud of the fact that we were willing and we were ready and that there were a handful of people within IPPF who believed that this was the right thing to do and who were prepared to stand behind that belief. So we started programs in some of our member associations. I'll give you 2 examples of work that we are doing in Kenya and work that we are doing in Columbia addressing different aspects of this comprehensive, integrated approach to reproductive healthcare. In the Family Health Options Clinic in Nairobi, we did work with the healthcare providers and nonmember associations to see what we could do to introduce HIV care into our clinics, which are traditionally family planning clinics. We did a lot of work. We did stakeholder meetings. We did training for our healthcare providers. We negotiated with the Ministry of Nairobi to involve us and include us in the response to HIV in that country and to date, we've got a lot of clients who are coming to our facilities who are seeking care and we are happy that we can provide this comprehensive care. These are the numbers of clients that have come through, clients that have been provided volunteer counseling and testing. We did not recreate what was already there. We took the guidelines from

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the ministry, the protocols for testing and we just aligned what was in those protocols to the clients that we serve. So to date, we have got women who have come into our antenatal care services that have been provided [INAUDIBLE] and now on the PMPCT program and through our community distributors who traditionally distribute family planning commodities, we have trained those community providers to do HIV, IAC, BCC linking people with networks of provision and care within the community. We've got a number of clients who are on antiretrovirals and the number are small for us because clients who walk into our facilities don't necessarily qualify for antiretrovirals because they are usually healthy women who probably didn't know their status and therefore, did not meet the criteria according to WHO and the CDC for antiretroviral care but I'm happy to say that with the team of healthcare providers in Nairobi, some of whom are here today, we've managed to get the Minister of Health of Nairobi to agree to give our clinics antiretrovirals for free because we don't have the money within IPPF to procure antiretrovirals but we [INAUDIBLE] it now because we know we can refer our clients to the Ministry of Health facilities or they can come to our clinics in a seamless continuum, comprehensive context and get the care that they need. Our healthcare providers have been trained on pharmacovigilance. In fact, we've been asked to provide further training to some of the people who are working

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in the public health sector in the Nairobi - Catchmont  
[misspelled?] area on pharmacovigilence and we had to make that  
investment. It didn't come cheap for an institution that  
doesn't do traditional HIV care. So we have those numbers now  
and we are confident that our clients are getting comprehensive  
care because we know we are not the only providers and they can  
go to other facilities for care. Another example is our work  
that we have done in Columbia where we have pushed healthcare  
providers within IPPF to think laterally, to think outside the  
box. We're dealing with so-called vulnerable groups. We're  
providing care for men who are in homosocial environments, in  
the army, working in prisons, working in the air force that men  
who spend lots of hours in the company of other men and are not  
necessarily in their home environments, who are working with  
gay men, and who are working with men who have sex with men but  
who don't identify openly as men who have sex with men - so  
these are men who have sex with men but who have - who are  
married, for instance. So we are dealing with the sexual and  
reproductive health needs of the partners of these men but we  
have trained healthcare providers in the [INAUDIBLE] clinic to  
deal with issues of sexual diversity and just as an example of  
the feedback we've received from the people we work with is  
that because there was a willingness to go beyond, to think  
about the needs of other people who don't traditionally come to  
family planning associations, and to involve them in a manner

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that respects their rights, that is humane, that is also inclusive - this is the kind of feedback you get when we are willing to just step outside of your comfort zone and work with people that you don't normally work with as defined in SRH. So what do we want to achieve within IPPF? We want to think holistically as far as is humanely possible to push our healthcare providers to include issues of ARVs in discussion. We're not saying that will be a solution for everybody's problems but at least, if we can provide the care, we should know where to refer clients to, we should know what to do with issues and we should be responsive to what we are facing in the day to day work that we do. We believe that by integrating it's already halfway to dealing with stigma because when people are confident, when people know what to do with problems then it's an easy interaction and it improves relations between healthcare providers and clients and within the community. We are happy to have participated in influencing some of the discourse. At an international level. The Global Fund now in its round 6 call for proposals will be looking at the inclusion of SRH interventions from countries who are asking for support and that's a shift. We know that the Global Fund has had to be pushed on many things including health systems, including MNE, the CCMS, the attempts to get civil society involved, and we're happy that this is a move in the right direction, an acknowledgment that SRH/HIV - two sides of the same coin, the

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way we see it and really if we are all convinced, if we continue to fight to make sure that what we stand for is what we believe in - that everybody has a right, that those rights need to be respected, this is the kind of world that we can aspire to be part of where people whether they are HIV positive or negative, whether they have other sexual practices, which we don't accept or not - have a right to fulfill their desires for parenthood, for fatherhood, for motherhood or however they want to describe or achieve those rights and I think we have a responsibility as healthcare providers to respond to the needs and the challenges that we face and I hope that we can all strive to help that kind of ideal world. Thank you. [APPLAUSE]

**ISABELLE DE ZOYSA:** Thank you Nono. I think we're particularly grateful to you for showing to us the results of these 2 very [INAUDIBLE] projects, the one run by the Family Planning Association of Kenya and the other by Profamiliar, which at the time that they started, would have been a very, very brave step but they've shown it can be done and I think a challenge, as Nono has put it to us is to replicate and scale up these projects in other places. So I now call on Javier. Javier, please - Javier [INAUDIBLE] is the Regional Representative of the International HIV/AIDS Alliance in Latin America and the Caribbean and Javier has been an activist for many years in the area of HIV/AIDS but he's also, I think, I know - been very engaged in these issues around sexual and

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reproductive health rights. Thank you.

**JAVIER [INAUDIBLE]:** Thank you Isabelle. I will try to present to you basically at the contribution from HIV/AIDS to the sexual and reproductive health agenda - a very brief introduction on how the Alliance works, International HIV Alliance and some more proactive ideas that we have been thinking in terms of partners. From the beginning, we realized that local community groups need to have access to - in their own countries - to resources and technical assistance that matches what local people need and networks that enable them to learn from and influence their peers. In the last 12 years, Alliance has been changing and have tapped [misspelled?] into the needs of the community, as you see, we've been changing dramatically the approach and the way we work and operate with our partners. Working with more than 1,500 CBOs from 40 countries, 70-percent of those CBOs that never worked on AIDS before - becoming to work as partners with International HIV/AIDS Alliance and currently having more than 55 linking organizations in different countries. We are also well known as providing some resources and tools to support process even with organizations that are not formally partners working with Alliance. There are four strategic directions that guide our way basically in terms of increasing coverage of community work, the famous work, in terms of scale up, build a capacity of civil society, policy and advocacy work and, of course, the

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organizational development of the family of more than 25 linking organizations currently making part - and networks making part of International HIV/AIDS Alliance. Over 11 years, I go with [misspelled?] International Conference of Population and Development identified integration of services as key to an effective response yet the separation of sexual and reproductive health and HIV sectors has remained despite the commission of common grounds, opportunities to maximize the potential benefits of an integrated approach are [INAUDIBLE]. Whenever one state tries a need [misspelled?] of health system approach, even that overwhelming majority of HIV infections that are [misspelled?] sexually transmitted or associated with pregnancy and childbirth of [INAUDIBLE] there's a moral imperative for sexual and reproductive health and HIV/AIDS service providers, policy makers, and donors to start engaging with each other in more constructive ways. Some old figures but basically show some trends in terms of assist [misspelled?] of expenditure, type 4 activity, which of course, these figures not include World Bank Map, that [misspelled?] foreign global fund to fight AIDS, tuberculosis, and malaria, which of course, dramatically further this trend. With these figures in mind, one can fully realize the power that ensuring HIV/AIDS policy and program support [INAUDIBLE] sexual and reproductive health agenda can have. In a number of high prevalence country are 15 years old, has over 67-percent chance of becoming infected by

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her or his 15<sup>th</sup> birthday. Even low prevalence countries today like Bujana [misspelled?] where adult prevalence is 2.7-percent, the probability of contracting HIV between the age of 15 to 50, it's 19-percent and in the case of Latin America, in the Andes region of Central America, a young man who might have sex with another man - they have between 22 to 25-percent probability to contract HIV/AIDS in the next 10 years of his sexual active life. A few things can be more related to the right and needs of these young people than reducing this risk. So basically we have been working in making international AIDS funding to civil society more effective because disbursement agencies have few staff, inability to process many small proposal, weak knowledge, experience on how to work with NGOs and CBOs, key population groups of small vulnerable groups, a lack of understanding of how to scale up HIV/AIDS response with the civil society. Disbursement agencies often lack capacity to select appropriate [INAUDIBLE] recipients to promote the participation of people living with HIV and AIDS and affected by AIDS. Civil society recipients need to engage in capacity assessment processes, the strategic planning and systematic delivery of capacity development, and of course, there is an issue of civil society participation and coordination at the national level. Prioritized countries at risk of losing funding are not succeeding with the request of renewed funding and where disbursement rates to NGOs and CBOs are slow. That's

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basically where most of the civil society - most of the agencies get focused on supporting civil society to become more effective and sometimes there is not enough time to revert trends in terms of lack of capacity or unresolved. While the issue of capacity is constantly acknowledged, there is no evidence of our response other than tightening [misspelled?] selection processes and reverting to international NGOs as recipients. We have a very brief experience on how we work at site level and how we try to integrate the approach. Basically we work in the majority of our countries supporting what we call key populations but more the sex workers, MSM, people living with HIV and AIDS and injecting drug users and of course, we support the work and engage directly with them at the site level to enable the environment and have increased capacity for them leading the response. We have also an experience in Zambia, for example, which is basically in terms of young people but it's a good example in terms of sexual and reproductive health and HIV/AIDS work at the site level where we focus on young people identify [INAUDIBLE] vulnerability - address that in a multisectorial partnership, we use many different approaches like local media including drama and radio and of course, we have these reflections [INAUDIBLE] how narrow sometimes could be the approach when we approach for the first time some of our colleagues in terms of integrating reproductive health and AIDS and I think my - the first

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presenter very well addressed the issue of prevention for people living with HIV and AIDS so I will not go too much in detail even it's one of my interests, topic of interest but of course, in the terms of integrating reproductive health, these experiences in Zambia with young people have already shown in a midterm results reported, greater practice of safer sex, higher condom use, fewer teenage pregnancies, so that's very initial results but I think we're having positive feedback in terms of how we work at the site level. I also bring another experience, which coming from my region and I am more familiar with, which is experience in Ecuador where we work with a program focusing sex workers, MSM, and people living with HIV and AIDS and one of our [INAUDIBLE] recipients in the field is a larger sexual and reproductive health organization in Ecuador, which is [INAUDIBLE] and basically we have been working together to become the clinics that they work in half of the country, in half of Ecuador - they have more than 25 clinics at the moment to make the clinics more friendly for the people we work with this vulnerable population and of course, as you can imagine, one of the main interesting examples was the challenge of having sex workers and even eventually transsexual people and MSM in the waiting room in one of these clinics, which of course, due to the self-sustainable approach that [INAUDIBLE] of their sexual and reproductive health organizations need to, in Latin America, have been working with - they have other

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targets of population to - as a usual client but the indications so far the last 3 years have been very positive. Those clinics, in very conservative cities in Ecuador, have been becoming a safe place for even people living with HIV and AIDS to come together to meet and to work. We're lifting levels of stigma and discrimination and there's also an interesting work in terms of policy at the site level and at the national level where [INAUDIBLE] now linking [INAUDIBLE] before a lot of advocacy work in order to make the law that covers all maternity related tests for women free was increased the coverage for sex workers. So currently sex workers have been - have access to VCT, for example, and other kinds of testing under the maternity free law in Ecuador and that was a result of combined advocacy and policy work between [INAUDIBLE] and Alliance. So back to the gender, I think there is a lot of work to do at the policy dialogue at the international level. You know the targets very well both for the sexual and reproductive health family and the AIDS family we know very well the targets and the challenge posed by those people we need to convince to keep increasing the funding and to keep increasing the funding that could be channeled to the civil society. Of course basically, I have been trying to go very quickly in terms of a very basic AIDS alliance agenda, which is related to sexual and reproductive health and I think there is this combined approach in both sides needs to bring very credible organization at the

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international level to disseminate the learning and to influence the [INAUDIBLE] more widely in the future. Very quickly before I finish, I want to move in how I see more in my proactive way - comments to finish, which is basically how we can recreate this partnership at the local community level, at the regional level, and at the global level. Basically as I said, based on my experience in Ecuador, we have an opportunity to work in sexual and reproductive health clinics with the key population groups, with MSM, with sex workers, and people living with HIV and AIDS, create this partnership at the city level [INAUDIBLE] of training and sensitization [misspelled?] of local health services, antistigma work with the private sector and the media in those small and conservative cities that we share, both at the AIDS movement and the sexual and reproductive health and, of course, at the community level - it's making those clinics more friendly for vulnerable populations and that's a process and I mean we have some examples and we know also that we have challenges. Of course, some of the partners of the sexual and reproductive health movement need to have the self-sustainable approach, the fee for services and there is a whole line in HIV/AIDS works in terms of access to services for free. There is the issue, as I raise, of people from vulnerable groups in the waiting room with some women who are the usual targets in some of the cities in some of those clinics and, of course, increasing the staff

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on both programs. I think, at the regional level, it's basically the terms of how we work together with the sexual and reproductive health movement in session workshops and regional conferences, how we move the regional policy making and advocacy work and we started in New York very few months ago in terms of universal access and the follow up of the new declaration of commitment the [INAUDIBLE] plus 5 and, of course, put the emphasis and support our country to set the national targets on universal access as soon as possible and, of course, self-collaboration and [INAUDIBLE] corporation and, of course, there's challenges at the regional level, different dynamics and ways to network in between the AIDS and the so-called sexual and - both - so-called movement, different regionalization and different meetings and, of course, feeling the consensus at the local and international level of the importance of this partnership. So basically at the international level, we know the challenges very well and, of course, we know the main funding sources. We need to target and get more resources to work together. We know some of the leaders in both movements that we can start having - keep having because it's already started - those meaningful dialogue on how we work together at all levels and I think this meeting, this kind of session is like the person, is a key contribution that - on this issue and, of course, sometimes when we think that 11 or 12 years ago we have been saying about this

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integration, it's very important and the strategic, probably the issue of timing and the sense of urgency it's always very important. Thank you very much. Mucho gracias. [APPLAUSE]

**ISABELLE DE ZOYSA:** Thank you Javier. I think that was a very rich presentation building on the approach that the Alliance has been championing to work with communities to work through partnerships shows how seamless, actually, the merging of sexual and reproductive health rights and services can be with HIV/AIDS services with the focus on clients and communities. So can I call now Lynn to tell us a little bit about some of the challenges, lets face it, in the policy arena that we face on working more and this effort to integrate, to merge of these two dimensions. Lynn - I forget to introduce her - I know her so well - Lynn Collins works with the United Nations Population Fund, UNFPA in New York. She has really been championing this issue for many years and I can tell you she does not give up. Lynn.

**LYNN COLLINS, MD, PHD, MPH:** Well actually I did give up on one thing - I had wanted to be a singer but I was terrified of microphones so that career didn't work out. See I have mic issues. Anyway, so I have seven minutes, I was told, to try to cover policy funding, institutional issues so I'm going to do that - operatic breath here and try and get all the words out as quickly as possible. Maybe this first section should really be titled "Groping in the Dark," which might sound good in the

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sexual context but in the context of linkages, it's pretty depressing. We really are hurting in the evidence base and I'm calling it sort of a hidden evidence base. We made a lot of claims in what's going to happen when we successfully link HIV and sexual reproductive health. We've said we're going to reduce stigma, we're going to bring sexual and reproductive health services to groups that haven't had it yet like sexual - men who have sex with men, sex workers, injecting drug users. We're going to improve efficiency. We're going to be cost effective, all of these things but we don't seem to have the evidence. Now some say it's because we don't have enough programming in place yet and this will come and we're all keeping our fingers crossed over this and I think we've heard some great examples so far. The other area that we're hurting on and we've heard this from the positive community time and again is we don't have the clinical guidance that we need and research on sexual and reproductive health issues for people living with HIV especially for positive women. Now, paradoxically, even when we have the evidence, it doesn't seem to be enough. I'm just going to ask for a show of hands, how many people have ever heard of the Gleal [misspelled?] call to action? Ooh, okay. Glasses half empty, half full. I don't know. That's a start. That's okay. Basically, the - once upon a time, two years ago in a beautiful little town in Switzerland called Gleal [misspelled?], thank you Kevin O'Reilley by the way, for

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choosing that location - I think it was you - we got together, some people from sexual and reproductive health and HIV/AIDS and we were trying to look at how we could really move mother to child transmission programming and there is very strong evidence that it will not move unless we use this accepted comprehensive approach, which includes primary prevention and prevention of unintended pregnancies in women living with HIV. We have cost benefit analysis evidence for this. We have all kinds of evidence and yet, we're stalled and we've seen at the recent review of the Ungas [misspelled?] that it's less than 10-percent coverage of PMTCT. Why is this? There are a lot of political reasons for this. Don't have time to go into them now. Seems to be a problem connecting lovely babies with sexual and reproductive health. I'll say no more on that. I think it's pretty obvious. But despite the lack of evidence, there is this imperative to act. We still have to do something. We can't wait until we get this nice evidence base in.

What about funding? I mean we have over half a dozen documents now where we claim that the international community accepts the concept of linking SRH, sexual/reproductive health and HIV/AIDS. Again starting two years ago with the Gleal [misspelled?] call to action, the New York call to commitment, and most recently with the political declaration in New York around the Ungas [misspelled?] review and yet it doesn't seem to be enough. Again, we're trying to talk about risk and

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reality here, a piece of reality. There seems to be some tension, maybe some rivalry over funding issues, with the HIV/AIDS community saying where have you been sexual/reproductive health people? You've been asleep for 25 years with a raging epidemic and now you come by and you want our money. So there are a lot of tensions we still need to work out in this area.

I think another problem that we're having in the funding realm is we're just not effectively funding programs for women especially the social drivers of the epidemic. We seem more comfortable in the health zone. We're not addressing gender-based violence. We're not addressing economic empowerment of women. We're not even addressing the female condom, which is pretty ridiculous. We are also not effectively supporting microbicide development especially microbicides that will enable you to become pregnant. It's impossible to become pregnant with a condom unless the penis is slipping in the wrong direction with the female condom, which is obviously not the way to use it.

In terms of the national AIDS plans and sexual/reproductive health plans, again, we're not making these connections. If you look at a sexual/reproductive health program that is not addressing segregation of HIV positive women postpartum, you have a problem. We should not be seeing maternity wards with women living with HIV in separate rooms.

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This is a failure of our ability to look at these issues in the context of each other.

Institutional needs are myriad - don't have time to go into all the health reform issues, et cetera. I mean I will say that again, there's some encouraging signs where we're seeing some cooperation between ministries of health, SRH people, and national AIDS control people so that is an encouraging sign but we're still having ridiculous vertical programming issues where you can't get condoms into mother to child transmission programming because of some ridiculous institutional structure.

The rights issue - we had a session on this just previous to this - sad but true, we'd like to think that we're all facing the rights issue from the same perspective but we're not and I can't even begin to start this dialogue right now. I'll just mention a few areas that are contentious - discussion of what is a slippery slope, when is universal testing really another word for mandatory testing? We're looking at issues of the rights of women living with HIV to be sexually active and have a safe and satisfying sex life. We're looking at the right to have children. These seem like basic issues but they're not. I mean we have reported cases globally of counseling against women living with HIV being sexually active and we also paradoxically, have cases where they're being overcounseled in family planning.

Decriminalization is another area of HIV transmission.

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I mean these, we're going to have to work through these rights areas somehow because there has to be some room for a shared perspective even if it's at the highest level in gender inequality.

Policy imperatives - I'm not going to go over this list. I am really going to say there are social drivers of the epidemic that are often overlooked when we talk about making policy changes. We can't just make small incremental policy changes at the clinic level, we also have to go for the larger issues including age of consent for young people so that they can access VCTs, so they can access condoms. We can't be afraid of these issues. We have to have more accountability instead of this constantly saying engagement of people living with HIV. What do you mean by that? How, what are the numbers that we need? Same with that for women, same with that for young people.

Vulnerable groups, I'll give you 5 words and I'm just going to use an example here. Someone comes into your clinic setting, you're a healthcare provider and you want to ask about sexual activity. It takes 5 words to say sexually active with women, men, or both, okay. It's a simple thing you can do and that's going to help bring in some of the issues for men who have sex with men, for lesbians, other categories and it's not going to be a disaster for the heterosexual population. So I think we really need to be realistic about how to do this and

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to really reach out to the vulnerable groups, which we are all naming here and it's going to be enhanced quality for everybody concerned and finally, I'd like to think that we can also achieve some common ground on the advocacy front and I'm just going to use one example here. We've already talked about some of the - female condoms and gender-based violence so I'm just going to mention child marriage. This is an area where you have high risk of HIV transmission. Child marriage has been considered a socially licensed sexual abuse and exploitation of children. Older men often are more likely to be infected than their child bride partners. The children have less say in the relationship to make any negotiating decisions. There's intense pressure to have children very early on in the marriage.

This all adds up to risk of HIV and I really think that this is an area where we can come together and get some consensus going and I guess parting words would be there's a lot of work left ahead. Hopefully, some of you can remember the Marxist era and I'll just end with this slogan that I love from those days, which is [IN FRENCH] - the struggle continues.

[APPLAUSE]

**ISABELLE DE ZOYSA:** But Lynn doesn't give up. Thanks Lynn for a very comprehensive and frank overview of some of the policy issues that face us. I think while we don't underestimate some of the operational and technical issues, it is our feeling that it's the policy and structural issues that

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have the biggest break towards making progress in this area and as we all know, things are getting worst probably rather than better but anyway, now lets look at some of the issues related to our knowledge in this area and how we can make progress building on that knowledge.

I'd like to introduce Naomi Rutenberg who's the Senior Program Associate with the Population Counsel and Director of the Horizons Operations Research Program. Naomi's been engaged in research on reproductive health and HIV for many years.

Thank you Naomi.

**NAOMI RUTENBERG:** Thanks Isabelle. Good afternoon. I'd like to thank the organizers and the panel for including the research topic and myself in this panel. I'd like to focus on the subset of the many linkages that have been discussed this afternoon and that's the integration of services of service delivery and one question that was raised as people contemplate this issue of integration broadly is - can we better meet the needs described that we've heard today through integrated services rather than other types of configurations of parallel services or other combinations and which combinations or which configurations or services are most responsive to the needs and most feasible? We need to keep track of what our health systems can deliver. There's been many positive experiences with integrated services described today and elsewhere but as Lynn pointed out, our documented evidence base is thin and this body

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of knowledge is essential for scale up. We need it for the advocacy, to generate the resources, to deliver on the integration, and we need to have those models of services that can then be replicated rapidly and repeatedly in many settings.

I did a quick search the other day for research on HIV and reproductive health. I started out with sexual and reproductive health but that didn't lead me far at all. The first place I looked is in a new repository and I picked two repositories of warehouses of information on the HIV and reproductive health that are readily available and accessible to many people so one is something that's been put together by Johns Hopkins University called [www.fpnhiv.org](http://www.fpnhiv.org), where I come from inside the Beltway, FP is a local term for reproductive health. I turned up 160 research documents in that warehouse, 42 on reproductive health, 38 of the 42 were on reproductive health and HIV but only 4 were peer reviewed, interestingly, so again we have evidence accumulating, much of it in program managers, heads and offices - some of it getting out in the forms of program briefs but very little, actually, going to that ultimate test sort of rigor and being firmly established and having its own way of circulating, which is the peer review level. I also looked in Popline [misspelled?], which has a tagline at the top of the website - your connection the world's reproductive health literature. There I found 70 articles on reproductive health and HIV but only 6 peer reviewed and 5 of

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the 6 were published in a single journal aptly titled "Reproductive Health Matter." If you really search, there are - you can find more things under combinations like family planning and PMTCT but I think it's pretty clear that the evidence base is quite thin. So to help - sort of get a handle on what this evidence base is and how we can fill it, I've put together for today's presentation, a very simple research framework for thinking about the integration issue with 4 dimensions to it and I don't know what dimension zero - where that came from. The first dimension is what I've labeled need or unmet need but what I mean by this is - is this is really the macro level question - what is the need at the macro level for integration and integration of services for meeting international goals such as Ungas [misspelled?], for meeting our public health goals, for addressing human rights - what information, what evidence do we have. The next dimension is demand and this is the micro level - demand. What kinds of integrated services do people want to meet sexual reproductive health and HIV needs? What combination of services, where do they want them, when do they want them, who do they want to provide them? Another dimension is what is availability and supply. What is the coverage of the services that exist - what is their content? What is their quality and finally, what is the use of these services and this helps us evaluate and validate our choices about those services. So I'm going to go

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through each of these dimensions very briefly, talk about the types of research that exist to inform them, give a couple of examples. So the first of the need and unmet need - this type of - this need for evidence, information - this area's mostly been addressed through policy reviews, modeling, and very broad documentation of unmet needs, for example, for unintended pregnancy.

So to give a few examples of the policy and program review that was done by Askew and Behr [misspelled?] and published in "Reproductive Health Matters," that looked at a variety of combinations of, again from mainly anecdotal and argued that there are efficiencies [misspelled?] in integrated over-vertical services so again, that you'll meet policy and program goals with better, with cost savings, with efficiencies to both the system and the users with integrated services. There's several models that look at the potential impact of family planning services at an HIV prevention modality. Some of the best known ones are by Stover [misspelled?], Swet [misspelled?], and Reynolds and these demonstrate how family planning can prevent HIV infection in children or, for instance, vulnerable children and what the cost effectiveness is compared to other interventions to prevent vertical transmission and then, as I mentioned, you get descriptions of unintended pregnancies especially among people living with HIV, for example, this article from West Africa, which talks about

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over 50-percent of pregnancies in the cohort of women living with HIV who participated in a research study were unintended.

Turning demand under this dimension, you get a lot of knowledge added to the practice studies, both quantitative and qualitative and there are quite a few here but they're scattered in time and locale and their size. Many of the qualitative ones particularly are quite small and you also have intervention studies that tested various interventions of types of integration, for example, voluntary counseling and testing into family planning or family planning into voluntary counseling and testing and looked at what the demand was for that. I've just completed a systematic literature review of a big body of the studies and several colleagues and particularly the ones about how HIV affects reproductive intentions and behavior of men and women living with HIV. We identified 208 articles that had something like this in the titles or the key words. In the end, we focused on 77 of them because the rest of them, again, were very general articles or think pieces or policy statements or a closer look did not quite fit our criteria. There were 55 quantitative and 22 qualitative and these come from - since 1985 to the present, from developed and developing countries and then what we did is we classified them under the outcomes they address - fertility intention, contraceptive use, pregnancy incidence, and abortion and we gave them these little colors by how strong the evidence was so

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green is this very strong evidence, there seemed to be enough studies, well done studies that have a consensus among their findings. Yellow is - seems to be pointing to a particular conclusion with again, enough number of studies and studies with the right types of designs. Red is the very conflicting evidence or methodologies that are questionable and black is just - there's not enough there to say anything about.

So without going to what these conclusions were, I just want to put this up there again, to show you that just in a couple of areas did we feel that there's a decent evidence or research base on the issues we're talking about and that was fertility intentions in developing countries and to tell you what we found, in a few words. What we found for fertility intentions of women and men in developing countries living with HIV looked just like the fertility intentions of women and men living in countries who don't have HIV that the fact that the community and social norms around childbearing dominated the fact that they were living with a virus. The only other one that was strong was the effect of abortion in developed countries and this was mediated by the introduction of HAART that there was - previously had some increases in abortion among women living with HIV in developed countries who had access to safe and legal abortion. Once HAART was introduced, there no longer were - the rates decreased and again, looked like women who were not living with HIV. The dimension's

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availability and supply of integrated services, the types of research here - situation analyses of these surveys in various operations research and there's been a fair amount of this going on, if you look at the slides - the reviews of guidelines and practices, for example, around family planning and ART.

Here are 3 studies that reviewed this recently, what's happening in very different settings. One of the study's in Ghana, one's in Uganda, one's in India, provided perspectives on various aspects of integration, for example, dual protection, field experience with delivery of family planning and PMTCT, family planning provision by VCT providers, VCT provision by family planning providers so it's starting to accumulate but on the other hand, while this is by no means an exhaustive list this is not the tip of the iceberg either and again, these are single studies in single clinics or sets of clinics scattered around.

A similar picture for use of integrated services, these are based mainly on studies of clinic populations - what are their behavior, what are they doing so again, you have all the various combinations - family planning, use by PMTCT clients, family uptake - family planning and uptake in VCT, ART among SRH clients, an example that we heard today, et cetera.

So just lastly, I want to talk a bit about filling the gaps. I think some significant gaps are still on the demand side, the consumer voice and especially demand for HIV services

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and sexual and reproductive health, if you think about that there are 2 directions, we actually have more information of people living with HIV, their demand for what kind of sexual and reproductive health services but less so the other way. A few years ago, integrating STI and HIV into family planning and MCH services was very much the rage but some of the interventions turned out to be not so effective and that sort of died and it's time to re-look at that and see what those opportunities are. There's so much to be done on policy and health systems research what structures are need from integrated steering committees at the top right down to the service delivery and what kind of guidelines as Lynn had mentioned are needed that support integration and where are the efficiencies. We need operations research on service delivery especially about capacitating and providers to provide an integrated service, to deal with their own values and to deal with their own demands and time flow and clinic issues.

There's also client flow and some of those were mentioned by some of the other speakers today, how do you make an experience that's comfortable for the clients and not overwhelming for providers and we need impact evaluation of integrated services of short and long-term outcomes - do they come? Do they adopt behaviors that contribute to meeting the sexual and reproductive health needs? Does this have longer term public health outcomes that we're looking for such as a

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reduction in unwanted pregnancies and reductions in STI or HIV infections and finally, we just need more research. There are very many settings, geographic settings, divisions within, rural areas, et cetera, that are not addressed at all and all sorts of populations including sex workers and men who have sex with men, drug users, and particularly girls left behind by the settings that we typically visit in our studies that have not been addressed. Thank you. [APPLAUSE]

**ISABELLE DE ZOYSA:** Thanks Naomi for guiding us through this very comprehensive review of the evidence base, as pointed out, it's not very strong but we need to continue to try and fill the gaps. We need this information, as Naomi says, for advocacy, resource mobilization to guide program design, and enhance service delivery.

We've got time for questions now. Those of you who have to leave, do pick up the documents that we talked about. It was Nono who mentioned the framework that - so we have developed and also the inventory of tools that can guide work in this area.

Are there any comments, questions for the panel?  
Anybody please come up to the mics. Please.

**MALE SPEAKER:** Yes. Thank you very much. My name is [INAUDIBLE] from Kenya. I just wanted to make one comment that when it comes to integrating HIV and SRH, one [INAUDIBLE] that we have is the donors. Despite the very clear desire expressed

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by Dorothy today that people living with HIV need SRH services, donors still don't seem to be excited to fund programs which will offer both services.

We all know that the last few years, about 5 years or so, policies changed and many reproductive health clinics closed down and we started opening up new clinics to offer HIV care. This does not all go well for integration and even as evidence continues to accumulate, we don't see any changes in these policies. I think the outreach should go out clearly is that we need to change some of the donor policies to embrace integration so that we can offer comprehensive services. I think the problem is not with the service provider. The service provider can give HIV service to one patient as well as FP services but when the donor says that my money should not be used to give a condom but you can use it to give ART, then where does it put us, becomes very tricky.

**ISABELLE DE ZOYSA:** Thank you for that comment. I think we'll take a few and then ask the panelists to respond so is that somebody I know?

**TILLY FRAMPAUR [misspelled?]:** Hi, yes. It's Tilly.  
Tilly Frampaur [misspelled?].

**ISABELLE DE ZOYSA:** Hi Tilly.

**TILLY FRAMPAUR [misspelled?]:** This is more of a comment. Thank you very much for your presentations. They're extremely good. I just wanted to say that in India, there is a

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different language around this. [INAUDIBLE] is conducting research on looking at the best ways to link SRH and HIV services in four states in India but they don't call it integration. In India, they call it convergence and I think this language is - can be quite helpful because it avoids the idea that you always have to have everything completely integrated in one stop shops because I think there are certainly some situations where you don't want integration, where you want separate services because that's the best way to go about it so I just wanted to tell people about the words - the language that's being used in India and how it can help to avoid some of the conflict that we are seeing. Thank you.

**ISABELLE DE ZOYSA:** Thank you. We need tips in this area. Next speaker please.

**LAURA:** Hi. My name is Laura. I work for the Program on International Health and Human Rights, Harvard School of Public Health and I guess I had 2 comments as well, the first of which builds upon the previous comment, which has to do with the language and in the work that I've been involved with in integration, I find I have real difficulties with the language because I think it's being used in very nebulous ways and I think that when different people say integration, they mean really different things and during the final presentation, I was just really grateful to see that breakdown of talking about integration of one individual service into another and to see

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this discussion about directionality, which I think is really important in terms of which populations are reached and the only other comment I'd like to make is that everybody's talked about the policy environment and the need for a conducive policy environment within which this work can take place and while I totally agree, I think that that is - it's insufficient just to look at the existence of the laws and policies and an element of analysis of the content and the level of implementation is also really important especially in this field.

**ISABELLE DE ZOYSA:** Thank you. Next speaker.

**KAREN LANE:** Hi. Karen Lane, I work with [INAUDIBLE] in [INAUDIBLE] Kenya. Kind of a comment and looking for feedback from the panel when we are talking about linkages and convergences and I'm look at these integrations of HIV, AIDS, with maternal and infant health and maternal and infant care and family planning but while I work with PMTCT and we talk a lot about prevention of mother to child transmission, I'm interested also in prevention of parent to child transmission and maybe integrating more of the partners and the husbands in our maternal and infant health care and family planning situations because, as healthcare providers in these antenatal clinics, when I do have men show up, we're always asking them where the wife or child is and they're kind of pushed aside or embarrassed to show up to test in these settings and I think

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couple counseling plays a really big role in integrating these services.

**ISABELLE DE ZOYSA:** Thank you. We'll take the next comment and have some responses.

**DR. VILAN [misspelled?]:** I'm Dr. Vilan [misspelled?] from Sri Lanka. I'm a clinician working with HIV patients and STD patients also. I would like to know how - now Dorothy mentioned that it's better if you have all the services in the same place but specialist TD [misspelled?] services and ART - those can be offered in reproductive settings at the moment with all the facilities or should we - when we say linkages, should we improve referral services and should we improve knowledge of healthcare workers with regard to these facilities?

**ISABELLE DE ZOYSA:** Thank you. Can we have some responses from anybody? No? I think there was some issues - or comments about the policy environment and how to deal with those at a global but also at the local level but I think there was some specific questions about the degree of convergence and how we use some of these words and the last question about are we recommending full integration of all services in a one stop shop. Some comments on that? I don't think we are but perhaps, you would like to comment on that. Naomi?

**NAOMI RUTENBERG:** I don't think it's a question of recommending integrated services of all types or in all

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situations. I think it's an empirical question that we need to do the research. What I was trying to pose is that one particular and important integration question is - are integrated co-located services the best way to go. It's the empirical question that we should research and based on that data make the recommendations. So while I understand the usefulness of thinking about other terminologies for the broader issue, we want to understand it certainly integrated and its narrow sense of co-located services provided together is a real service delivery option that we want to certainly explore and keep in mind.

**FEMALE SPEAKER:** Yeah. My view on this is that I think we need to be responsive to what is happening on the ground. There are a lot of things that influence how healthcare providers provide care. There are policy issues, donor issues, environment issues, and [INAUDIBLE] or whatever and I think the key and the challenge is to be responsive to the needs of the communities we serve. If there isn't any other facility that provides care then your view or your vision should be to try and respond to the needs of the people but if there are other healthcare providers who are willing to be part of this continuum of care then you involve them. I think it's hard for us to wait for all the evidence, to gather all the data. That takes time. People need care. They need it now and somehow we need to find a way to respond.

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**ISABELLE DE ZOYSA:** Any other comments from anyone?

Dorothy?

**DOROTHY ODHIAMBO:** I also tend to think that it's critical that we do a lot of advocacy and raise the consumer voices with the donors because if these are emerging needs, the people really need services that are more comprehensive. Then donors must just listen to these voices and pick these issues up and do something about it and I think it's critical that we raise these issues wherever we are. I mean we start fitting in - into places where we are allotting donors and talking to them or consulting with them and showing them even if you don't have enough evidence that these are needs that are already there and people want certain - people want services in a certain way and they just have to respond to them the way they are.

**ISABELLE DE ZOYSA:** Well thank you. I think we're actually finishing on time so that's very good. I'd like to thank you for your participation. Thank all the panelists for some very excellent presentations and challenge you to come back in 2 years time with more evidence, more experiences that we can talk about, and some policy breakthroughs that we can brag about. Good luck.

[END RECORDING]

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