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Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities for scaling up

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Title

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Annex 4, SRH, HIV and AIDS: approaches, experiences and effectiveness, developed by Claudia Sambo (available separately)

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ABBREVIATIONS

ANC	Antenatal Care
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
CCM	Country Coordinating Mechanism
CPR	Contraception Prevalence Rate
FHI	Family Health International
FP	Family Planning
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GSC	Global Steering Committee
HAPAC	HIV/AIDS Prevention and Care Programme
IDU	Injecting Drug Use
IMAI	Integrated Management of Adult Illnesses
IMPAC	Integrated Management of Pregnancy and Childbirth
IPPF	International Planned Parenthood Federation
ISP	Institutional Strategy Paper
MAP	Multi-Country AIDS Program
MNCH/FP	Maternal, Neonatal and Child Health/Family Planning
MDG	Millennium Development Goals
MSM	Men who have sex with men
MOH	Ministry of Health
NAC	National AIDS Commission
NACP	National AIDS Control Programme
PEPFAR	Presidents Emergency Program for AIDS Relief
PLHA	People Living with HIV or AIDS
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Family Planning Agency
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

1 SUMMARY

1.1 Background and purpose

This DFID commissioned review (April 2006) explores the policy, financing and institutional factors that enable or constrain the integration of sexual and reproductive health and rights (SRHR) programmes, with policy and programmes for HIV prevention, and AIDS treatment and care. Based on a review of literature, key informant interviews and policy and programme analyses, this brief summarises the main barriers to developing linkages and discusses possible strategies and opportunities for engagement and strengthening linkages.

1.2 Global commitments and promising approaches

There is a renewed emphasis on the need for policy and programming to jointly address SRHR, HIV and AIDS, particularly in the context of the commitment to universal access to prevention, treatment, care and support. These commitments recognise that universal access can only be achieved through and alongside strengthening the health system. This implies integrating HIV and AIDS related services into programmes for primary health care, mother, neonatal and child health (MNCH), SRH, TB, and nutrition, as well as education and social services.

Alongside the international commitments, and backed up by evidence, there is growing consensus on the key priorities, where scale up will result in more relevant and cost effective programmes with greater impact.

Additionally, with the feminisation of the HIV epidemic, and women accounting for half of HIV infections, HIV is just one of many SRH risks to the health of both women and their children. Strengthened MNCH services that take HIV into account can provide the platform for reaching many women and children at risk of infection, or already living with HIV. These services have great potential to contribute to achieving the MDGs, in particular reducing child and maternal mortality and responding to HIV and AIDS.

Not all types of HIV and AIDS related services can be integrated into sexual and reproductive health services (and vice versa). In countries with concentrated epidemics, routine SRH services may have limited success in meeting the needs of vulnerable but stigmatised populations. Several targeted HIV programmes have successfully included key RH services that meet people's wider SRH needs.

MNCH and FP providers are unlikely to be the primary source for health services for men and young people. Increased STI service coverage has been achieved through targeted special programmes for men. There is also broad consensus on the need and effectiveness of providing comprehensive education and life skills, through school and community programmes, and separate "youth friendly" services for adolescent girls and boys.

With growing numbers of people aware of their status and on anti-retroviral treatment (ART), it is critical to respond to their SRH needs and rights, including HIV prevention needs. HIV positive women, and men, need to be able to make informed SRH choices and have access to SRH services such as family planning advice and contraceptive supplies. Pilot programmes for including services such as family planning (FP) in voluntary counselling and testing, and prevention of mother to child transmission, and ART treatment services demonstrate both client satisfaction and cost effectiveness.

1.3 Key challenges to scaling up

Strong international commitments but limited scale up

At international level major agreements and commitments emphasise the importance of approaches that link SRH, HIV and AIDS and other key services such as child health and TB treatment. These include the ICPD Programme of Action, the UNGASS 2001 commitments, the Glion and New York calls to action, and UNAIDS' Strategy for Intensifying HIV Prevention. The drive for universal access called for by the UN General Assembly includes strong support for an approach whereby HIV related interventions are integrated with broader health services including MNCH, SRH and TB. Recent progress has been made to include universal access to reproductive health as a target under MDG 5.

Yet despite the existence and support for these commitments, successful efforts to scale up have been limited. This is partly because promoting synergistic approaches between these major areas is perceived to be programmatically complex. More significantly, existing policy, institutional and financing arrangements for HIV prevention, and AIDS treatment and care, and for SRH programmes are exacerbating the separation of programmes rather than providing incentives to bring them together.

Trends in donor financing undermine rather than support linkages

Total donor expenditures for population and AIDS activities (as defined by ICPD 1994) have changed dramatically over the last decade with RH/FP expenditures declining from 73% in 1995 to 34% in 2004 and STI/HIV/AIDS expenditures increasing from 9% in 1995 to 54% in 2004. New data released in 2006 show that, in absolute terms, AIDS related funding has risen from well under US\$1 billion in 1995 to nearly US\$3 billion by 2004 (and a reported US\$8 billion by 2006). However, expenditures on RH/FP rose to only about US\$1.6 billion by 2002, with minimal increase since then. This is concerning given the continued need for these services and their important contribution to HIV related outcomes.

The World Bank and the US Government (USG) are currently the largest donors to HIV/AIDS. The USG has also been financing much of the innovative programming to develop synergies between RH and HIV. But RH/FP commitments by the US, traditionally the major donor, appear to be falling, with a proposed decrease in the USAID FP/RH budget of 20% in 2006/7. The World Bank's internal evaluation of its support to global health partnerships found that effective advocacy has driven up AIDS spending, while overall spending on the health sector (including SRH) has increased more slowly. The Global Fund's policy focus is on HIV and AIDS related programming, and financing covers commodities directly linked to HIV prevention, or AIDS treatment, care and support. As of mid 2006, very few programmes addressed linkage issues.

Funding modalities can distort health funding and weaken health systems

While there is a clear need for increased funds for HIV and AIDS, there is a concern that this finance is often narrowly earmarked for specific programmes and that these programmes are also narrowly defined. HIV-related activities receive substantial funds which are 'off budget' and inflexible, creating parallel systems to those set up to support basic health services and other programmes. Separate financing and management of supplies and logistics is common for anti-retroviral drugs and other HIV related commodities, in Kenya and Malawi for example. SRH programmes are also recipients of targeted financing and technical assistance that may not take HIV and AIDS implications into account.

The shift from project and programme funding to budget support and sector wide approaches, coupled with high profile disease focused financing can reduce both resources to, and visibility of, specialised programmes such as SRH. There is also growing concern that, in Uganda and Zambia, for example, where fiscal ceilings affect the health budget, earmarked funds for HIV and other communicable diseases are crowding out government allocations to other priorities such as SRH. This may also limit resources for basic services which have direct implications for the effectiveness of integrated responses, including STI management, FP services, and antenatal, delivery and postnatal care.

Institutional arrangements and support for targeted disease specific programmes create incentives that weaken synergistic approaches

The growth of targeted financing through initiatives such as the GFATM, PEPFAR, and the 3 by 5 Initiative provide few incentives for HIV stakeholders to integrate with SRH programmes either structurally or through policies and programmes. These disease specific initiatives have ambitious targets with funding disbursements linked to output indicators. Delivering well financed vertical programmes that are easier to manage, and which can achieve results, resonates with demands of powerful political and clinical elites at all levels. Strong incentives to deliver 'quick wins' through targeted approaches can result in rapid coverage increases, but at the cost of longer term cross cutting strategies that strengthen health services more generally.

Policy making and programmatic processes for HIV and SRH at international and national levels have, for historical reasons, developed separately. Bridging this gap is challenging. Institutional divisions between SRH and HIV exist at donor and multilateral headquarters, perpetuating separate policy development. At country level, these divisions also persist with policy and programming for HIV and SRH financed, managed and implemented independently, and often supported by different divisions within technical agencies and implementing partners. For example, in Kenya and Malawi, safe motherhood programmes funded by DFID in the early 2000s focused on access to essential obstetric care, and did not address HIV, for example by exploring the inclusion of PMTCT, which was already being piloted in relevant districts in Kenya.

Additional finance for HIV and AIDS programming represents an important opportunity to draw in staff to the public sector to work across programmes at facility level. However, the continued separation of programmes can create perverse incentives. Localised brain drains of SRH workers switching to HIV funded programmes are reported in Kenya and Zambia for example. In Rwanda, doctors in the NGO sector receive six times the salary of public sector equivalents. Global initiative funding and programme requirements can also limit opportunities for integration of procurement and supply systems, reported in Malawi.

Little progress in a 'health sector wide' response to HIV and AIDS

At national level, there are significant policy, system and institutional barriers to developing synergies, which are reinforced by donor policies and earmarked funding streams. While support to NACs and the Three Ones principles is promoting a unified approach to the national response, national level SRH and HIV programmes still tend to be separately administered, funded, and supported by different technical agencies. There is little evidence as yet of how HIV/AIDS and SRH programmes, and other key health services, will develop closer linkages or will align with national health plans to ensure that the health sector as a *whole* is capable of responding to the challenges of HIV and AIDS.

Rise of religious conservatism can impact on comprehensive and integrated programming, further separating HIV and SRH services

At national and international levels, religious conservatism is a growing force affecting SRH promotion and HIV prevention programming. Among donors, USG policy and financing requirements such as the Mexico City Policy (Global Gag Rule) and the 2003 Act for US Leadership Against HIV, TB and Malaria 2003 is resonating with, and reinforcing local religious conservatism, especially in Africa.

Provisions of the 2003 Act related to prevention are based on the ABC approach, **A**bstinence, **B**e faithful and as appropriate, use **C**ondoms. The law requires that 20% of all PEPFAR funds be allocated to prevention, of which at least 33% must be spent on abstinence programmes. A recent analysis by the US Government Accountability Office (GAO) reports that earmarking requirements are challenging the ability of country teams to deliver comprehensive approaches that respond to local epidemiological contexts and social norms. This is the case in both generalised epidemics where many people are likely to be exposed to HIV in sero-discordant couples, and in concentrated epidemics where it is key populations who are at higher risk of exposure, and where abstinence is rarely an option.

These findings, together with many anecdotal reports point to the risk that USG policy and its interpretation are having a 'chilling' effect, and undermining the development of comprehensive programming, for both at risk and general populations. Overall, there is a major risk that the impact of these policies lies in the further separation of HIV and AIDS programmes and services from those that meet the SRH needs of sexually active adults, and of young people.

Where government is not robustly leading the response and lacks strong support from its UN partners, this can lead to a patchy and confusing picture at country level. Informants to this review referred to a 'geographical lottery', especially for young people, where national leadership across sectors may be weak and types of information and services depend entirely on the programme's source of funds.

International leadership for the promotion of linkages is weak

The UN agencies have a key role to play in providing technical support and leadership but there is broad consensus that much more progress is needed. UNFPA has not substantially developed its leadership role on integration issues or on scaling up comprehensive approaches for young people. Although UNAIDS' Intensifying HIV Prevention strategy urges for strong linkages with SRH, several PCB members are keen to see greater efforts to promote practical strategies at country level, as part of the UNAIDS co-ordinated process for division of labour, mandated by the Global Task Team. As PMTCT lead, there are also concerns about UNICEF's limited advocacy for PMTCT as part of routine MNCH services. WHO has made progress with 3 by 5, but the recent evaluation found that prevention did not feature sufficiently in the initiative, and linkages with SRH and other health services have been slow to develop institutionally.

1.4 Enabling processes to promote linkages

In some countries, government, civil society and donor processes are enabling progress in promoting linkages.

- ***Improved government and donor co-ordination is helping to develop HIV and AIDS policies and plans for the health sector as a whole.*** For example, the DFID funded Essential Health Services Programme (which also supports the emerging SWAp) in Kenya includes mainstreaming HIV in all its outputs, with a focus on SRH. In Zimbabwe, recent efforts have been made by DFID to bring

maternal and child health stakeholders together with HIV experts to design support to the MNCH programme that takes HIV fully into account.

- **Cross programme working groups and task forces have helped develop linkages.** For example in Zambia, the MTCT Working Group requires PMTCT donors to support all elements of antenatal care. In Kenya, the PMTCT task force has enabled the RH and HIV/AIDS programmes to develop joint guidelines, protocols, training and supervision schedules. In Uganda, a range of stakeholders developed joint policies and guidelines to support delivery of VCT, PMTCT and ART services and of integrated care.
- **Synergies have been promoted through allocation of funds to support cross cutting posts together with programme resources.** For example, the GFATM funded PMTCT post in Zambia is based in the RH division, not the HIV/AIDS programme, which is leading the incorporation of PMTCT into routine MNCH services.
- **Demonstration projects with scale up plans, together with targeted finance and expert technical assistance help to develop the linkages.** For example, several USAID implementing agencies, such as PSI, FHI and Population Council are providing this support to integrating FP, VCT and PMTCT.
- **The role of 'dual champions' as high level advocates in national and international agencies has great potential in building support and ownership.** For example, Ghana's presidential adviser is an SRH and HIV and AIDS expert, and the chair of Nigeria's NAC has a reproductive health background, which is felt to increase their openness to considering linkages.

1.5 Opportunities for engagement

Actions on commitments

There are four specific areas where action on commitments is particularly needed.

- a) Maintaining and promoting the credible and evidence based position on comprehensive prevention approaches, especially for youth friendly SRHR information and services, including HIV and AIDS.
- b) Continuing advocacy and support for social marketing as a crucial component of the HIV and AIDS response and wider SRH needs that supports the wider acceptability and availability of affordable male and female condoms and contraception, and helps to counter any negative effects of national and international religious conservatism.
- c) Building and promoting the case for investment in existing SRH services, that reach women at risk or already HIV positive, to deliver better HIV-related, SRH and child health outcomes, and linkages with other critical services such as TB.
- d) Developing the case for including RH interventions in HIV and AIDS programmes for vulnerable populations and for women and men with HIV, as part of comprehensive prevention, treatment, care and support services.

Opportunities among multi and bilateral donors

- a) Developing shared positions among European donor agencies, such as SIDA, NORAD, and the Netherlands, who expressed considerable interest in this agenda, and building on the strong position expressed in the EU Prevention Statement. Equally, key foundations, including Hewlett and McArthur are potential collaborators.
- b) Opportunities are opening up at the World Bank for building stronger links between hitherto separate AIDS and health funding streams, including consultation on new strategies for HIV and AIDS in Africa and for health, nutrition and population.
- c) Continued advocacy for leadership and action on linkages especially at national level by the main UN agencies.
- d) As GFATM stakeholders, agencies may consider strengthening their position on relevant policy issues, such as a broader definition on what constitutes programmes

and commodities for 'HIV prevention, treatment, support and care'. Equally, as a country driven mechanism, involvement and advocacy may take place in the context of agency contributions to CCMs.

e) Advocacy may be considered to raise the profile of HIV in the Reproductive Health Supplies Coalition and the new Partnership for Maternal, Neonatal and Child Health, which is considering how to best integrate HIV related concerns.

Support to harmonised country processes with key stakeholders

The development of linkages has made most progress where key stakeholders have been involved in clear and feasible policy processes and funding strategies.

a) Support to sector wide management processes represents a major opportunity for developing a comprehensive health sector response to HIV and AIDS, as part of universal access commitments. Sector strategies can provide opportunities for stronger strategic and operational linkages between the MOH's various programmes, and co-ordinated efforts to strengthen health and HIV/AIDS policies, HR, procurement, supplies and infrastructure development.

b) Donors can support harmonised processes by promoting joint task forces and funding technical co-operation and MOH posts for mainstreaming HIV into relevant health services. Reproductive health commodity security working groups can support more effective condom policy and programming, along with development of private sector participation, public private partnerships and a total market approach.

c) There is continued rationale for high level and catalytic financial and technical support to SRH services (for example MNCH programmes that fully take HIV into account) at country level, ideally programmed in line with the national sector strategy)

d) Support to the NAC for civil society responses and mainstreaming in key sectors provides opportunities to address wider structural issues such as gender inequalities through female education, and ensuring inheritance rights, and a cross ministry and civil society response to the needs of young people.

e) Major opportunities lie with involving the not for profit and private sector, and the demand side, through voucher and social marketing/franchising programmes, for example.

2 PURPOSE AND BACKGROUND

The aims of this review are: a) to describe the priority areas for synergies between sexual and reproductive health and rights (SRHR) and HIV and AIDS policy and programming; and b) to discuss constraints and opportunities for developing these in the context of international and national policy processes and funding mechanisms, and involvement in wider efforts for scaling up basic health services and for universal access to HIV prevention, and AIDS treatment, care and support.

Based on literature review, key informant interviews and policy and programme analyses, this report summarises current evidence and commitments, and comments on progress at country level, in sections 3 and 4. Sections 5 and 6 explore the main barriers and constraints to developing linkages and possible opportunities for DFID and others' wider engagement. The review is complemented by a short case study of progress in Kenya, carried out with a DFID AIDS scoping mission in February 2006 (see section 5).

3 SCALING UP LINKAGES: RATIONALE AND PROGRESS

There is renewed emphasis on the linkages between sexual and reproductive health and HIV and AIDS, particularly in the context of universal access commitments and the UNGASS review in mid 2006.

3.1 Rationale

The rationale for identifying and scaling up priority linkages lies in five main factors.

1. There are growing numbers of people who know their HIV status, with over 1.3 million women and men on ARV treatment in 2006. But most lack access to SRH services – prevention counselling, family planning and other SRH services are not routinely part of voluntary or diagnostic counselling and testing services, or offered during ART care. People's rights to informed fertility choices are routinely ignored at best, and there is evidence of abuse, where HIV positive women are encouraged not to have children (ICW 2004).

2. There is broad recognition that the objectives of universal access to HIV prevention, and AIDS treatment, care and support cannot be achieved without strengthening the existing health system, including policy, infrastructure, human resources, supplies and services to deliver them. The universal access process emphasises the need to integrate HIV related services into programmes for primary health care, maternal, neonatal and child health (MNCH), SRH, TB, nutrition, as well as education and social services.

3. With the feminisation of the HIV epidemic, and women accounting for half of HIV infections, HIV is just one of many SRH risks to the health of both women and their children, compounded by gender inequalities and poverty. There is also increasing evidence of the role of HIV infection in increasing maternal morbidity and mortality (McIntyre 2003). In high prevalence countries, strengthened MNCH services that take HIV into account can provide the platform for reaching many women and children at high risk of, or already living with HIV, and has the potential to improve SRH, HIV and child health outcomes.

4. The prevention of HIV as a primarily sexually transmitted infection requires approaches based on promoting and protecting people's SRH and rights, with special attention to addressing the social, cultural and economic factors that make women and girls vulnerable (IWHC 2006, GCWA 2006). Poverty, discrimination, gender inequality and stigma also drive high rates of HIV infection among men and women in marginalised

groups who have sexual and reproductive health needs. Rights based approaches are crucial to the HIV, AIDS and SRH response as well as contributing to wider poverty reduction and development efforts.

5. There is growing awareness that the impact of conservative political and religious opposition to proven, comprehensive approaches to both preventing HIV and promoting SRHR needs to be better understood and addressed at national and international levels.

3.2 Current initiatives

Renewed emphasis is shown in several initiatives aiming to mobilise action among stakeholders working in SRH and HIV. These are shown in the table below.

1. Evidence reviews and case studies	WHO is finalising a review on evidence for integrating SH into RH services for women, men and young people (WHO 2005 draft); WHO, UNFPA, UNAIDS and IPPF have produced an inventory of resources and are doing case studies in Kenya, Serbia and Haiti
2. Frameworks and tools	WHO and UNFPA developing guidelines and tools on fertility choices and desires of positive people; clinical guidelines for women living with HIV to be published in 2006 by WHO with support from the Hewlett Foundation; WHO, UNFPA, UNAIDS and IPPF have produced a framework for linkages and an inventory of resources (2005); WHO is finalising tools for IMAI (managing adult and adolescent illness) and IMPAC (pregnancy and childbirth), to complement IMCI; IPPF's tool with ICW and other PLHA networks, the index on 'Stigma and discrimination: human rights and stigma', including SRH related issues.
3. Research and demonstration approaches	IPPF's new models of care (treatment in a conventional SRH setting; prevention for vulnerable groups through SRH services); PATH India operations research on convergences in four districts in India; USAID and partner approaches to integrating FP and HIV related services; Population Council Frontiers Project with young people and vulnerable groups.
4. Advocacy through coalitions and partnerships	Joint advocacy with major donors and others through new partnerships e.g. IPPF and the International HIV/AIDS Alliance; SRHR Network, Interact, Engender Health and others for inclusion of new MDG indicators related to SRH and linkages; the International Women's Health Coalition's 'With Women Worldwide – a compact to end HIV/AIDS'; the Global Coalition on Women and AIDS; the USAID Working Group for FP and HIV under its Global Leadership Programme.

3.3 Progress in making priority linkages

There is emerging consensus, backed up by a growing evidence base, on the main priorities for developing linkages. A literature review carried out for this study describes pilot and demonstration programmes that have increased both SRH and HIV related service utilisation and outcomes (Annex 3 and 4).

Decisions on what services to integrate are dependent on a country's epidemiology (of HIV); vulnerable groups; power base, roles and relationships of major stakeholders; the maturity of HIV, AIDS and SRH programmes and the contraceptive prevalence rate; the structure and organisation of health services; and knowledge and evidence about what is likely to be most effective and efficient. Integration efforts should not necessarily be across all levels of action in all services, but rather should look pragmatically at what linkages make most sense given the context and client needs. The main areas where programme synergies have potential in scaling up services for key client groups in generalised and low prevalence or concentrated epidemics are summarised in Table 1.

Table 1: Priority linkages by service and target group

	Inclusion of HIV/STI prevention and other services in FP/MNCH (mainly married women)	Inclusion of SRH services in HIV related programmes (incl. for PLHA)	SRH and HIV in targeted programmes for young people and men	SRH and HIV services for key vulnerable groups
Generalised epidemics e.g many sub-Saharan African countries	<ul style="list-style-type: none"> - Education/counselling on sexuality and HIV/STI prevention into FP/MNCH services; condom promotion - VCT and PMTCT integration into FP/MNCH services, involving male partners where possible - ART for HIV+ women (VCT and PMTCT as entry point) - Social marketing and social franchising for HIV and SRH products and services 	<ul style="list-style-type: none"> - FP services, eg contraceptive advice/supplies/referrals and condoms in VCT and PMTCT services - Provision of SRH services and contraceptive supplies for PLHA registered with treatment programmes, including MNCH access for women - Social marketing and social franchising for HIV and SRH products and services 	<ul style="list-style-type: none"> - Education/counselling on sexual and RH issues included in HIV programmes for young people in formal and informal settings; condoms and contraceptives - Youth friendly services providing VCT and ART referral - SRH issues for orphans and vulnerable children - VCT and condoms, SRH education in STI services and male outreach programmes 	<ul style="list-style-type: none"> - SRH issues in HIV programmes for key vulnerable groups eg sex workers, partners and clients, migrant workers and families, MSMs
Lower prevalence countries and concentrated epidemics e.g. Central and Eastern Europe, Asia, Latin America	<ul style="list-style-type: none"> - Education/counselling on STI/HIV in FP/MNCH - STI diagnosis and management into FP/MNCH (including syphilis screening) - Integration of other HIV related services eg PMTCT and VCT in local high prevalence areas 	<ul style="list-style-type: none"> - Integration of SRH advice/services into HIV services where provided (eg major tertiary and secondary facilities) for all client groups 	<ul style="list-style-type: none"> - Education/counselling on sexual and RH issues included in HIV programmes for young people in formal and informal settings; condoms and contraceptives - SRH issues for orphans and vulnerable children - VCT and condoms, SRH education in STI services and male outreach programmes 	<ul style="list-style-type: none"> - SRH services in HIV programmes for key vulnerable groups, partners and clients eg sex workers, IDUs, MSMs, migrant workers etc

4 COMMITMENTS AT INTERNATIONAL LEVEL

At international level, major agreements and commitments emphasise the importance of approaches that link SRH, HIV and other key services such as child health and TB treatment, and the need to strengthen the existing health system to deliver them as integrated services.

- Through the ICPD Programme of Action and the Beijing Platform for Action, governments have committed themselves to providing comprehensive and integrated SRH and rights for women, men and adolescents.
- UNGASS 2001 commitments have promoted and enabled sustained and high level political commitments to the response. Key goals include the provision of youth friendly services, life skills education and access to male and female condoms.
- In line with UNGASS commitments, in 2005 the G8 and the UN General Assembly World Summit called for a package for HIV prevention, treatment and care with the aim of as “close as possible to universal access to treatment for all those who need it by 2010”. The G8 statement also states that limited health system capacity is a major constraint to universal access.
- Since then, UNAIDS and co-sponsors have worked with country and regional partners to develop practical strategies for moving towards universal access, through an approach whereby HIV related interventions are integrated with broader health services including MNCH, SRH and TB.
- ‘Intensifying HIV prevention’, UNAIDS’ global prevention strategy, draws on international SRHR and HIV commitments including ICPD, and takes into account that the vast majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. It recommends stronger linkages with SRH, and comprehensive and appropriate sexual education and life skills, as well as wider efforts to tackle gender inequalities and stigma.
- MDG 5 now includes a new target to ‘achieve universal access to reproductive health by 2015’. This reflects strong recommendations made in the Investing in Development and Millennium Project Task Force reports, reinforced by the UN World Summit, 2005.
- International recognition of the need for linkages between SRH and HIV services is demonstrated by the Glion and New York calls to action, followed by the Abuja high level forum on PMTCT in 2005.
- Commitment to the Three Ones principles and processes such as the Global Task Team’s division of labour recommendations, and the recent review of the comparative advantages of the World Bank and the GFATM, have identified factors that affect the ability of countries to implement effective programmes (Shakow 2006, UNAIDS 2005). These processes offer potential to increase co-ordination among multilaterals, donors and government departments working in HIV and SRH through better dialogue, programme coordination and a clearer delineation of agency responsibilities.

5 POLICY, FINANCING AND INSTITUTIONAL ARRANGEMENTS: CONSTRAINTS TO SCALING UP

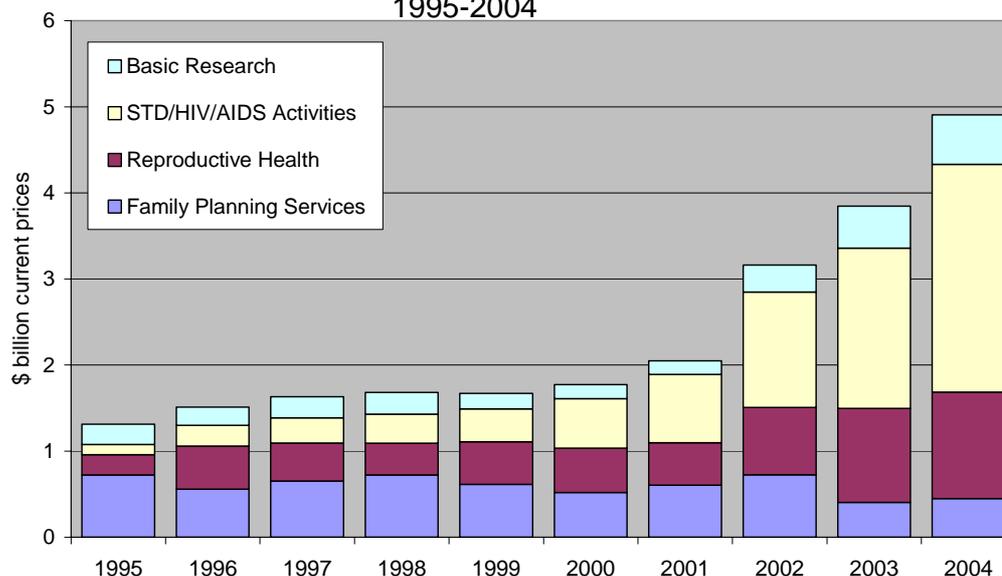
Despite international commitments, and the promising approaches described in previous sections and Annexes 3 and 4, successful efforts to scale up have been limited. Part of the reason is due to programmatic challenges and the need for context specific approaches to be developed.

However, the most significant barriers lie in policy, institutional and financing arrangements. National and international policy and processes tend to increase the separation of HIV and SRH programmes, rather than providing incentives to bring them together.

5.1 Financing trends

The policies of several of the major AIDS and SRH donors are not providing a favourable environment in which to implement international commitments to developing linkages and strengthening health systems, with the significant exceptions of some bilaterals and foundations. The key players are the major bilateral donors, including the US, UK, Germany, Netherlands, Norway and Japan. In addition to bilateral funds, multilateral finance is programmed by agencies including the World Bank, the EC, and the GFATM.

Figure 1: Donor expenditures on population assistance activities 1995-2004



Source: UNFPA/UNAIDS/Netherlands Interdisciplinary Demographic Institute Resource Flows Project (draft figures July 2006)

Total donor expenditures for population and AIDS activities (as defined by ICPD 1994) have changed dramatically over the last decade with RH/FP expenditures declining from 73% in 1995 to 34% in 2004 and STI/HIV/AIDS expenditures increasing from 9% in 1995 to 54% in 2004. While AIDS and RH data is sometimes difficult to disaggregate, in absolute terms, AIDS related funding is estimated to have risen from well under US\$1 billion in 1995 to nearly US\$3 billion by 2005 (and a reported US\$8 billion by 2006). However, expenditures on RH/FP rose only to about US\$1.6 billion by 2002, with limited increase since then. This is concerning given the continued need for these services and their important contribution to HIV related outcomes.

5.2 Major donor and technical agency support

The World Bank: Now the largest donor/lender to HIV and AIDS activities, the World Bank's internal evaluation of its support to global health partnerships found that effective advocacy has driven rapid growth in AIDS spending, while overall spending on the health sector, including for RH, has increased more slowly (World Bank 2005). The majority of the Bank's funding for HIV is programmed through the Multi-country AIDS Program, where support is channelled through National AIDS Commissions and at least 50% of resources finance the civil society and NGO response. Many of these NGOs have been set up relatively recently and focus on HIV and AIDS, and although the possibilities for integration are there, they are not developed.

The US Government: The USG is the largest AIDS bilateral donor, through PEPFAR and is also the major national contributor to the GFATM. It has also been the leading RH and FP donor, and has been financing much of the innovative programming to develop linkages between SRH and HIV, particularly for FP services. However, it is proposing reductions in the USAID family planning and reproductive health budget, by about 20% in 2006/07 (Guttmacher Institute correspondence). Prospective cuts are already being discussed in countries such as Zambia and Uganda. While overall USG allocations to SRH remain unclear, the picture is not encouraging.

DFID UK: The UK is the second largest bilateral donor to HIV and AIDS, and a major contributor to GFATM and UN agencies such as UNAIDS. It also continues to be a major supporter and advocate for SRHR through both multilateral support to UNFPA and other UN agencies, and country level technical and financial assistance to governments, including financial support and technical programme posts and social marketing programmes with the private sector. Country level programming is increasingly stressing linkages. DFID's AIDS response is set out in its Taking Action strategy which highlights synergies with SRHR, and addressing gender inequities (DFID 2005). The evaluation currently taking place is examining these questions, among others. It is noted here that the official summary omits these references and is more focused on HIV and AIDS. DFID's position paper on SRHR does not have equivalent policy status to Taking Action (DFID 2004).

Global partnerships and the UN system: The global partnerships and coalitions that aim to co-ordinate the technical response and mobilise resources for MDG priorities have a critical role. However, the new co-ordination Partnership for Maternal, Newborn and Child Health does not yet mention HIV in its core communications, a missed opportunity for advocacy on HIV as an essential part of safe motherhood, newborn and child health services. The Reproductive Health Supplies Coalition, which supports co-ordination among donors and implementors, includes some HIV stakeholders, but HIV and STI linkages are not currently given high priority.

UNFPA as the lead agency for SRHR linkages and for young people has not made substantial progress, reportedly in part due to the lack of evidence that hampers efforts to scale up integration in practice. In collaboration with UNAIDS, WHO and IPPF, it has developed a 'why, how and what' approach with developing a framework for integration, a resource inventory and three case studies on Haiti, Kenya and Serbia-Montenegro scheduled for completion in 2006.

UNICEF leads on PMTCT. There have been concerns about the focus on prevention of transmission (as opposed to the three other pillars of primary prevention, prevention of unintended pregnancy, and care/treatment for the mother and baby) and the fact that services are often offered outside routine MNCH care. The Inter

Agency Task Team is addressing these issues, with stronger support for programmatic guidance for PMTCT as a core pillar of maternal and newborn health.

WHO is addressing institutional barriers between the HIV, TB and Malaria and Family and Community Health clusters through cross cutting posts and other departmental linkages. However, at regional and country level, departmental mindsets and scarce resources hinder synergies. While the integrated management of adult and adolescent illness (IMAI) and IMCI management approaches hold potential for supporting comprehensive health care for acute and chronic illness, the IMPAC (integrated management of pregnancy and childbirth) tool is much less advanced.

Although UNAIDS' Intensifying HIV Prevention strategy addresses linkages with SRHR, several PCB members are keen to see greater efforts to promote and coordinate linkages at country level, particularly through the Global Task Team's guidance and processes for the division of labour agreed in 2005.

The GFATM: The major new multilateral financing instrument for communicable diseases, the GFATM, had, until mid 2006, placed little emphasis on linkages between SRH, HIV and AIDS in policy documents, guidelines, proposals or progress and financial reports. Policy documents refer to key international commitments and disease-focused initiatives such as the Stop TB Partnership, Roll Back Malaria, and the 3 by 5 Initiative but there is no acknowledgement of international commitments linking SRH and HIV.

GF guidelines specify use of funding for HIV, TB and malaria related activities, including commodities, for prevention, case, treatment and support. At a recent meeting of donors and GFATM representatives (International HIV/AIDS Alliance Jan 2006), it was said that contraceptives do not normally qualify as HIV related commodities. This supports anecdotal reports that South Africa's Lovelife programme was not able to include contraceptives in its programme budget.

Reproductive health expertise was limited among the 27 representatives on the outgoing technical review panel, although gender and social development expertise was strong. Further, the current GF monitoring and evaluation framework has no explicit indicators that promote or monitor synergies between SRH and HIV and AIDS.

A rapid analysis of the current funded proposals suggest that there are very few which explicitly mention the use of Global Fund grants to support the integration of SRH, HIV and AIDS services. An exception is Haiti's response to HIV/AIDS (2002-2007) which includes funds for the GHESKIO NGO network, which provides an integrated package of services including HIV and reproductive health services.

To an extent this situation reflects limited demand at country level. The System Wide Effects study of the GFATM found that many reproductive health players did not participate in GF planning processes at country level (Abt Associates 2005). Despite guidelines that enable broad representation on the CCM, an IPPF survey found that few SRH organisations are aware of or represented on CCMs, in part because of their limited engagement with HIV and AIDS (IPPF/GTZ 2005).

GF processes at country level tend to be dominated by disease specific agencies, and GF activities are rarely planned to integrate with reproductive health, family planning or other preventive care services. In Malawi, one of the few countries that successfully bid for Round 5's health system strengthening funds, there are reports

of requirements to allocate budget lines for example, for human resources, directly to HIV related activities (see Box 1).

Two main reasons explain the absence of linkages: first, the Fund's primary role as a country driven financing instrument (and its lack of influence on priority setting processes at country level). Second, the urgent need to prioritise HIV specific interventions, as expressed by the former Global Fund director Richard Feachem: 'What would you first emphasise? Linkages, which are maybe operationally complex to achieve? Or would you emphasise firstly a blitz on prevention... and within that a focus on the high risk groups; plus scaling up testing rapidly, and beginning to make treatment and access to treatment a serious proposition'. (UK APPG interview 2005).

Box 1: Impact of GFATM and other aid instruments

The System-Wide Effects (SWEF) study of the GFATM at country level found that reproductive health players did not participate extensively in GF planning processes, and that GF activities are not integrated with reproductive health, family planning, or other preventive care services. Although systems for commodity procurement and disbursement have been strengthened in Ethiopia, fewer improvements have occurred in Malawi, where parallel procurement and distribution are taking place for most HIV related commodities.

In Malawi, the sector wide approach promotes an essential health package, an integrated approach at district level, and support to an emergency human resources programme that includes staff incentives. However, the national scale up plan for HIV related services has not been fully translated into costing and operational plans. PMTCT is achieving very patchy coverage and is not well integrated into the system. Scaling up VCT and ARV treatment is a highly visible objective for the government. This, together with the fact that major sources of HIV funds are off-budget, drives the pace of scale up.

While Malawi is viewed as a success story in scaling up ARV access, there is evidence of resource shifts away from community health programmes including reproductive health, towards AIDS activities, as well as TB and malaria. The Round 5 health system strengthening grant was programmed in line with Malawi's emergency HR plan, which includes resources for additional health surveillance assistants (community health workers). Although the intention was to deploy these staff across primary health care functions, including SRH, political pressure coupled with GFATM programming requirements means that they are being deployed as counsellors to VCT centres. While this strategy may deliver against targets in the short term, it may not be sustainable and cost effective in the longer term (eg higher burn out rates among dedicated HIV staff and missed opportunities for community based referrals and continued prevention activities).

Sources: Review interviews and Abt Associates 2005

5.3 Impact of increased and targeted AIDS funding at national levels

Overall, the impact of greatly increased and targeted AIDS financing at country level, coupled with reductions in FP and RH funds, risks undermining efforts at system strengthening and effective linkages. Patterns of funding and technical assistance, and ways of working with MOH programmes, do not always support linkages between programmes and with the wider health system.

While there is a clear need for funding the expanded HIV response, the wider concern is that finance allocated is often narrowly earmarked for specific programmes, which are narrowly defined (Box 2). HIV and AIDS activities are receiving substantial funds, which are mainly 'off budget' and inflexible. Initiatives such as GFATM and PEPFAR have set ambitious targets and deliverables, with funding disbursements linked to performance. Indicators tend to be linked to

coverage/output, not impact measurements. These create strong incentives to deliver quick wins through vertical or narrow approaches that result in rapid coverage increases but not necessarily longer term impact.

HIV stakeholders have few incentives to integrate either structurally, or through policies and programmes. Delivering well financed vertical programmes that are easier to manage, and which can achieve results, resonates with demands of powerful political and clinical lobbies at all levels. Informants used the term “dis-integration” to refer to the increasing separation of HIV and SRH programmes at country level. While support to NACs and the Three Ones is promoting a unified approach, the dominance of the often disease focused CCM and the HIV/AIDS programme in the MOH tends to inhibit cross programme activities within the MOH.

Box 2: Disproportionate and inefficient financing in Rwanda

A recent assessment of Rwanda’s ability to achieve the MDGs indicates that one of the major problems with targeted funding is the tendency to focus on discrete projects, rather than taking the opportunity to strengthen the delivery of a minimum package of services through financing channelled through government, in support of the health insurance schemes.

This fosters narrow approaches and inefficiencies. Rwanda has 21 official donors, mainly disbursing funds via over 40 NGOs. PEPFAR alone is said to disburse funds via more than 50 separate implementing organisations, resulting in cases where the same district or the same facility is receiving support from several different agents, although the funding all comes from a single donor.

The review describes a ‘gross misallocation’ of resources, with funding distributions reflecting donor strategic objectives rather than country need – the government manages only 14% of donor health aid. Rwanda receives over \$47m for HIV/AIDS, disproportionate in a country with a 3% HIV prevalence rate, compared with only \$1million for childhood illnesses, and very low coverage of maternal and child health interventions.

Source: Foster et al 2006

The shift by major RH donors such as DFID from project and programme funding to general and sector budget support, coupled with highly visible disease focused financing, can reduce the profile of programmes such as SRH. In many countries, increased government and off budget donor funding for HIV and other communicable diseases has taken place in parallel with reduced allocations of financial (and human) resources to SRH. In Kenya, off-budget support to AIDS, according to a recent public expenditure review is nearly two-thirds of total on-budget support to health. While AIDS financing has increased, resources are often limited for the basic services that have direct implications for the effectiveness of the response, including STI management, FP, antenatal, delivery and postnatal care.

There is also growing concern that - given hard fiscal ceilings for the health budget - earmarked health sector funds for HIV and other communicable diseases are crowding out government allocations to other priorities such as SRH (Ooms and Schrecker 2005, DFID HRC 2005). As a result of budgetary pressures, central budgets for SRH programmes tend to be cut or under-spent, and donors respond by substituting government spending with off-budget funds. This also accords with some donor preferences for commodity or project support, rather than sector or budget support.

Sector health strategies supported by SWAps usually prioritise a minimum or essential package of activities delivered through integrated district level

management. These processes face many challenges as staff take on more responsibilities without a corresponding increase in technical and financial resources. There is often inadequate technical support to programme implementation and lack of resources to address system level weaknesses. At the same time, staff at district and facility level are often managing several budgets linked to earmarked programme finance, and different arrangements for commodity supply, training and supervision.

Technical assistance programmes for SRH and HIV continue to have an important role. However, several safe motherhood programmes (eg Kenya, Malawi) supported by DFID in the early 2000s focused mainly on access to emergency obstetric care, and did not take HIV into account, despite rising HIV prevalence among clients and the presence of pilot PMTCT programmes in the relevant districts in Kenya. This represents a missed opportunity to develop a holistic approach to improving maternal and neonatal health in the context of a generalised HIV epidemic.

5.4 Policy, institutional and other issues at national level

There are significant policy, system and institutional barriers to developing synergies, which both reflect and exacerbate financing trends.

At the level of national development planning, few poverty reduction strategies provide analysis of links between poverty, development, population, HIV and AIDS, or address linkages between SRH, HIV and AIDS in the health section. There is strong evidence for the impact of adverse health outcomes linked to communicable diseases on poverty, and hence a case for investment. However, there is less evidence to demonstrate the impact on poverty, and on the burden of disease, of poor reproductive health outcomes, including unintended pregnancy and early childbearing, which disproportionately affect poorer women (Greene and Merrick 2005). Furthermore, challenges that affect PRSPs more generally, such as strategy development, implementation, and monitoring and evaluation, also affect capacity to take forward HIV and SRH linkages.

Legislative and policy frameworks provide an overarching enabling environment for effective action on both HIV and SRH, and promotion and protection of sexual and reproductive rights. Laws related to issues that have implications for HIV, AIDS and SRH, e.g. gender-based violence and sexual coercion, discrimination, early marriage, female genital mutilation and widow inheritance, are either non-existent or not enforced. Few countries have a legal framework that protects the SRH and rights of women and men, and the wider human rights of women that enable them to access information and services. Existing laws and regulations, for example, on mandatory and opt-out testing, abortion, and partner and parental notification, can also contribute to violations of sexual and reproductive rights and act as barriers to accessing services.

A review of 16 countries found that policy making processes for HIV and AIDS and SRH are still mainly managed and implemented separately (Policy Project 2004). Policy separation reduces opportunities for developing comprehensive integrated approaches at programming and service delivery levels.

National level SRH and HIV/AIDS programmes tend to be separately administered, funded, and supported by different technical agencies, and often managed through decentralised integrated administrative systems at provincial or district level. Several departments or administrative entities need to be involved in planning and organizing integrated services, and collaboration between these different actors is often inadequate (Mayhew 2000).

Separate institutions may be procuring commodities, developing policies, drug lists, training manuals and technical guidelines that cover FP, MNCH and STI/HIV/AIDS with little interdepartmental consultation. In Malawi, for example, it is reported that both the Safe Motherhood Initiative, funded by DFID, and the Reproductive Health programme, funded by USAID, independently attempted to revise the curricula of all training institutions in the country in the 1990s (ICRH/GU, 2000).

Financing and co-ordination of supplies is of particular concern. Separate supply systems often exist for ARVs and other commodities funded by the GFATM and PEPFAR, while RH commodities and drugs for opportunistic infections and STIs are subject to frequent stockouts. There are moves to improve reproductive health commodity security in many countries, but condoms continue to be supplied separately by national HIV/AIDS control programmes, and linkages between RH and HIV condom policy and programming tend to be weak, with limited participation in national RH commodity security working groups (DFID HRC 2006).

Policy-implementation disconnects at national and regional/district levels are widely cited by informants and in the literature. Implementation is constrained by inadequate financial resources and a lack of shared operational policies – regulations, guidelines and protocols. In Swaziland the low uptake of VCT/PMTCT services in antenatal care was attributed to lack of a PMTCT education and communication strategy despite policy formulation several years earlier (Policy Project 2004).

Box 3: Challenges remain at country level: the case of PMTCT

Despite the many promising approaches, coverage at country level remains patchy and inadequate for STI diagnosis and treatment, for MNCH services that take HIV into account, and for comprehensive approaches to HIV prevention and SRHR promotion for young people.

Continuing low take-up of PMTCT services illustrates this issue. PMTCT is widely acknowledged to be failing its potential: services reach only 10% of pregnant HIV positive women (and 5% in much of Africa). PMTCT services have been introduced in 100 countries, but are available nationwide in only 16 (Unicef 2005). Despite often high levels of ANC attendance, in many countries PMTCT services are available only at secondary level, with serious impact on equity of access by the poor. Of the 11 pilot countries starting PMTCT in 1998, only Botswana, with a reasonably well resourced and equitable health system, had achieved national coverage of at least 50% of women in need by end 2004, growing to 73% in 2005.

The overarching problem is that PMTCT services are usually financed, managed and supervised as an add-on or standalone programme, functioning alongside often poorly resourced MNCH services. PMTCT has rarely been fully incorporated as a core component of an MNCH service that has been enabled to take the implications of HIV into account, in terms of implications for contraceptive choice, maternal health or infant feeding, for example. The main barriers to scale up cited by review informants and in the literature, including the evaluation of 11 pilot programmes in 2003, lie in weak health systems, limited human resources and supplies (including lack of on site ARVs), lack of male involvement and community mobilisation, and persisting fear of and actual stigmatisation by providers and communities (Rutenberg 2003).

Linked with these constraints are risks. There are anecdotal reports in Kenya and other countries that, as HIV testing is introduced into poorly resourced ANC settings, women may feel under pressure to be tested. High rates of fall-off after registration persist – while women may consent to have an HIV test, studies in Kenya and Zambia indicate that at least a quarter of women do not return to find out their results (Rutenberg et al 2003). There are growing reports that fear of stigma may even be deterring some women from seeking other ANC services as well as PMTCT.

Lack of coherence in policy and operational guidelines means frequent inconsistencies in cost recovery policies, e.g. user fees for some SRH services, including payment for contraceptives and ANC tests, but not for some HIV related services such as PMTCT or condoms (WHO 2005). Equity of access is a major challenge, given the weaknesses at peripheral level. Low income and marginalised groups are disproportionately affected by unwanted pregnancy, unsafe abortion, child mortality, poor maternal health, HIV and other STIs. Some services, such as ANC may meet the needs of the poorest while other services such as PMTCT may only be available at secondary facilities.

Human resource capacity is a major constraint, with peripheral health facilities in particular suffering severe staff shortages. As well as international and regional migration, there may also be a localised brain drain of SRH programme/policy workers switching to funded AIDS programmes (reported in Kenya and Zambia). A recent review in Rwanda found that physicians employed by NGOs to deliver HIV and AIDS services were paid almost six times as much as physicians paid by the MOH (Foster et al 2006). Such differences in salaries make it particularly challenging to keep well qualified health personnel in the public sector. Additional finance for human resources is an important opportunity for recruiting staff into the public sector and several countries are drawing on GFATM and PEPFAR funding to offer three year contracts, with plans for continued funding by government. However, as Malawi's experience (Box 1) illustrates, funding requirements and HIV specific targets may not always enable health workers to work across services or programmes.

5.5 The impact of religious conservatism

At national and international levels, religious conservatism is a growing force that is affecting SRHR promotion and HIV prevention programming. Among donors, USG policy, such as the Mexico City Policy (Global Gag Rule) and AIDS legislation, in particular is resonating with, and reinforcing local religious conservatism (SIECUS 2005). Where government is not robustly leading the response, and lacks strong support from its UN partners, this can lead to a patchy and confusing picture at country level. Informants to this review referred to a 'geographical lottery', especially for young people, where national leadership across sectors may be weak and types of information and services depend entirely on the programme's source of funds.

5.6 USG AIDS legislation and impact on comprehensive programming

Provisions of the AIDS related legislation, the US Leadership Against HIV, TB and Malaria Act 2003, related to prevention are based on the ABC approach, "Abstinence, Be Faithful and, as appropriate, correctly and consistently use Condoms." Application of the ABC approach is through population-specific interventions that emphasise abstinence for youth, including the delay of sexual debut and abstinence until marriage; HIV testing and fidelity in marriage and monogamous relationships; and correct and consistent use of condoms for those at high-risk, including sero-discordant couples.

The law requires the allocation of 20% of all PEPFAR funds to prevention, of which at least 33% must be allocated to abstinence until marriage programmes (known as AB funding, which includes abstinence only and be faithful). Funds for AB may be programmed with those for 'other prevention' activities, including condom use, and

there are several such programmes, for example in South Africa, Botswana and Zambia.

To date, documented effects mainly concern how the law is being applied and interpreted by the Office of the US Global AIDS Co-ordinator (OGAC), US country teams and contracting agencies. A recent analysis by the US Government Accountability Office (GAO) found that requirements challenge team ability to design programmes that respond to key elements of the ABC model in specific contexts, and report sometimes perverse and concerning effects at country level (GAO 2006). The large majority of the 20 US country teams report that AB spending requirements make it difficult to respond to the local epidemiological context and social norms (which is stipulated in the legislation). Nearly half the teams also reported that the requirement to segregate programme finances reduces their ability to deliver flexible and comprehensive approaches especially for at risk groups.

Social marketing is both the major source of condoms, as well as contraceptives in many countries, and critical to behaviour change. The US has been a world leader in, and major funder of social marketing, but its support is affected by funding requirements. The GAO review found that, although central guidance is mainly well understood, teams are uncertain about which condom related activities are permissible, especially the difference between condom information and condom promotion.

In countries with generalised epidemics, teams reported confusion – while condom use can be encouraged among discordant couples, it is not clear whether strategies such as social marketing are permitted even when much of a country's affected population are discordant couples who do not know their status (considered the major at risk group in for example Kenya's PEPFAR strategy). One country team reported that its allocation to social marketing was at risk, due to the need to report its AB spending target. In this unnamed country, US finance had traditionally paid for marketing and promotion, with condoms supplied by another donor (probably DFID).

The recent US GAO report findings and anecdotal reports indicate a risk that USG policy and its interpretation are having a chilling and undermining effect on the development of comprehensive programming strategies, especially in generalised epidemics. In Kenya, a media programme for young people has chosen not to renew PEPFAR funding, due to reluctance to strengthen messages about less than 100% condom effectiveness. There is also a danger that the promotion of condoms mainly with 'at risk', and often stigmatised groups, and their association with 'immoral sex', will further stigmatise condom use and limit opportunities for shifting social norms towards safer sex and dual protection.

Overall, the approach taken by US contracting agencies is a cautious one, marked by an understandable reluctance to 'bite the hand that feeds us'. As one country based informant emphasised: 'It's very frustrating. We can only give confusing messages now. It's like giving someone a vehicle, but then telling them they will have an accident. So why would they bother to use the vehicle?'

5.7 Limited role of civil society and private sector

Community based programmes involving existing community health workers and community members represent a significant and neglected community resource for service delivery. However, it appears that there are very few links made between health programmes, such as home based care, community based DOTS TB and SRH services (the latter are not covered in PEPFAR financing criteria for home

based care for example). This risks a serious missed opportunity and a danger that similar parallel initiatives will be developed by SRH or TB programmes, also in need of community mobilisation.

NGOs and CBOs play an increasingly important role in HIV responses, in community based mobilisation, in social marketing and providing community based prevention and care services, and in reaching key groups, such as MSMs, and sex workers. However, the primary focus of many of these organisations is HIV and AIDS, often with sexual, but not reproductive, health expertise. Additionally, there has been an increase in funding of faith based organisations with limited experience of working in HIV or SRH. PEPFAR funding is contributing to this through awarding funds to a range of inexperienced faith based groups who focus on narrow prevention programmes (SIECUS 2005). USG legislation does not require them to provide information to clients about condoms.

SRH NGOs often play a major role at national level in providing and advocating for SRH policy and services. Many already have a good track record of working with government. However, while many have been slow to take HIV into account, they also rarely have policy influence in CCMs, for example or are not in receipt of AIDS funds (IPPF/GTZ 2005).

The private sector is an important provider of AIDS treatment and care and SRH services, especially to key vulnerable groups. However, the quality of care and treatment for issues such as STIs is usually poor and clients rarely receive counselling or advice about safer sex. Interventions are needed such as social franchising to improve service quality and affordability.

5.8 Enabling processes to promote linkages

In some countries, government, civil society and donor processes are enabling progress in promoting synergies (see also Box 4 Kenya case study).

- In Kenya, stronger government and donor co-ordination are helping to develop HIV/AIDS policies and plans for the health sector as a whole, to strengthen the sectoral response across programmes. The maturing SWAp process is providing an enabling environment. The DFID funded Essential Health Services Programme includes mainstreaming HIV in all its outputs, with a focus on SRH, and the HAPAC AIDS programme provides strategic support to the NAC and the HIV/AIDS programme.
- Cross programme working groups and task forces have helped develop synergies. The Zambian MTCT Working Group requires PMTCT donors to support all elements of antenatal care. (Rutenberg et al., 2002). Kenya's PMTCT task force has enabled the RH and HIV/AIDS programmes to develop joint guidelines, protocols, training and supervision schedules. In Uganda, a range of stakeholders developed policies and guidelines to support delivery of VCT, PMTCT and ART services and of integrated care.
- Synergies have been promoted through allocation of funds to support cross cutting posts together with programme resources. The GFATM funded PMTCT post in Zambia is based in the RH division, not the HIV/AIDS programme, which is leading to better incorporation of PMTCT into routine MNCH services. Uganda's RH division also plans to appoint a PMTCT focal point.
- Demonstration projects with scale up plans, together with targeted finance and expert technical assistance help to develop the linkages. Several USAID implementing agencies, such as PSI, FHI and Population Council are providing this support to integrating FP, VCT and PMTCT.

- The role of 'dual champions' as high level advocates has great potential in building support and ownership, in both national and international agencies. Ghana's presidential adviser is an SRH and HIV/AIDS expert, and the chair of Nigeria's NAC has a reproductive health background, which is felt to increase their openness to considering linkages.

Box 4: Linkages between SRH and HIV: Kenya country perspective

Kenya has made progress with scaling up linkages between SRH, HIV, and AIDS in several key areas, although institutional and financing challenges continue. The need for integration is referred to in a number of Kenya's new key policy documents, including the national health strategic plan, the health sector plan for HIV/AIDS, and the new national HIV/AIDS strategic plan (mainly in the area of prevention). The RH strategy and FP/RH guidelines highlight the relationship between HIV and maternal health, and emphasise safe sexual practices including abstinence, dual protection advice and the use of barrier methods to prevent infection.

Kenya: Progress with key priorities

STI services: STI counselling and treatment/referral have been integrated with ANC, FP and general curative services. STI services now being offered in 9 out of 10 facilities, although operational challenges remain in terms of staff time and capacity, inadequate supply of STI kits and limited condom provision and safer sex counselling.

VCT: National access to VCT has improved dramatically both in terms of sites and uptake and FP services are now included in VCT guidelines. A joint HIV and RH taskforce developed a national integration strategy based on four levels of integration. However, common problems include VCT centres being financed and developed independently, which hinders integration. Pilot work with the Population Council has also begun to integrate VCT services into FP provision. There are also concerns that both VCT and DTC (diagnostic testing and counselling for STI, TB and other clients) are focusing on increasing numbers on ART treatment (in line with targets), rather than as an opportunity for prevention counselling for people testing HIV negative.

PMTCT: The PMTCT strategy and its implementation represents a degree of integration with existing RH services, with a joint technical working group and shared supervision with other RH services. PMTCT services are available nationwide and at all levels of the health system. However, PMTCT coverage remains low at 10% of all HIV pregnant women. Pathfinder International's work in improving PMTCT integration at facility level has shown that strengthening basic ANC services and infrastructure, as well as community education improves both PMTCT and ANC uptake.

ARV treatment: There are over 100 comprehensive care centres nationwide where the clinical focus is ART care. Referrals are offered for other health services such as STIs, SRH needs and TB treatment. RH expertise is not represented on the ARV taskforce. IPPF is working with Family Health Options, its Kenya affiliate, to develop a more integrated model using traditional SRH services as an entry point to VCT, PMTCT and ART.

Vulnerable groups including youth: Approaches to providing access to prevention, treatment and care for vulnerable groups such as sex workers have largely been HIV focused and rarely take wider RH issues into account. A new policy for comprehensive adolescent SRHR, including HIV and AIDS, was launched in 2006, which provides a major opportunity for mobilising cross government and civil society action. The SRH needs of orphans and vulnerable children are beginning to be acknowledged. Multisectoral programmes that address the SRH and HIV needs of adolescents in several districts are being developed and implemented by the Frontiers consortium, including the Population Council and PATH.

Continuing challenges

Historical relations and dominance of the AIDS Control Programme in the national response has led to some tensions, unclear leadership and confused roles between MoH and NAC. NAC reforms and new senior management are reducing competition and should improve

scope for coordination and linkages but RH participation in high level AIDS related bodies, including the national AIDS commission remains limited.

While a sector wide approach is emerging, Kenya's MoH is still dominated by vertically run, parallel service delivery programmes which limit the involvement in RH staff in HIV programme development and planning. The HIV/AIDS programme receives earmarked support from PEPFAR/CDC, and opportunities for strengthening infrastructure for MCH for example are limited. Annual AIDS funding to the health sector has risen from \$12m in 2001 to \$71.4m in 2004. SRH funding has fluctuated but remains under \$10m. Off-budget support to AIDS, according to a recent public expenditure review is nearly two-thirds of total on-budget support to health.

Anecdotal reports suggest that national religious conservatism is compounding the impact of USG policy, and that comprehensive prevention strategies are being undermined. Despite the fact that sero-discordant couples are defined as a major at risk group, there are reports that demand for condoms is dropping, while significant finance is enabling the expansion of AB only approaches.

Source: Kenya synergies case study 2006, Pathfinder 2005

6 POTENTIAL OPPORTUNITIES FOR ENGAGEMENT

6.1 Actions on commitments

There are four specific areas that present opportunities for DFID and other agencies with strong SRHR, HIV and AIDS commitments.

a) Maintaining and promoting the credible and evidence based position on comprehensive approaches to prevention, especially providing youth friendly SRH information and services, including HIV and AIDS. Clear national leadership and strong government support can provide a robust environment in which the evidence for comprehensive approaches can be defended, and where national and international implementing agencies can confidently negotiate their case with funders. Where appropriate, advocacy with partners such as UNAIDS, UNFPA and IPPF may be needed, to encourage them to proactively support a multi stakeholder position across government ministries and civil society.

b) Donor support of social marketing is a crucial component of the HIV response and wider SRH needs. Distribution and promotion of condoms and contraceptives through social marketing (including the mass media) can create a significant halo effect that supports the wider acceptability of male and female condoms, and helps to counter any negative effects of national and international religious conservatism. Support to social marketing can also provide much needed resources for research into, and promotion of, dual protection messages.

c) Building and promoting the case for investment in existing MNCH services, as a cost effective route to reach women at risk and who are already HIV positive, to improve HIV, SRH and child health outcomes, and to strengthen linkages with other critical services such as TB.

d) Developing and promoting the case for including SRH interventions in programmes for vulnerable groups and for PLHA, as part of comprehensive prevention, treatment, care and support services.

6.2 Opportunities with multi and bilateral donors

Several donor agencies expressed interest in these issues during this review. Potential areas for collaboration include better understanding and responding to the impact of religious conservatism. Equally, key foundations, including Hewlett and McArthur are potential collaborators.

The EC's new policy framework and Africa strategy continue to show strong commitment to addressing HIV and AIDS in the context of SRH and gender inequalities. Advocacy is needed to ensure budgetary allocations through Commission thematic budget lines, and at country level, through the process of developing new country strategy papers in 2006.

Opportunities are also opening up at the World Bank for building stronger links between hitherto separate HIV and health funding streams, where SRH has had a low profile, and for influencing grant and loan investments, including consultation on new strategies for HIV and AIDS in Africa and for health, nutrition and population.

Continued advocacy is needed for leadership and action on linkages by the main UN agencies, especially UNFPA and UNAIDS. Ongoing reform processes may consider how to ensure that stronger normative support is offered to governments, and ensure that SRHR continues to receive emphasis, given bilateral funding trends.

GFATM stakeholders may consider strengthening their positions on relevant policy issues. Consideration could be given to a broader definition for 'HIV prevention, treatment and care', so that key SRH services (especially FP advice and commodities) can be financed where appropriate. Equally, as a country driven mechanism, involvement and advocacy may take place in the context of agency contributions to CCMs.

Advocacy may be considered to raise the profile of HIV and AIDS in the Reproductive Health Supplies Coalition and promotion cross programme approaches to commodity security. Similarly, the new Partnership for MNCH is considering how to best integrate HIV related concerns.

6.3 Supporting harmonised country processes with key stakeholders

Progress on synergies has made most progress where developing clear and feasible policy and funding strategies have involved key stakeholders.

As part of wider investment in public sector reform, donor support to sector wide management processes represents a major opportunity for developing a comprehensive health sector response to HIV/AIDS, as part of universal access commitments. Sector strategies can provide opportunities for stronger strategic and operational linkages between the MOH's various programmes, and co-ordinated efforts to strengthen policies, human resources, procurement, supplies, infrastructure development and services.

HIV/AIDS and SRH programme plans may seek to jointly harmonise targets and performance benchmarks with the national AIDS strategic plan and health sector plan. Donors can support harmonised processes by promoting joint task forces and funding technical assistance and MOH posts for mainstreaming HIV into relevant health services (eg Kenya and Zambia), or for harmonising procurement processes and supporting government owned commodity accounts, and advocating for any programme financing to SRH to take HIV needs into account and vice versa (e.g. treatment services). Reproductive (and sexual) health commodity security working groups are helping to build better understanding across RH and HIV/AIDS programmes, and to support effective condom policy and programming, along with development of private sector participation, public private partnerships and a total market approach.

There is continued rationale for high level and catalytic financial and technical and support to SRH services (that fully take HIV into account) at country level, ideally programmed in line with the national sector wide approach. Demonstration projects with targeted finances and technical assistance to scale up operations are helping to develop linkages.

Explicit, agreed division of roles and responsibilities between NACs and MOHs are conducive to integrated approaches to HIV/AIDS and SRH policies, programming, and service delivery. Co-ordinated by the NAC, HIV is also taking its place as a development issue. This has implications for mainstreaming in key sectors and for action in education, legislative frameworks etc. These processes provide opportunities to address wider structural issues such as inheritance rights for women and young people, and a cross ministry and civil society response to the needs of young people.

HIV funding is often pooled in a separate 'AIDS basket' or other joint financing arrangement to support the NAC. Where donors are involved in health sector and

HIV/AIDS SWAps, they can influence planning and resource allocation processes, such as the World Bank's support to both health and HIV/AIDS in Burkina Faso, where integrated commodity supply chains have been strengthened.

Further research could focus on exploring and comparing the likely effectiveness and impact of proposals for achieving universal access, such as strategies for deployment of human resources in Malawi, impact of programmatic support for reproductive and child health (which takes HIV and AIDS into account e.g. Eritrea and Zimbabwe), and new strategies such as demand side financing for maternal health (e.g. Kenya) and performance based contracting (e.g. Rwanda).

6.4 Civil society and private sector engagement

Major opportunities lie with involving the not for profit and private sector, and the demand side, through voucher and social marketing/franchising programmes, for example. Promising developments have not been taken to scale, and require shifts in national government thinking concerning public sector stewardship functions as well as new financing mechanisms.

Donors are supporting several models as part of national strategies for financing the non-government response to HIV and AIDS (eg Tanzania, India, Zambia), managed by a management agency but governed by the NAC and other partners. While these mainly focus on HIV and AIDS, the Challenge Fund in India has convergences between HIV, AIDS and SRH as one of its themes. These types of funding mechanisms could promote integrated approaches, through grant making criteria for example.

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A member of the review team attended the Consultative Meeting on the linkages between HIV, AIDS and SRHR, organised by IPPF and the International HIV/AIDS Alliance in January 2006, and accompanied the DFID Kenya AIDS scoping mission in February 2006.

ANNEX 3

Progress in making priority linkages

(See Annex 4 for literature summary: available as separate file)

1 Including HIV interventions in existing services

1.1 STI/HIV prevention and STI management

STI/HIV prevention is now integrated into FP and MNCH policy and strategy in many countries. A WHO review of progress in the 1990s found increased quality of services, improved providers' attitudes and communication skills about sex and sexuality, and increased access and utilisation of services, due to expanded coverage and outreach to men, youth or other groups not previously the focus of FP (WHO 1999). Provision of STI services had not driven away FP clients, as had been feared. With sufficient resources and training, cultural barriers to discussion of sexuality and resistance of service providers to integration of new tasks had been managed successfully (Mayhew 2004, Askew and Berer 2003).

However, there are continuing technical and programming challenges for delivering syndromic STI management, especially for women. Lack of infrastructure and supplies has also meant that while information and counselling services may be incorporated, clients may be referred for diagnosis and treatment of STIs. Reorienting services and programming approaches remains a challenge. Many FP and MNCH programmes have yet to make the transition from fertility control to provision of integrated sexual and reproductive health care, and do not yet take HIV/STI considerations into account, including issues of prevention and dual protection, and contraceptive options for HIV positive women.

Men are a key target for STI services and their health needs differ from women. There is mixed evidence on whether men are or are not attracted to family planning settings that serve women. Increased STI coverage has been largely achieved through diversification and special programmes for men, rather than through the integration of STI services into existing FP/MNCH settings (Foreit et al 2002). However, in Bangladesh, adding STI diagnosis and management services for men in rural health centres, traditionally targeting women, has proved effective in increasing STI services for both men and women (Population Council 2000).

1.2 VCT, PMTCT and ART services

Where there are high rates of HIV infection and high utilisation rates of FP/MNCH services such as ANC, incorporating HIV interventions into existing services is a cost effective method to reach female, mainly married clients. Although at risk of infection, or already HIV positive, they may not use free standing services such as VCT due to stigma, lack of access or information and also because they perceive themselves at low risk of HIV infection.

Overall, the research suggests that, where adequately resourced, including HIV related services in SRH programmes helps to increase utilisation and benefits to clients across a range of SRH and HIV needs.

Community based FP distributor networks have been successful in delivering HIV information and condoms, as well as FP. In Zimbabwe, programme monitoring of FPA pilot programmes suggests that integration delivers synergies: VCT referrals have increased eight fold over a two-year period, and both male and female condom distribution increased dramatically (FHI Network 2004). Access to and use of FP has also improved, due to for example provider retraining, strengthened referral and

supply systems. The FPA networks included male agents, and also proved effective at reaching men.

In low prevalence settings, community based FP programmes can provide a strategic opportunity for introducing HIV prevention into RH and community development approaches. Community based approaches to integrate HIV into existing community outreach have been developed in Ethiopia, which have resulted in increased uptake of condoms and other FP, as well VCT referrals (Pathfinder International 2005).

Pilot projects that integrate VCT and PMTCT services into FP/MNCH services in resource constrained settings have been reasonably successful (FHI 2004). Monitoring information from pilot programmes in Cote D'Ivoire and Ethiopia suggests that integrating VCT into MNCH/FP services can reduce stigma associated with HIV, increase awareness of healthy sexual behaviour, increase access to and use of VCT services and reduce the costs of VCT services (FHI 2004).

Different strategies are being used in different contexts, depending on what makes sense. For example, PSI in Zimbabwe found that trying to integrate FP services (in addition to advice and information) into VCT sites was inappropriate as FP services were already widely available, but offering VCT at FP clinics made sense.

Research in Kenya, Zambia and Cambodia indicates that good quality counselling and effective communication skills can lead to increased acceptance of HIV testing (Colton 2005, Horizons 2002, FHI 2004). Countries such as India, Botswana, Kenya and Malawi are introducing routine provision of HIV testing as one of a number of antenatal blood tests in MNCH/FP services (and other general health services), from which women can opt out. When fully informed of the benefits of testing, women in high prevalence settings appear to be willing to receive a test. A study carried out in Zimbabwe in 2005 demonstrated that of 285 women, 55% had actually been tested for HIV in pregnancy but 80% would be willing (AIDSMAP 2005).

Strengthening existing services to incorporate and deliver the range of interventions is critical. Pathfinder International's programme with nearly 200 clinics in Kenya improved basic ANC services and infrastructure alongside introducing PMTCT (Colton 2005). The number of new ANC clients has increased, as well as higher rates of acceptance of HIV counseling and testing, and increased Nevirapine uptake by mothers and babies. Key components included a sensitization campaign (for providers, traditional birth attendants and communities), training service providers in PMTCT and counseling, upgrading facilities to improve privacy, and developing two way referral systems between community health workers and the health facility to improve follow-up. PMTCT has become the norm for women, who feel less stigmatised.

IPPF is developing a model of care with family planning associations in Kenya, the Dominican Republic and Rwanda which uses traditional SRH services as an entry point to VCT, PMTCT and ART (IPPF 2005). Early results after one year of operation are positive: the holistic approach reduces stigma, and numbers of male and female clients for all services have increased.

1.2 Including SRH in HIV and AIDS service settings

The inclusion of SRH interventions in services such as VCT and ART treatment is beginning to receive more attention, especially as part of the emphasis on prevention, treatment, care and support in universal access strategies (Lule 2002, various WHO, IPPF, UNAIDS sources).

Integrating FP in VCT services has had some success. For example, Uganda's experience of integrating family planning into VCT services provided by the AIDS Information Centre demonstrated an 8% increase in demand for contraceptives over time and HIV positive clients reported that integrated services better met their needs (Asimwe and Hardee 2005). Following reports of stigma against clients referred to local health facilities by its VCT service, the GHESKIO NGO network in Haiti integrated on-site primary care services into its stand-alone VCT centres, including HIV and TB care, treatment of STIs, and reproductive health (Peck 2003). Clients valued the package of services, and utilisation increased.

ART scale up is providing new opportunities to deliver and reinforce risk reduction interventions – positive prevention. Recent empirical evidence from Uganda demonstrates that provision of ART, prevention counselling and partner VCT, reduced sexual risk behaviour among HIV infected adults by 70% (Bunnell 2006).

Pilot programmes in countries such as Haiti and South Africa are demonstrating the feasibility of integrating HIV prevention and services targeting PLHA in HIV treatment and health care settings. Haiti's Partners in Health programme provides free integrated prevention and treatment services at primary care level and evaluations have shown sharp increases in detection of HIV infections and uptake of VCT and ART, and TB DOTS treatment completion (Global HIV Prevention Working Group 2004). This evidence supports arguments for the better integration of prevention activities into ART programmes to help reduce HIV transmission, as also recommended during the recent evaluation of the 3 by 5 Initiative.

However, almost no activities have yet addressed wider SRH needs in the context of scaling up treatment and the public health approach to ARV treatment. WHO and UNFPA, with Engender Health, are now developing a framework and tools to support reproductive choices by PLHA that respects their rights to SRHR as well as treatment access.

This includes addressing a key issue: lack of guidance and respect for the reproductive choices and access to fertility control for HIV positive women and men (ICW 2004). Attitudes to HIV positive women and pregnancy depend on the extent of a community's openness about HIV and AIDS, its fertility norms and its exposure to PMTCT services. In India, Dominican Republic and Thailand, surgical sterilisation is a commonly advised method for positive women, suggesting that priority is given to reducing the number of infants born with HIV, rather than protecting the reproductive rights of mothers. In Uganda and Kenya, providers have discussed the tension between the public health approach and reproductive rights in their counselling services (Rutenberg and Baek 2005).

Access to contraception is part of PLHA rights to reproductive choices. However, although family planning has been adopted as one of the elements of national PMTCT programmes, family planning utilisation is not monitored or evaluated as part of PMTCT services. Although services may be available in the same facility (and therefore defined as integrated), they are not always incorporated into routine care. Recent Population Council analysis of eight countries across Africa, Latin America and Asia found that availability of FP services at same sites as PMTCT did not mean that an integrated service was provided (Rutenberg 2004).

Analysis compiled by FHI indicates that prevention of unwanted pregnancy among HIV positive women, by adding FP to PMTCT services, could double the impact of PMTCT in preventing infant HIV infections as well as contributing to the women's own health (Best 2004). Success factors include the closer linking of family planning

services and counselling in space and time to PMTCT programmes and placing more emphasis on FP counselling for HIV positive women during the ante and post natal periods (Rutenberg 2005).

1.3 Programmes for vulnerable groups

The literature review found few examples of HIV programmes that provide a range of SRH services to vulnerable groups such as female sex workers, or that take the SRH needs of men who have sex with men, or male and female IDUs, and their sexual partners into account (Mayhew 2004, Des Jarlais 2005). In interviews, informants cited their concerns about missed opportunities: vulnerable groups are receiving HIV services that mainly address their sexual health needs, notably condom provision, HIV/STI education and access to STI services. Lack of knowledge about reproductive health and limited access to contraception or safe abortion contributed to unwanted pregnancies as well potential new HIV infections.

However, where SRH, HIV and AIDS services have been offered together, they have proved popular and effective. These include the Sonagachi project targeting sex workers and their families in India, the PRIME II project working with young sex workers and clients in the Philippines, the Nicaragua STI voucher scheme for sex workers and their clients, and the Colombia Profamilia programme for MSM.

Experience of integrating HIV and STI services into existing public SRH services is mixed: in Ecuador for example, SRH service providers were unwilling to facilitate the uptake of services by key populations, who suffered stigmatising attitudes and did not access the services they were entitled to (International HIV/AIDS Alliance 2004). On the other hand, some IPPF affiliates are having some success in tailoring its SRH services to meet MSM needs. In Pakistan, the referral of HIV positive commercial sex workers to FP clinics who then refused to treat them, led to the integration of FP provision through a private VCT provider targeting this group.

1.4 Programmes for young people

Comprehensive prevention education and services for young people combine a range of interventions that include access to youth friendly services, community based mobilisation and peer support and in-school education. Examples include the AYA programme in Ghana, Lovelife in South Africa and Amref's Tanzania Mema Kwa Vijana programme. Evaluation findings include greater self-esteem and self-efficacy, and knowledge about SRH issues, increased condom and contraceptive use, delayed sexual debut, reduced number of sexual partners, and greater likelihood of seeking appropriate treatment for STI symptoms. Mozambique's Geracao Biz programme has successfully combined youth outreach with access to health services, for SRH and HIV related needs, including VCT and PMTCT.

There is no evidence to demonstrate the effectiveness of abstinence-only programmes, either in developing or developed countries (see Box 1).

The review found virtually no research on effective approaches for orphans and vulnerable children even though there is growing evidence of early sexual debut, increased risk through coercive sex and violence, and high risk behaviours to support themselves and their families, especially among girls (FHI 2005).

Box 1: Comprehensive and abstinence-only approaches for young people

Evidence on the value of comprehensive sexual and reproductive health approaches versus HIV specific approaches (and particularly abstinence-only-until marriage) is reasonably clear, although there is limited data from developing countries. Evaluations of abstinence-only-until-marriage programmes in several states in the United States show that these programs fail to limit sexual activity among adolescents or provide them with the skills they need to negotiate sexual relationships in order to abstain (Hauser 2004).

A 2001 report analysing evaluation studies of HIV prevention and sexuality education programmes in the US concluded that programmes that included information about the use of condoms and contraceptives as well as abstinence can successfully delay the onset of sex and increase the use of condoms among sexually active teens (Kirby 2001). Two studies comparing abstinence only programmes with comprehensive programmes, conclude that the latter have longer term results including greater levels of abstinence as well as condom use (Schreck 1999, Jennott et al 1999).

Impact on young people's behaviour in developing countries is also stronger when programmes combine information and skills building on abstinence, delayed first sex and safer sex (CCP 2003, Fitzgerald et al, 1999, Alford 2005). Evidence from Zimbabwe raises concerns that unless the full facts are given to young people, misconceptions result. Another survey among university students indicated that nearly half of those surveyed believed that having oral or anal sex constituted abstinence (Horan et al 1998).