

PATH Convergence Project

Convergence of HIV and SRH Services in India Impacts on and implications for key populations

A Literature Review

(January 2007)

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Anti Natal Care
ART	Anti Retroviral Therapy
BCC	Behaviour Change Communication
CBRHA	Community Based Reproductive Health Agents
FP	Family Planning
FPAK	Family Planning Association of Kenya
FSW	Female Sex Worker
GTZ	German Technical Cooperation
HDN	Health Development Network
HIV	Human Immunodeficiency Virus
ICRH	International Centre for Reproductive Health
ICW	International Community of Women living with HIV/AIDS
IPPF	International Planned Parenthood Federation
MCH	Maternal Child Health
MOH	Ministry Of Health
MTC	Mother-to-child
MTCT	Mother to Child Transmission
NGO	Non Governmental Organisation
PEP	Post-Exposure Prophylaxis
PMTCT	Prevention of Mother-To-Child Transmission
RCH	Reproductive Child Health
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	United Nation's Program on HIV/AIDS
UNFPA	United Nation Population Fund
UNICEF	United Nations Children Fund
VCT Services	Voluntary Counselling and Testing
WHO	World Health Organisation

Summary

Experience with convergence processes has been accumulating substantially in recent years, even while initiatives remain mostly project-based and therefore patchy. This review gathers some of this experience and explores the implications and potential benefits of these initiatives from the perspective of three groups of people for different reasons important to the HIV/AIDS landscape: HIV positive men and women; young sexually active men and women; and female sex workers. Bearing in mind issues of gender and sexuality which mediate responses to convergence processes, and which compound the stigma and discrimination associated with HIV/AIDS, the review notes that convergence requires firm roots in the rights approaches advocated by these key groups to address their needs in comprehensive ways.

People living with HIV often face discrimination in general health services which needs to be extensively addressed where HIV services are located in them. Stand alone HIV service points which have added-on SRH services are often preferred by positive people but remain in some cases challenged by problems of quality, coverage, and inadequate skills to comprehensively address sexual matters. Like general health systems, they are at risk of obscuring women's rights to control their fertility by sometimes coercive efforts to prevent positive people from having sex or getting pregnant. Recent literature exploring the fertility intentions of positive people places their fertility choices firmly in the realm of social relations which in many contexts associate motherhood with status – a situation which converged services have the potential to address more explicitly.

Young sexually active people, and in particular girls, have even less access to regular health services than older women in some places, and are hampered by social vetoes on adolescent pre-marital sexuality. Efforts to make reproductive health services more youth friendly are more successful when they combine good provider training with general improvements in clinic facilities and outreach activities in the community, including advocacy and working with schools and the media. Youth centres which combine SRH/HIV services with social or educational activities have also shown promise for reaching young people.

Work with female sex workers is hampered by roots in approaches which are largely concerned with the infective potential of their sex organs for the sake of the wider populations whom they service, with the result that integration initiatives remain mostly confined to adding on STI services to HIV education and sometimes coercive condom promotion programmes. Convergence initiatives which keep sex workers' rights firmly in the foreground and work with their agenda have the potential to contest the social processes constructing sexuality which place them at high risk of stigma, discrimination and social exclusion.

Evidence points to the importance of promoting a central role for these key groups in taking convergence forwards, but efforts to do are challenged by a number of management and policy issues affecting the implementation of integrated services. Experience suggests that training in SRH/HIV combination service provision is most effective when intensive, participatory, extends beyond facility based workers to the community, and takes account of the difficulties providers face in resource-poor settings. Supplies of drugs, basic equipment, and human resources are often difficult to sustain in contexts of increased demand stimulated by converged services, and funding systems which mitigate against integration – although maintaining supplies for Universal Precautions could be a significant strategy for tackling stigma and discrimination. Separate funding streams for HIV and SRH, and separate management systems continue to hamper co-ordinated efforts, though progress has been made

in some places. Meanwhile a conservative global political environment has strengthened the hand of groups working against reproductive and sexual rights. The central challenge is to meet these practical demands while keeping people and their rights firmly in the foreground.

1. Introduction: the ‘convergence’ landscape

Experience with the processes and outcomes of the convergence of SRH and HIV services and structures has been accumulating rapidly – although somewhat patchily – in the last few years. High levels of official commitment to exploring the synergies between SRH and HIV environments and objectives (e.g. WHO 2006) are gradually translating – despite a range of enduring challenges – into a body of evidence around what happens when services are integrated.

SRH/HIV ‘convergence’ or ‘integration’ refers, with good reason, to a very wide range of activities or processes undertaken with the broad objective of capturing the ‘missed opportunities’ which add-on services or overlap areas in SRH and HIV offer. It involves different levels of policy and management, including governments, donors, public health providers, private clinics, and community outreach systems (GI 2006); and different combinations of referrals, information provision, counselling, behaviour change communication (BCC), family planning (FP), ante-natal care (ANC), testing, and treatment. It also involves advocacy at policy levels and in the community. A useful distinction can be made between ‘convergence for mainstreaming’ HIV into SRH services and ‘convergence for quality’ of vertical HIV services. ‘Mainstreaming’ convergence has the broad objective of deeper penetration of HIV services into the general population – by combining them with existing SRH or services such as FP and ANC – usually in settings in which the HIV epidemic is relatively generalised. ‘Convergence for quality’ is concerned primarily with increasing the use-value of HIV services by adding on various components of more comprehensive SRH services – for example, by adding family planning services or abortion referrals to VCT services points – usually in settings where the epidemic is concentrated in certain areas or populations (though it is rarely limited to these). Recent experience, however, has highlighted a strong need for both strategies in both settings (GI 2006).

1.1 ‘Mainstreaming’ convergence

There continues to be a strong commitment to basing the scale-up of existing programmes on a solid evidence base, which is beginning now to come together on specific aspects of convergence – in particular around the integration of various HIV services into existing FP/MCH/ANC arrangements – to the extent that certain ‘lessons’ are now beginning to emerge. Convergence of this kind has included a range of activities, such as adding VCT or HIV education and counselling services to ante-natal care and / or family planning service points; introducing ‘opt-out’ HIV testing into ANC and medically supervised childbirth systems; linking MCH services to PMTCT and/or extending these to lower service delivery levels; offering ART in TB and ANC clinics; including STI treatment and testing in ANC or other public services.

Emerging lessons include that there are indeed benefits of integrating services in terms of increased coverage and client satisfaction: one recent assessment of an EngenderHealth project to integrate VCT into FP and RCH services in public health facilities in Tanzania found that the service attracted more women than stand-alone VCT test centres and also increased the testing of partners of FP service users, hence bringing the added benefit of drawing men into involvement in FP and RH services (Mphuru et al. 2006). A study in South Africa assessing the impact of adding an additional service – in this case HIV information and VCT – on the original service – in this case family planning services in public health facilities, found no negative impact on the original service (Mullik et al. 2006). Issues of costs are also

beginning to be positively assessed: another South African study found it more cost effective to introduce VCT into family planning settings than establishing stand-alone services, providing staff have the time to provide counselling (Homan et al. 2006). In Ethiopia and Ukraine, integrating HIV prevention into MCH programmes has also been found to generate considerable cost savings (Perchal et al. 2006). In Kenya, where a national strategy to integrate services has been underway for some time, enabling conditions have been identified as a conducive MOH structure in which both RH and HIV programmes report to the same department; the inclusion of HIV and FP components in the national reproductive health strategy; and the existence of service provision guidelines which require the integration VCT and PMTCT with FP and maternal health, amongst others (Koskei et al. 2006).

Other lessons suggest a need for caution: the implications of conducting good quality HIV counselling for staff time need careful assessment (Ross et al. 2005; Mullick et al. 2006; Janowitz et al. 2002; de Koning et al. 2005; Maharaj and Cleland 2006; Gichuhi 2004). Staff burn-out and the turnover of trained staff may be problematic (Asare et al. 2006; Ross et al. 2006); in-service training is key, but may not lead to consistently good counselling. ICW (2004) points out, for example, that many women undergoing HIV testing in ANC contexts are not offered post-test counselling, and may not even have been told what the tests were for. It may be necessary to thoroughly integrate sexuality and human rights training into nursing and medical school curricula (EngenderHealth and UNFPA 2006).

There are also a range of enduring ‘missed opportunities’ in integrated service contexts: in MCH + PMTCT, there is often little attention given to the STI and HIV prevention needs of HIV negative women, despite the risks of becoming infected after pregnancy. The promotion of condom use amongst HIV negative women is also often low (de Koning et al. 2005) and the linking of HIV positive women post-PMTCT to ARV services is often absent.

In addition to these problems, services attached to ANC/MCH/FP provision are known not to reach certain groups of people, in particular women who are not pregnant; women who do not and/ or are not permitted to access FP services; a large proportion of men; and people who for a variety of reasons have difficulties accessing public health facilities.

This review looks specifically at evidence of, and the potential for, benefits and pitfalls of various forms of SRH/HIV convergence initiatives for three specific groups of people: men and women with HIV; young sexually active men and women; and female sex workers. Each of these groups is to different extents socially disadvantaged; rarely have their SRH/HIV needs addressed in the context of ‘mainstreamed’ services, and yet for different reasons are key to the HIV landscape.

2. Factors mediating HIV/SRH convergence

2.1 Gender and sexuality

Any convergence initiative of whatever form needs to take account of certain critical features of the HIV environment. These features are acknowledged as having had strong influence on the trajectory of the epidemic as well as on the performance of programmes to address it. The first is gender, a key determinant of power. It has been established for some time that gender inequality fuels the HIV epidemic and is responsible for the rising rate of infections in young women, and that women and girls now account for over half of new infections. HIV infection

rates reflect the impact of discrimination: gender inequality limits women's rights and agency, diminishes their ability to protect themselves from infection, and strengthens barriers to accessing quality treatment and care (Germain and Woods 2005; Milward 2005). Gender is also a key mediator of sexuality: masculinity and femininity are social and cultural constructs defining appropriate male and female behaviour, including sexual behaviour. Gender-appropriate sexual behaviour is often key for accessing social acceptance and other privileges. An important part of the assessment or planning of converged services is the consideration of how far convergence has or will facilitate women's access to services, how it affects gender relations, and how far it can contribute to addressing gender inequalities.

2.2 Stigma and discrimination

Stigma and discrimination are further critical features of the HIV landscape. HIV-related stigma has been identified as a major barrier to the development of effective HIV prevention programmes, whether integrated with other services or not (Reidpath and Chan 2005; HDN and AIDS Care Watch 2006). Manifestations of stigma in terms of social exclusion and the discriminatory delivery of health care are often referred to in integration literature.

Nevertheless, stigma and its effects are less often unpacked or precisely defined. The body of knowledge on HIV-related stigma has however been growing recently, as have attempts to map out how it can be measured. Stigma has been defined as an "attribute that is deeply discrediting" (Nyblade 2006) and stigmatization as the "process of marking individuals and groups judged to be unworthy of social investment" (Reidpath and Chan 2005). Link and Phelan (2001) identify four interrelated components of stigmatization: labeling 'differences'; associating differences with negative attributes; separating "us" from "them"; and status loss and discrimination. They note that these processes take place in contexts of social, economic and political power and are used to legitimize inequalities such as those of gender, race, ethnicity or class. The end results of stigmatization – exclusions; restricted access to resources etc – is discrimination, and is often referred to as 'enacted stigma' (Nyblade 2006).

2.3 Layered stigma

A key issue for understanding stigma related to HIV is that different stigmas can be 'layered' in any one individual and may not be independent of one another. HIV-related stigma can, for instance, be layered with stigmas associated with personal characteristics such as gender, race, or sexual orientation. 'Enacted stigma' for women, for instance, can take particularly strong forms when compounded by gender inequality, such as violence, abandonment, neglect, and ostracism from family and community. HIV-related stigma interacts with, and is compounded by, stigmas associated with routes of transmission such as sex work and injecting drug use (Reidpath and Chan 2005).

Discrimination as a result of stigma is rife and serious in many health services. It is a critical issue of concern when developing integration initiatives, and especially when integrating HIV services into existing health structures, at the cost of stand-alone facilities. Numerous studies comment on discrimination by service providers in the context of add-on HIV services at MCH centres (Feldman et al 2002; ICW 2004; Infante et al. 2006; Welbourne 2004; Mawar et al. 2005) and note that this constitutes a major barrier towards seeking testing or treatment.

2.4 Trajectories of stigma in integrated services

Some experience is emerging of interventions which have been successful in reducing stigma in the context of integrated services. De Koning et al. (2005) report on successful pilot projects where good training and growing knowledge of staff has reduced stigma at the clinic

level. HIV positive women attending integrated services in Zimbabwe felt that nurses had really changed their negative attitudes after training, and health workers attending workshops were credited with taking women's criticisms on board and recognising their responsibilities in addressing stigma issues (ICW 2002). Training, however, is clearly not always enough to solve the problem: in Mexico, Infante et al (2006) report persisting notions amongst trained health workers of HIV positive patients being hopeless, associations of HIV with death, and of 'innocent' and 'guilty' victims according to ideas of risk behaviour.

Stigma also operates powerfully at community levels, placing stigmatized people at risk of social exclusion, ostracization, and violence, and strongly influencing treatment seeking behaviour. Mshana et al. (2006) identify ongoing pervasive stigma as the major barrier to accessing hospital-based ARV treatment in Kisesa District, Tanzania. Community level interventions working on stigma and discrimination have had some successes in reducing discrimination. In a review of such interventions in Southeast Asia, Busza (2001) reports that a focus on process is a common feature, and emphasises that, as such, reducing community-level discrimination can be integrated into any approach to HIV/AIDS.

The persistence of community level stigma and discrimination makes resolute confidentiality a central issue for HIV/SRH integration, even in circumstances where facility-level discrimination has been reduced. Experience emerging from integrated services on this issue appears to be mixed. Mawar et al. (2005) describe hospital-based services in Maharashtra, India, where disclosure often occurs without the knowledge of the patient; HIV diagnoses are listed on open charts; and biohazard labels are used conspicuously to identify HIV/AIDS patients. In Mexico, Infante et al's study found that 38 percent of health workers think that employers have a right to know about their employee's HIV positive status. De Koning et al. (2005) point out that in integrated PMTCT services it is inevitable that several people including ANC health workers and records clerks will know a patient's HIV status. Separate HIV/AIDS wards clearly mitigate against confidentiality. However, Rutenberg et al. (2002) report that workers do maintain confidentiality if its importance has been highlighted in training.

Confidentiality – valued because of the risk of attracting stigma from being known to be accessing HIV services – is also an important issue for stand-alone HIV service points, which combining other less stigmatised services in the context of convergence can contribute to resolving. A study in Kenya describes the desirability of ambiguity around which service is being accessed in integrated facilities (Gichuhi 2004). Young people in particular seem to value the confidentiality suggested by VCT facilities which also offer services not associated with sexuality or high-risk behaviour (ICRW/Population Council 2001), as will be discussed below.

2.5 Stigma and routine testing

De Koning et al. (2005) report that in areas where HIV testing is routine – for instance, integrated with standardized ANC checks – stigma decreases. Routine testing has been standardized in private hospitals in Nairobi, and in Botswana, for instance (and in some high-income countries such as the UK and parts of the US). A study on attitudes to routine testing in Botswana (Weiser et al. 2006) found that most participants were very much in favour of routine testing and believed it would decrease barriers to testing and HIV-related stigma. Rutenberg et al. (2002) recommend the wide implementation of 'opt-out' pre-natal HIV

testing in ANC settings, in which pregnant women are routinely tested, but have the option to refuse.

However, the potential for routine testing to reduce stigma has to be carefully assessed against some major hazards. A commentator in a recent Global Electronic Forum dialogue (EngenderHealth et al. 2006) pointed out that "... the least powerful (especially many women, and the poor, the rural, and the unemployed) are unlikely to disagree openly with anything instructed or requested by a health professional, even though it may not be what they want." De Bruyn and Paxton (2005) argue that not enough consideration is given to the impact routine testing may have on the lives of women who test positive – impacts which may include abandonment and physical abuse. Opt-out perinatal testing carries the danger of privileging the rights of the unborn child – or of the health service which wishes to capture those 'missed opportunities' – over the rights of the mother, particularly in (the widespread) circumstances where no support services are available to protect women's rights and enable them to live healthy lives after a positive diagnosis, and where ARV is not available beyond PMTCT (de Koning et al. 2005).

The issue of informed consent to routine testing is extremely slippery, especially in highly stratified societies which distribute power unequally, so that the authority of the medical community compounds social status inequalities between doctor/health worker and client. The Botswana study found that 68 percent of women felt unable to refuse the HIV test. Nearly 30 percent of women in a Nigerian study indicated that they would not be willing to test even if it were routine (Daniel and Oladapo 2006). The same commentator to the Global Electronic Forum dialogue suggests that many women will not verbally 'opt out' from testing, but may not return for results, and may avoid seeking ante-natal healthcare at all if they know it implies an HIV test (EngenderHealth et al. 2006).

2.6 Human rights

Factors such as gender and HIV-related stigma influence how people enter and experience convergence processes. They structure the inequalities through which different groups of people have different levels of access to different kinds of services, and unequal experiences with them. The notion of human rights, in focusing on the rights that all people should have but which certain groups do not, can serve to establish better recognition of and action on these inequalities. The literature concerning the experiences of key groups such as sex workers, HIV positive people, and young people draws repeatedly on rights language and documents setting international rights standards to draw attention to the abuses of rights taking place within and beyond health contexts, and to how these abuses are socially and historically rooted (De Bruyn 2005; Wolffers 2003; ICW 2004).

Taking SRH/HIV convergence forward requires a solid and generalised notion of human rights embedded in all practices in order to place the experience of the client sufficiently centre-stage. Human rights perspectives on HIV processes have the potential to contextualise health in the broader canvas in which people live their lives, and to draw attention to how people suffering discrimination of a variety of forms can be enabled to claim their rights. Sexual and reproductive health approaches have much in common with rights approaches because, to be fully implemented, they need to come to terms with sexualities and the social processes which control and place judgment on them – and emerging from this relationship, progress has been made in articulating a notion of sexual rights (Correa et al. 2005; Cornwall 2006). In the HIV/AIDS field, conceptions of rights to health, to a life of dignity, and of

human rights in general have fuelled a variety of promising responses. The challenge for the convergence agenda is how to build on these foundations, and, alongside the practical demands raised by management, implementation and monitoring issues, to keep people, and their rights as people, firmly in the foreground.

3. Key groups 1: Women and men with HIV

Women and men with HIV face specific reproductive health needs which are not being adequately met either through ‘mainstream’ integration or through current practice norms in stand-alone HIV services. They are also particularly the targets of stigma and discrimination, which can limit their access to health services, threaten the quality of treatment they receive, and make their health situation only one of a variety of challenges. Groups articulating the experience of women with HIV continue to flag the hazards of integrating HIV services to regular health services as a single strategy, advocating the need for separate HIV services integrated with SRH services until such time as the reproductive and human rights of people living with HIV are adequately recognised by health systems, and HIV-related stigma and discrimination are neutralised (ICW 2004; EngenderHealth et al. 2006). Health care provider attitudes are frequently cited as a source of barriers to integrated services in general health care settings becoming accessible to HIV positive people. Surveys in Asia indicate that more than one in four people with HIV—and more in some countries—have experienced HIV-related discrimination in health-care settings. More than one third have had confidentiality about their HIV status breached, and 15 percent have been refused medical treatment (UNAIDS 2005).

Layers of stigma in the community associated with simply being HIV positive compounded by transmission route-related associations with sexual promiscuity or other high-risk behaviour present particular opportunities and difficulties for convergence initiatives. Confidentiality, for example, may be difficult to maintain in stand-alone services in neighbourhood settings, but may be increased by adding SRH services, so that the anonymity of those seeking HIV services is maintained. Stigma in the community as a result of not breastfeeding an infant in response to PMTCT advice, (Gray 2006; EngenderHealth/UNFPA 2006), may be more difficult to address.

For women living with HIV, the situation is complicated by a tendency to subsume their rights beneath a generalised policy priority to prevent perinatal transmission (EngenderHealth/UNFPA 2006). In most low-income countries, HIV positive women do not continue to receive ARV outside PMTCT programmes, i.e. sometime after delivery (de Koning et al. 2005) – a situation which sends clear messages about the status within health programmes of the women’s own rights. The convergence agenda has the potential to stimulate better follow-up of post-PMTCT women through MCH community care.

3.1 Demand for integrated services

There is a clear stated need for better quality services integrating SRH issues into HIV service points from a variety of sources. A study in Brazil found that many women relied on and preferred specialized HIV centers offering prevention and treatment; family planning, gynaecological services and PMTCT (EngenderHealth / UNFPA 2006). In Ghana, a study found nearly 40 percent of women visiting two ART clinics said they would like a provider to speak with them about family planning (Adamchak et al. 2006). There is also a variety of evidence of unmet family planning needs amongst HIV positive women – for example in

Uganda (Matovu 2006) and in Ghana (Adamchak et al. 2006), as well as indications that clients are willing to access pairs of services at the same facility (Pullum et al. 2006).

Some of the demand for integrated services comes from users of VCT clinics, who may or may not be HIV positive, but are often linked at least by referrals to counselling and treatment centres for those who test positive. In Kenya, a study of one VCT clinic offering FP services found that the demand for family planning outstripped the demand for VCT (Koskei et al. 2006).

3.2 Experience with integrated services

Experience with integrated services of this type is mixed, as is the quality of services offered. In Haiti, STI treatment and other reproductive health care services have been offered at VCT centres for some years, and an assessment found that nearly 20 percent of clients were provided with family planning (Peck et al. 2003). An early assessment of a pilot project in Ghana integrating family planning at ART treatment centres found that family planning counselling and a variety of contraceptives were being provided (Asare et al. 2006). Many initiatives offer only limited SH services, relying at best on referral mechanisms for services not offered in-house. In Brazil, for example, EngenderHealth/UNFPA (2006) report that there were gaps in the capacity of integrated HIV centres to offer comprehensive care – for example abortion services, treatment of unsafe abortion, cervical cancer, breast cancer and asymptomatic STI screening, and postnatal care all had to be sought elsewhere.

While Rutenberg and Baek (2004) note that making family planning available at PMTCT sites does not necessarily imply the successful integration of HIV and family planning messages, a study in Ethiopia reports reasonably high uptake of modern contraceptive methods in some VCT and PMTCT settings (Asnake and Abera 2006), and in Rwanda, 90 percent of HIV positive women who were offered family planning at a PMTCT-VCT site accepted a method (Ngendahimana and Blyth 2006). Several studies highlight that training of providers in family planning counselling is important to the success of such initiatives (Reynolds et al. 2006; Asare et al. 2006)

Like for initiatives developing comprehensive SRH services, integrated services may require new skills on the part of providers in discussing sexual matters comfortably, which are not easy to achieve. Providers may need intensive training to help them introduce a sexual health focus in discussions with clients, and technical knowledge on the advantages and disadvantages of different contraceptive methods in various contexts (de Koning et al. 2005). Intensive training has been shown to have at least modest effects on client-provider communication (Adeokun et al. 2002), but short courses have sometimes also been found to fall short of providing the skills to discuss sexual matters thoroughly (ICRH/GU 2000).

3.3 Reproductive intentions of HIV positive women

Integrating family planning services in HIV service settings has the potential to produce several health benefits: HIV positive women who do not wish to be pregnant are provided with the resources to control their fertility; the number of MTC transmissions can be reduced by avoiding pregnancy; and the ‘dual protection’ role of condoms can be promoted, as protectors against pregnancy and HIV transmission¹. Many integration efforts have largely

¹ Though the advisability of promoting condoms as contraceptives, given their poor record on consistent use and when there are more reliable methods available, continues to be debated (Wright

been driven by concern to fill these gaps, and have thus sometimes been at risk of obscuring women's rights to control their fertility – which might include desiring children despite being HIV positive.

A further opportunity – to help those who do wish to be pregnant to do so safely – has only recently begun to emerge in the picture, perhaps partly as a result of greater experience with integrated services, which have gradually seen the need to come to terms with this issue. A body of evidence is beginning to emerge around the reproductive intentions and fertility issues for HIV positive women, as well as around abuses of the rights of HIV positive women to fertility.

Actively discouraging HIV positive women from having children appears to have been a relatively widespread response to mother-to-child transmission issues, especially in contexts of limited resources, but including in settings where PMCTC services are available (Fleischman 2006). These reactions are partly due to concerns about the child's welfare, partly due to fears that pregnancy can further lower the immunity of HIV positive women, but partly also a blanket response caused by HIV-related stigma (Rutenberg and Baek 2004). Ethiopian HIV positive women and men in the EngenderHealth / UNFPA study (2006), for example, had been clearly counselled to avoid both pregnancy and sex on the basis that sexual activity weakens the immune system and makes them more vulnerable. Providers in the same study said they discourage HIV positive women from getting pregnant; some disagreed that these women have a right to fertility, but acknowledged that they would still provide care including PMTCT. In the Ukraine sample, providers felt that women should not make decisions about fertility without their approval. A study in South Africa found many HIV positive women facing disapproval from both community and health care workers for getting pregnant, and some complained of only being granted a legal abortion after agreeing to sterilization (de Bruyn and Mallet 2006).

A recent review of the literature on HIV status and fertility intentions suggests, however, that HIV status has little effect on reproductive intentions and behaviour. Preliminary results of the review indicate that pregnancy rates are more reflective of age, number of children, and intrapersonal motivation to bear children, rather than knowledge of HIV status (Rutenberg et al. 2006). Available qualitative data suggests that the availability of ART and PMTCT may increase or restore fertility intentions, (Mpangile et al 2006; Degu et al 2006; Rutenberg et al. 2006) but even in their absence the proportion of women intending to bear children may remain high (Cooper et al. 2006).

HIV positive women intending to bear children thus face a dilemma: most services sometimes in place apparently to help them make informed reproductive choices in fact are ill-equipped to do more than discourage them from having children. Brazilian women in an EngenderHealth / UNFPA study rarely shared their reproductive intentions with health providers; in South Africa, another study interviewing HIV positive people found that only 26 percent of women and 12 percent of men had discussed reproductive intention with providers (Cooper et al. 2006). If they do articulate a desire to become pregnant, information on how to

2003; de Koning et al. 2005). Many integrated services promote condom use combined with an alternative contraceptive, usually termed 'dual method' (Wright 2003).

do so safely is piecemeal, relatively difficult to put into action, and anyway unlikely to be forthcoming (see Guttmacher Institute and UNAIDS 2006) ².

Focusing on women's rights – including HIV positive women's rights – to reproductive choice, and developing ways to meet these rights, may be particularly critical in convergence initiatives in the many contexts where women's social status and motherhood are intimately linked, and/or where others – such as husbands, mothers-in-law, or the state -- have the social power to play out their own vested interests in a woman's childbearing trajectory. In these contexts, pregnancy may be a route not only for fulfilling a desire for children, but also to regain value and rights as a mother (EngenderHealth / UNFPA 2006), or may be pressured or forced by others (de Bruyn and Mallet 2006). In some contexts, not having a child is considered worse than AIDS (Rutenberg and Baek 2004). In any context, pregnancy may offer high self-esteem for women, and a possible defence against the 'dehumanizing effects of living with HIV' (Guttmacher Institute and UNAIDS 2006). A widespread emphasis within health systems on women-when-pregnant, including within HIV services via PMCTC, may have contributed to the privilegeding of pregnancy in women's lives (EngenderHealth et al. 2006).

3.4 HIV positive men

Partly due to the fact that the vast majority of integration initiatives have in effect attempted to combine HIV services with some form of reproductive health services (ANC, family planning, or mother-child health) – and therefore there has been relatively little experience in integrating HIV services with comprehensive sexual health services -- the focus of virtually all discussion on integrated services and HIV positive people has actually been on HIV positive women. Relatively little has been said about the experience of integrated services for HIV positive men; and almost nothing on the reproductive intentions of HIV positive men. One exception is a study in Sao Paulo, Brazil, which found that nearly half of HIV positive men wanted children, and especially those who had no children yet (Paiva 2003). The neglect of issues such as these reflects a wider challenge of bringing men into family planning and ANC initiatives and of recognising and promoting fathering roles in general health services (de Koning et al. 2005).

4. Key groups 2: Young sexually active men and women.

A growing awareness of the critical role of young people in the HIV epidemic, and of their particular vulnerabilities within it, has forced the HIV/AIDS community to gather their resources to find ways of addressing young people in particular. Young people now account for almost 2 million new infections every year, and more than half of new infections in sub-Saharan Africa. Young women are particularly affected (Ross et al. 2006). Initiatives to confront this situation have brought to light several issues which are particular to, or particularly significant to, young people. These include the differential access to health services of young people, and particularly young women, compared with older people; issues around adolescent sexuality and social restrictions on it – in particular for girls; and issues related to the costs of services.

² Options for sero-discordant couples include artificial insemination if the woman is HIV-positive; or if the man is HIV positive, limiting sex to key moments in the menstrual cycle and when the man's viral load is undetectable, or the more expensive 'sperm washing' in which sperm are separated from HIV-causing agents before insemination (Guttmacher Institute and UNAIDS 2006).

4.1 Access to health services

A key concern for initiatives which aim to integrate HIV services into existing reproductive health services is that young women in some countries have far less access to the health system than older women, so integrated services may entirely miss large parts of this particularly relevant population. For example, a recent study found that adolescent girls in Bangladesh, India, Indonesia and Nicaragua were significantly less likely than older women to receive antenatal care with skilled personnel, and adolescents in Bangladesh, India, Indonesia, Nepal and Brazil were significantly less likely to have a skilled birth attendant at delivery (YouthNet 2005), a finding which receives corroboration from other sources (e.g. Rimal et al. 2003). These gaps exist above and beyond the more generalised problem that many women in developing countries are barely reached by ANC services. Young women's use of post-natal child health services such as immunisation is also significantly less than older women in a variety of countries throughout Africa, Latin America and Asia (YouthNet 2005), some of which do not show such differentials in antenatal care, which may have implications for integrated PMCTC services relying on ANC referrals, and for which regular follow up is necessary.

4.2 Sexuality issues

Some of these access differentials may be explained by social relations in which age is a mediator of power, so that young people in general have access to less privilege than older people. Much of it, however, may also be explained by social vetoes on adolescent sexuality – or, more specifically, on adolescent girls' pre-marital sexual activity. Such vetoes effectively place a stigma on girls who are known to have sex without social sanction, which is potentially compounded with HIV-related stigma. De Koning et al. (2005) report that rates of premarital sexual activity among women range from 2–11 percent in different parts of Asia to 45–52 percent in sub-Saharan Africa, and emphasise that a critical challenge to integrated services is in addressing adults' – including health workers' – difficulties in accepting adolescent sexuality.

In some settings girls are not eligible for HIV or sexual health treatment at health centres unless they have someone to speak on their behalf (ICW 2004). Guardianship issues may also conflict with an adolescent's right to confidentiality, which may then be abused as a matter of course. Married adolescent girls may, although exempt from vetoes on having sex, have particular difficulties negotiating the timing and frequency of sex, and condom use (Bruce 2002), and may also be required to have a guardian's approval (husband or father) to access reproductive health services.

Sexuality issues embedded in notions of masculinity can also dissuade young men from seeking sexual health information in public settings. Men are often reluctant to seek healthcare also because they view this as a sign of weakness, and feel pressured into hiding their lack of knowledge, stifling their ability get information on HIV/AIDS.

Issues around sexuality make young people particularly concerned about privacy – a concern which may work in favour of developing HIV facilities within larger hospital complexes where anonymity is more likely to be available, and where a variety of services work to disguise those accessing sensitive ones. Young people in Kampala, Masaka and Nairobi clearly preferred the idea of accessing HIV tests in hospitals – except some noticeable

preferences for youth centres, presumably where these operated in ways which maintained confidentiality (ICRW/ Population Council 2001).

4.3 Costs

Young people generally have less access to cash than older people, making them potentially more price-sensitive when seeking health care. One study in Uganda and Kenya found that most young people who had tested for HIV accessed free or subsidised tests. Of those who paid, most did so with their own money, but mothers, partners and spouses also commonly paid for tests (ICRW/Population Council 2001). Needing money from others for tests may compromise confidentiality, and may be an impossible challenge particularly for young women who are sexually active outside social or parental sanction.

4.4 Experience with youth-friendly integrated services

Integrated services which have made specific attempts to address young people can broadly be categorised into two main types: youth-friendly reproductive health services as part of general health services, and ‘youth centre’ type venues offering a variety of health and non-health services. Certain forms of these have recently been identified as promising by WHO’s comprehensive study on services for young people (Ross et al. 2006).

4.5 Youth-friendly general reproductive health services

WHO’s review (Ross et al. 2006) of the evidence from developing countries on preventing HIV/AIDS in young people has some clear implications for convergence initiatives. For convergence of HIV services into general health services, a number of interventions are identified which increase the use of these services by young people. Strongly recommended are interventions in which service providers in health service settings are trained to deal with young people sensitively; which make general improvements to clinic facilities; and which also undertake activities in the community to increase service demand and community acceptability. HIV/AIDS information and counselling; STI testing and treatment; and condom provision are key components of successful interventions. A project operating in eight clinics in Lusaka, Zambia, for example, made specific efforts to involve the community, using participatory ‘learning for action’ exercises to sensitise local people to adolescent sexual and reproductive health (Mmari and Magnani 2003). In 4 health centres in Jinja district, Uganda, health workers were trained in communication with adolescents, and a district health team was trained as supervisors and subsequent trainers. But in addition, games and recreational services were introduced at the health units, and adolescents were involved in the design and development of the project (Mbonye 2003). As part of a broader effort to create a favourable environment for reproductive health services for young people in Zimbabwe, several clinics with trained nurses developed ‘youth corners’ (Scheepers et al. 2004).

With the gradual rise in the acceptability of sex education, or ‘Family Life Education’, in secondary schools, some promising initiatives have attempted to link up the curriculum directly to local services. A project in Brazil, for example, paired ten clinics with secondary schools and established direct contact between the school where a SRH curriculum was being introduced and clinics, where service providers had been trained to address adolescents appropriately (Magnani et al. 2001). A Frontiers programme in Bangladesh similarly made efforts to link training in health services with school reproductive health curricula: clinic staff visited schools to describe services and monitor education; teachers were trained to deliver the curriculum. This programme also made explicit attempts to address cash difficulties for

adolescents by allocating those attending education sessions with a card entitling them to visit a doctor free for one year (Bhuiya et al. 2004).

Linking up with awareness campaigns through the media – especially television – has also shown promise: a national programme in South Africa, in co-ordination with the ‘loveLife’ multimedia programme, aimed to catalyse an adolescent-friendly ethos in all government clinics through improved management systems, infrastructure and clinical capacity. Quality Improvement Teams were constituted from within clinic staff who developed and implemented action plans; adolescent-friendliness ratings were introduced and external assessments conducted every two years (loveLife 2004).

4.6 HIV and reproductive health services in ‘Youth Centres’

A number of projects have set up or developed stand-alone youth reproductive health centres, often dealing with stigma and confidentiality issues by ‘disguising’ sexual health and HIV services amidst general skills-building and/or social activities. Such ‘disguises’ work both to increase confidentiality – people seen entering the building could be accessing one of a range of activities – and also to ‘normalise’ sexual health issues by placing them alongside non-health related, familiar activities. In Rwanda, for example, a purpose built centre for youth-friendly sexual and reproductive health services including VCT and STI treatment, also operated skills-building and social activities (Neukom et al. 2003). The Family Guidance Association of Ethiopia observed a high demand for services when they began integrating STI diagnosis and treatment with VCT into family planning services at selected youth centers with support from UNICEF in 2003 (Kaba and Alem 2006). A centre in the Central African Republic offers sports and cultural activities alongside sexual health education and services, and has seen a substantial rise in the use of health facilities, as well as in parental approval for the centre (de Koning et al. 2005). This model has also been used in emergency settings: the youth centre in an IDP camp in northern Uganda offers reproductive health services including STI management, HIV counselling and testing, family planning and Infotainment (Adong 2006).

Despite some clear successes with this model, de Koning et al. (2005) note some potential problems: young people may access them only for recreational activities, ignoring the SRH/HIV services; and positive impacts on knowledge and attitudes do not necessarily translate into reductions in risk-taking behaviour. Senderowitz (2000) notes that stand-alone centres may be difficult to sustain because of high costs, but de Koning et al. (2005) add that the cost-effectiveness of well-attended centres has not been sufficiently evaluated.

4.7 Emerging issues

Highlighting the ‘dual protection’ needs of women for contraception and protection against HIV infection, in the course of advocacy for integrated services, has also encouraged emphasis on a third protection issue: that of safeguarding the future fertility of young women. To young women for whom giving birth is a rite of passage which confers social status, this issue may be critically important. Brady (2003) emphasises the need for comprehensive STI diagnosis and treatment for young women in the context of integrated HIV/SRH services, given the associations between STIs and infertility; and ICW (2004) expresses concern that there is not enough research on how ART affects young women’s fertility. Where sterilization continues to be the prevalent form of family planning, and may be more forcefully offered to HIV positive women, young or not, in the context of HIV-related stigma, family planning

initiatives connected to HIV services need to be particularly vigilant in establishing whether clients wish to start, postpone, or avoid pregnancy.

5. Key groups 3: Female sex workers

Female sex workers (FSW) comprise a group especially vulnerable to HIV infection, for a variety of reasons including that in heterosexual sex, male to female infection is easier than female to male. In ‘concentrated epidemic’ situations, female sex workers’ clients may also have a higher than average likelihood of carrying the virus. Gender is a central component of relations between female sex workers and their clients, and HIV/AIDS prevention programmes promoting condom use as a main strategy have struggled for years to address the implications of these power relations in condom use negotiations. Gender inequalities between FSW and their clients – as well as in their broader lives – are sometimes compounded by age and other social relations such as class, race, or ethnicity.

Sex work is also highly stigmatized. Sex workers often live on the margins of society and, as such, their access to general public health services can be severely limited. Health awareness interventions operating through schools or the media are also unlikely to reach them (Ross et al. 2006). Sex workers with HIV suffer from the compounded stigma associated with both sources, and are likely to be placed in the ‘guilty victim’ category operating in stigmatization processes, making them even more likely to receive poor treatment in public health settings or elsewhere. Discrimination against sex workers – ranging from sub-standard and / or humiliating treatment to treatment refusal – is widespread across many different country contexts (see for example Seshu 2003; Khonde and Kols 1999; Téqui 2004; Vuylsteke et al. 2001).

This review found surprisingly little evidence of integrated SRH/HIV services directed at or interested in outreach to sex workers, or even of attempts to simply combine family planning information or services in vertical HIV awareness and prevention services for sex workers. More specific STI prevention and treatment services appear, however, to be relatively often combined with HIV/AIDS programmes with sex worker target groups. There is, on the other hand, some evidence of a need for integrated reproductive health programmes including family planning and safe abortion services amongst sex worker populations: a study in Cambodia, for example, found that a very low proportion of sex workers were using any modern contraception method bar condoms, and that a high proportion had had at least one induced abortion (Delvaux et al. 2003). In Bangladesh, a study emphasising the links between health and human rights amongst sex workers, identified a need for family planning, STI treatment and abortion rights (Haq 2006). The apparent evidence of lack of *demand* for such services is more likely to be indicative of an absence of the right to claim rights on the part of sex workers, than an indication of the lack of perceived need. Sex workers may also be cautious – in the process of voicing a demand for SRH services – of reinforcing the near exclusive focus on their reproductive functions established by a range of HIV/STI intervention programmes (Alexander 1999).

HIV/AIDS interventions targeting sex workers are at risk of falling into two potential traps. The first is a discursive problem: emphasising the association between sex work and HIV threatens to compound stigmatization of sex work and workers, including for those who are HIV negative. Increased stigma increasingly jeopardises the social situation of sex workers, including whatever access to health care they can achieve. Labeling them straightforwardly as vectors of disease in single-point condom promotion programmes can cause further social exclusion which is difficult to undo.

The second is that targeting sex workers is often, explicitly or implicitly, merely an instrumental approach driven by the wider objective of protecting non-sex worker populations (clients and clients' families). Reducing HIV amongst sex workers is tacitly posited not as important in itself, but as the key to protecting the 'innocent', thus further stripping sex workers of their human status. Sex worker fora have argued, for example, that the 100 percent condom use campaigns amongst sex workers in Thailand and Cambodia are driven by the fear that 'men would infect their wives, the "innocent good women", not that they would infect women sex workers, "the dirty bad women"'³ Even 'empowerment'-focused projects with sex workers are subject to being used instrumentally, with the overall objective of getting sex workers – via 'empowerment' – to comply with condom use and STI treatment advice for the sake of the 'innocent' populations they have sexual networks with.

Integrated services certainly offer the potential for bypassing these traps by drawing attention to and addressing sex workers' 'ordinary' health needs such as family planning and ante-natal care, and by promoting sex workers' health in general, thus drawing the focus away from the infective potential of their sex organs (Wolffers 1999). But any approach without firm roots in a strong conception of sex workers as the bearers of human rights, and with legitimate claims to be treated as such, or which does not actively contest stigma and the social inequalities it is allied with, risks co-option by stigmatization process already at work. Sex workers' health programmes in which a clear recognition of the sex workers' human rights is not established amongst all partners are vulnerable to reinforcing social exclusion (Wolffers 2003).

5.1 Integrated STI services

Many projects have grouped together HIV/AIDS prevention and treatment of other STIs in projects for sex workers, not least because of the presence of STIs increases the transmission of HIV. There have been mixed successes. A recent evaluation of a project for female bar workers in Tanzania, for example, which provided VCT, clinical check ups, syndromic management of STIs and reproductive health information found a significant reduction in HIV incidence attributable to the combination of information and services (Riedner et al. 2006). An evaluation of an STD/AIDS project for sex workers in Bali combining educational activities with STI treatment recorded an increase in condom use and decreased incidence of trichomoniasis (Ford et al. 2002). Similar results have also been found elsewhere (e.g. Ghys et al. 2001). Other reports, however, suggest that such projects are sometimes coercive and abuse the rights of sex workers – for example, 100 % condom use programmes which are enforced by the police (Longo and Ditmore 2003); or limited to the agenda of donors and researchers and confined to a narrow focus on their sexual activity, thus bypassing sex workers' own priorities (Wong and Gray 2004).

5.2 Sex workers and general reproductive health services

Other projects have explored and/or tried to improve the access of sex workers to general reproductive health services – though often still mainly for the purposes of STI treatment. In Cambodia, for example, it was found that in public sector health clinics offering STI treatment coverage of sex workers was high (Sano et al. 2004); in Cote d'Ivoire, it was found that nearly 30 percent of sex workers in the study used a public hospital or health centre for their last STI episode, even though private clinics and a free confidential clinic were available (Vuylsteke et

³ 100% Condom Use Policy in Thailand: A perspective from Empower <http://apnsw.org/apnsw.htm>, accessed 4-1-07

al. 2001). A programme in Nicaragua distributed vouchers to female sex workers for use at various public, private and NGO providers – but only for STI tests and treatment, health education, and contraception counselling (Gorter 1999; Shaw and Aggleton 2004). An IPPF project in Uzbekistan managed by the Uzbek Association for Reproductive Health attempted a broader approach, by offering sex workers pregnancy testing along with HIV and STI testing in their reproductive health facility (IPPF n.d.).

5.3 Need for a rights perspective and an empowerment approach

The wide gulf between many narrowly focused STI/HIV sex worker interventions and the perspectives of those working on sex workers' rights strongly suggest that a broader approach is needed, and must be at the heart of initiatives carrying HIV/SRH convergence forward. Convergence approaches that keep sex workers' rights firmly in the foreground, include sex-worker participation at meaningful levels and work explicitly with a sex worker-driven agenda, have the potential gradually to challenge the social inequalities out of which sex workers come into being, and, in working on sexual health, to contest the social processes constructing sexuality which place them at such high risk of stigma, discrimination and social exclusion. Work on sexual health and rights has the potential to open up and forge larger alliances with HIV/AIDS activists, sex workers, and people living with HIV (Correa et al. 2005).

6. Policy and Management Challenges

Evidence points to the importance of promoting a central role for members of these three key groups in taking the convergence agenda forward. Evaluations of programmes working with young people show the paramount importance of involving young people themselves in programme planning and design, implementation, decision making and evaluation (GTZ 2002; Finger et al. 2002; de Koning et al. 2005). Similarly, sex workers and people living with HIV must be given space and enabled to influence and lead the agenda (Jana et al. 1999; ICW 2004; Guttmacher Institute/UNAIDS 2006). Rights approaches are powerful tools to contest the multiple ways in which stigma and discrimination continue to constrain this endeavour.

Certain challenges to this agenda are beginning to be articulated, with more or less consistency, in the literature. These include practical issues around the management of integration initiatives and the role of health workers; administrative issues such as the structure of funding and the poor state of many health services; as well as issues concerning the wider political contexts in which convergence is taking place.

6.1 Health Workers

Health workers work at important junctures for either reproducing or challenging stigma, and priority needs to be given to their training in both technical and human rights issues to increase their potential for addressing stigma and delivering services effectively. There is growing evidence that involving health workers in the planning of sexual health interventions improves their ability to discuss sexual health issues, for example, and that bottom-up approaches focusing on areas which health workers themselves feel they can improve, is effective (de Koning et al. 2005). Training may need to be intensive: a project in Egypt to integrate sexual health counselling into FP sessions found their less intensive training sessions left providers still too embarrassed to discuss sexual issues sufficiently (Abdel-Tawab et al. 2000). But good training can resolve many issues: POLICY project work in Uganda found their training did help overcome resistance by health workers who saw integration as

increasing their work burdens (Druce et al. 2006). There are suggestions that training may need to be generalised at all levels of the health service: the Haiti Partners in Health project involves both clinical and non-clinical staff in addressing non-medical impediments to HIV care in PHC settings (Druce et al. 2006). A Population Council project to reduce discrimination in hospitals in Delhi also involved all levels of health workers in the hospitals, not only doctors, in developing a ‘people with HIV-friendly checklist’ to act as a gold standard of non-discriminatory care in a self-assessment process (HDN and AIDS Care Watch 2006). Training also needs to be properly balanced for the various integration combinations being promoted: Rutenberg and Baek (2004) report that in PMTCT/FP combination initiatives, FP often only constitutes a small component of training, on the assumption that workers are already FP trained, although this is often not the case. Another Population Council project in Nairobi found providing job aids such as flipcharts and checklists to use during counselling sessions helped ensure both that all relevant topics were covered, and also made it easier to start talking about sensitive topics, as clients are aware that there is a standard, routine list (de Koning et al. 2005).

Training may also need to extend beyond health facilities: a Pathfinder International project in Ethiopia trained around 8000 volunteer Community Based Reproductive Health Agents (CBRHAs) to take FP, RH and HIV/AIDS prevention messages into remote communities, and FP supplies into factories and markets. They were specifically trained in counselling as well as in addressing large groups of people. A similar programme in Zimbabwe trained community-based contraceptives distributors in the provision of HIV/AIDS information and making referrals (Druce et al. 2006). A Pathfinder International project integrating PMTCT in Kenya found the role of community health workers was key to the referral system.

At the same time it is important to be realistic about the limits of the role of health workers as pioneers in sexual and human rights advocacy: many work under very difficult circumstances with poor pay and conditions in which it is not possible to maintain even basic HIV universal precautionary measures (Aisien and Shobowale 2005; EngenderHealth et al. 2006). Several reports point out that it is often health workers’s fear of infection which fuels health worker discriminatory attitudes to positive people, including a reluctance to treat them (Bharat 2004; HDN and AIDS Care Watch 2006). Although this fear is often exaggerated, given that the risk of HIV transmission from patient to health care worker is relatively small⁴, and can therefore be partly addressed through information and training, the reality of situations in which providers have to work without adequate supplies of gloves, gowns, masks, adequate needle disposal systems and post-exposure prophylaxis (PEP), or even soap and water for washing hands (EngenderHealth/UNFPA 2006), needs to be taken into account. Convergence initiatives may need to work in ways supportive of efforts to improve adherence to Universal Precautions in health facilities, as part of a strategy to tackle stigma.

6.2 Supply challenges in weak health systems

Closely related to the issue of essential supplies and systems for maintaining universal precautions, several projects cite supply issues as impediments to the successful implementation of programmes. Many under-resourced and poorly administered general health services already struggle with difficulties in maintaining supplies of basic drugs, and

⁴ Estimates place this risk at 0.23% to 0.5% per exposure and depends on the viral load of the patient and the amount of blood transferred. HIV requires a higher amount of blood transfer than, for example, Hep B (WHO/UNFPA 1999)

with overwhelming patient loads. Several projects report difficulties maintaining supplies of drugs, condoms and other essentials to support the programme, sometimes in the context of the increasing demand generated by successful exercises. A large-scale Pathfinder International (PI) PMTCT project in Kenya, for example, experienced stock outs of testing kits, nevirapine and contraceptives due to increased uptake (Druce et al. 2006), - an experience which is echoed in many other PMTCT integration settings (Rutenberg and Baek 2004).

Supplies of human resources are also a frequently cited difficulty. The Kenya PI project experienced staffing problems; and a project linking FP to HIV in Ghana cited staff turnover as an ongoing challenge (Asare et al. 2006). Maharaj and Cleland (2004) emphasise that staff shortages in South Africa resulting in heavy patient loads produce the intractable problem of providers being under pressure to deal as quickly as possible with patients' explicit needs, instead of taking the time to explore non-presented needs which converged services may offer the opportunity to address. Long queues and waiting times are also cited by clients and important impediments to accessing services. Maharaj and Cleland recommend reducing administrative duties and training lay counsellors to assist medical staff as ways to address this problem, once again suggesting the need for convergence initiatives to look beyond the medical community for implementation support.

Staffing problems have been exacerbated in some places by structural factors, in particular funding streams, which can influence local economies in counter-productive ways. Druce et al. (2006) identify localised brain drains of SRH workers into better funded HIV programmes in Kenya and Zambia as an ongoing challenge, and note that in Rwanda, doctors in the NGO sector earn six times the salary of public sector equivalents.

6.3 Funding streams

Historically rooted separate funding streams for HIV and RH work appear to be major obstacles to the co-ordination and co-operation required by convergence. Conflicts between vertical (often donor-led) and horizontal programmes, and separate funding structures represent one aspect of these challenges. HIV-related activities receive substantial 'off budget' and inflexible funds, creating parallel systems to those supporting basic health services, and sometimes at the cost of ensuring that the health sector as a whole is capable of responding to the challenges of HIV/AIDS (Druce et al. 2006). Some projects report competition from different sectors, or territorial issues, as impediments to smooth implementation. A Family Planning Association of Kenya (FPAK) project to integrate HIV treatment into SRH services felt the initiative was not well received by specialist HIV/AIDS service providers (IPPF 2005). A POLICY project initiative in Uganda integrating FP into VCT and PMTCT settings expressed a concern that offering full-scale FP services would result in competition with FP providers, as well as struggling with co-ordination issues because of the vertical management of FP, VCT and PMTCT programmes (Druce et al. 2006).

Convergence initiatives require co-ordination and co-operation between different MOH departments, as well as between donors and governments. Cross-programme working groups have been effective at promoting convergence in some settings: in Zambia, an MTCT working group requires all elements of antenatal care to be supported by PMTCT donors. In Kenya, a similar working group has helped RH and HIV programmes to develop joint guidelines, protocols and training. Cross-cutting posts have also helped to build links and synergies

between the streams: a major PMTCT post in Zambia, for example, is based in RH, not in the HIV/AIDS programme.

A relatively neglected aspect is the key management role played at the district level in contexts of decentralisation, and the need to disentangle conflicts presented by vertical programmes to district managers and providers. Clarity is needed on how different HIV and RH bodies and departments relate to each other, and to the district health authorities (Mayhew 2003; Lush et al. 2001). Donors may also need to re-examine their reporting requirements which by consuming too much administration time can weaken the ability of health systems to deliver services (GI 2006).

6.4 Political environment

Putting the priorities of a convergence agenda supportive of key groups in the HIV landscape into action has been increasingly challenged by certain aspects of the global policy environment. Conservative forces in the global political environment which have led the penetration, for instance, of the U.S ‘gag rule’ and ‘prostitution pledge’ have caused funding and management problems for a variety of organisations working on reproductive rights both within and outside of the HIV/AIDS field; and to those working with sex workers on empowerment and rights. The Mexico City Policy or Global Gag Rule prevents organisations supporting, supplying or referring for abortion from receiving US funding, and has had the additional effect of reinforcing local religious conservatism, especially in Africa (Cohen 2003; Druce et al. 2006). The ‘prostitution pledge’ requires all organisations receiving private or public US funding to adopt a policy stating that it does not promote, support, or advocate the legalization or practice of prostitution, hence undermining the promotion of sex workers rights, especially their rights as workers, and threatening a variety of promising sex-worker focused interventions (CHANGE 2005; HRW 2006; Fleishman 2006).

Work to counter regressive forces effectively promoting stigma and its consequences is necessary through advocacy at all levels from governments to communities, based on an understanding of the layering of the stigma so that informed policies and interventions can be developed that will address the entire experience of stigma (Reidpath and Chan 2005). Convergence necessarily involves the discursive integration of sexual and reproductive rights, as well as emphasis on the human rights of HIV positive people and sex workers, well beyond health service points.

Several studies now point to the cost effectiveness of aspects of both major convergence directions (Stover et al. 2006; Druce et al. 2006), and de Koning et al. (2005) emphasise that primary prevention is most cost effective, lending weight to the promotion of health education interventions. While there seems little doubt of the potential benefits of integration for many different sectors of the population, convergence initiatives will need to continue to work on these challenges, and in particular, be steadfast in maintaining a focus on the perspectives and rights of key disadvantaged groups.

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