

Integrating Reproductive Health and HIV/AIDS Programs

Strategic Opportunities for PEPFAR

A Report of the CSIS Task Force on HIV/AIDS

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Contents

| | |
|---|----|
| Acknowledgments | IV |
| Introduction | 1 |
| Status of the U.S. Response toward RH-HIV Integration | 4 |
| The Case for PEPFAR Support to Integrated RH-HIV Programs | 5 |
| Promising Programs: Examples from the Field | 11 |
| Moving Forward: U.S. Policy Constraints | 23 |
| Recommendations for Strategic Integration | 29 |

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Integrating Reproductive Health and HIV/AIDS Programs

Strategic Opportunities for PEPFAR

Janet Fleischman

Introduction

Twenty-five years into the AIDS epidemic and halfway through the initial five-year phase of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR),¹ there is increasing international consensus, including within the U.S. government, about the imperative to target women and girls. With women now constituting 60 percent of those living with HIV/AIDS in sub-Saharan Africa, and young women accounting for three-quarters of 15- to 24-year olds living with the virus, this is an urgent agenda.² PEPFAR is well positioned to build on this consensus and make integration of reproductive health (RH), family planning (FP), and HIV/AIDS services a major new priority.³ RH-HIV integration presents important opportunities for PEPFAR to expand its impact and to

¹ PEPFAR is a \$15-billion U.S. government global program over five years with 15 focus countries, largely in Africa: Botswana, Côte d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia, as well as Guyana and Haiti in the Caribbean, and Vietnam in Asia. PEPFAR also includes HIV/AIDS programs in an additional 96 countries.

² Moreover, the core obstacles to addressing reproductive health are the same as those fueling the AIDS epidemic, including the vicious cycles of poverty, gender-based violence, discrimination in access to education and services, and women's lack of control over their sexual and reproductive lives. Adolescent girls in particular bear the brunt of the intertwined issues of teenage pregnancy, sexually transmitted infections (STIs), and HIV, exacerbated by intergenerational sex and sexual violence.

³ Integration in the health sector indicates that a facility is offering two or more services during the same operating hours, with providers of both services encouraging clients to consider using the other service. When integrated services are not colocated, they include a strong referral system. Services can also be integrated outside clinic settings through community outreach, youth programs, and education activities. See "What Is Integration?" *Network: Integrating Services* 23, no. 3 (2004).

improve its prospects for achieving its prevention, care, and treatment goals. It is also a new way of thinking in larger terms about how to enhance the sustainability of PEPFAR and to overcome the barriers to broader access for HIV/AIDS services.

This is an especially critical moment for PEPFAR to expand prevention programs, which are necessary to ensure the long-term success of global AIDS efforts. Integration is a feasible means to achieve multiple key goals: prevent new HIV infections among women and girls; reduce HIV transmission from mother to child (prevention of mother-to-child transmission [PMTCT]); prevent more AIDS orphans; and support HIV-positive women's reproductive rights and fertility choices. Reproductive health and HIV services have generally been funded separately and operated vertically, which means that clients see a different provider for each health service. Yet with over 80 percent of HIV infections sexually transmitted,⁴ addressing reproductive health and HIV together would better serve the needs of clients and health care providers in a more comprehensive, cost-effective, and efficient manner.⁵

Inevitably, some U.S. policymakers will be uncomfortable with the premise of integrating reproductive health and family planning into HIV/AIDS programs, often considering "reproductive health" to be a euphemism for abortion services. Yet reproductive health covers a broad range of women's health issues, including detecting and treating sexually transmitted infections and supporting HIV-positive women's desire to have children safely. PEPFAR officials can use new evidence from the field to make the persuasive case that integration represents a bridge to achieve PEPFAR's objectives. With women and girls in PEPFAR focus countries so acutely vulnerable to HIV infection, the United States has ample motivation to ensure that its AIDS programs recognize and address emerging gaps in treatment, care, and prevention services. On ethical and operational grounds, those women and girls accessing HIV testing and treatment through PEPFAR programs have a compelling need for RH and FP services, especially relating to their fertility choices, just as women and girls accessing RH and FP services have a critical need for HIV information and services.

This paper will discuss the centrality of integration, building on existing data, current programs, and research recently conducted in the field, in an effort to provide timely input to the Office of the Global AIDS Coordinator (OGAC) and to Congress. It is also intended to help inform debate as Congress, the administration, and others begin to weigh what critical policy adjustments will be needed in the follow-on phase to PEPFAR that will begin after FY 2008. It argues that RH-HIV integration is a pragmatic, achievable, and cost-effective approach, and one that leads to concrete policy recommendations. By integrating services, PEPFAR can also make better use of prior U.S. investments in the health sector and preexisting capacity and expertise. This paper calls for OGAC to issue guidance on RH-HIV integration to the PEPFAR country teams, for PEPFAR programs to incorporate RH/FP into existing HIV programs and to integrate HIV into RH/FP

⁴ National Institutes of Health, National Institute of Child and Human Development, "Sexually Transmitted Diseases and Infections (STDs and STIs) and HIV/AIDS Research," <http://www.nichd.nih.gov/womenshealth/STDHIV.cfm>.

⁵ See John Stover et al., "Are Cost Savings Incurred by Offering Family Planning Services at Emergency Plan HIV/AIDS Care and Treatment Facilities?" POLICY Project, Washington, D.C., March 2006, <http://www.policyproject.com/abstract.cfm/2741>.

programs, for input to be sought from women’s health advocates and networks of women living with HIV/AIDS, and for OGAC to make the case for RH-HIV integration to U.S. policymakers.

Integrating HIV and reproductive health has the potential to produce important HIV-related outcomes. Indeed, recent international consensus statements have urged strengthening these linkages.⁶ As Dr. Ndugga Maggwa from Family Health International (FHI) in Kenya put it: “When we think about HIV and reproductive health issues, it boils down to one thing—people have to have sex if they’re going to get HIV, STIs, unplanned pregnancy. They have to have unprotected sex—it’s the common denominator.” He continued by explaining the problems with creating vertical programs: “A joint, integrated approach would get more mileage.... The question is how to build bridges between the two kinds of programs so they mutually reinforce each other.”⁷

Integration of services does face many challenges, notably: the lack of trained health professionals; reductions in donor funding for RH and FP, as well as separate funding streams for RH and HIV; issues of provider bias, especially against HIV-positive women who are sexually active; U.S. congressional and policy restrictions pertaining to both RH and HIV funding and activities; and the lack of political conviction up to now by donors and national governments alike to make RH-HIV integration a policy priority. In addition, RH/FP programs have been weakened when the response to the AIDS crisis has drawn health professionals and resources away from RH programs. Promoting linkages between AIDS programs and reproductive health services for women is an important way forward, and one that can help to capitalize on the new resources available for HIV/AIDS and the limited funding for reproductive health services.

Although RH-HIV integration is a logical step for PEPFAR to reach its goals, it has only recently begun to emerge as an important issue. At this stage, a few PEPFAR country programs have begun promising innovations that integrate reproductive health or family planning with HIV programs. Most programs do not yet acknowledge the importance of linking reproductive health and HIV/AIDS. Yet this report shows that these issues are gaining prominence in AIDS programs and that there are relevant examples of integrated RH-HIV programs funded by PEPFAR. One critical next step is for OGAC to proactively support funding for integrated RH-HIV programs and to promote efforts to operationalize strategies toward that end.

⁶ See “The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children,” a consensus advocacy statement from a consultation in May 2004, http://www.who.int/reproductive-health/stis/docs/glion_cal_to_action.pdf; and “The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health,” statement deriving from a Joint United Nations Program on HIV/AIDS (UNAIDS)–United Nations Population Fund (UNFPA) consultation in June 2004, <http://www.unfpa.org/publications/detail.cfm?ID=195>.

⁷ Interview with Dr. Ndugga Maggwa, director of field programs and technical services, Family Health International (FHI), Nairobi, Kenya, February 23, 2006.

Status of the U.S. Response toward RH-HIV Integration

Over the past year, OGAC has demonstrated a greater commitment to addressing women and girls. OGAC's first two annual reports to Congress outline the significance of gender and the emerging U.S. approaches. Gender has also figured in many senior-level speeches. OGAC established an interagency technical working group on gender in the summer of 2005 and convened a gender consultation in June 2006, which OGAC officials signaled will lead to gender-related programmatic interventions.

Where PEPFAR falls short is in operationalizing these stated commitments, notably by including targets or indicators on gender in PEPFAR. As one senior administration official put it: "things that don't have targets tend not to be measured."⁸ The lack of targets or indicators on gender has direct consequences for gender-focused programs under PEPFAR, and PEPFAR's stated commitment to gender will need to include monitoring of programs and measurement of appropriate targets.⁹

PEPFAR's main impact to date has been demonstrated in its treatment program, where over 60 percent of those receiving treatment under PEPFAR are women.¹⁰ This adds additional weight to the importance of providing optimal information and services to the HIV-positive women enrolled in its programs, especially related to pursuing their fertility desires with appropriate counseling and as safely as possible.¹¹

Integrated RH-HIV strategies are consistent with the guidance issued to the PEPFAR country teams for the 2007 Country Operational Plans. These themes include: scaling up programs that work; improving the quality of programs and the linkages between program areas (care, prevention, and treatment); focusing on sustainability, both programmatic and management; and increasing the number and diversity of program partners. In each of these areas, RH-HIV integration makes obvious sense.

The timeliness of addressing these issues was also evident at PEPFAR's 2006 HIV/AIDS Implementer's Meeting, held in Durban, South Africa, in June 2006, where a satellite session was convened on FP-HIV integration issues. That session reviewed several unfolding projects ranging from integrating FP services into voluntary counseling and testing (VCT) in Kenya, sexual and child-bearing needs of people on antiretroviral treatment (ART) in Tanzania, increasing access to quality integrated HIV and FP services in South Africa, determinants of pregnancy among women on ART in Uganda, and pregnancy-related events in antiretroviral (ARV) treatment programs.

⁸ Interview in Washington D.C., June 6, 2006.

⁹ See Janet Fleischman, *Strengthening HIV/AIDS Programs for Women: Lessons for U.S. Policy from Zambia and Kenya* (Washington, D.C.: CSIS, May 2005), http://www.csis.org/media/csis/pubs/0505_strengthening.pdf.

¹⁰ As of March 2006, PEPFAR is supporting ARV treatment for 561,000 people. See PEPFAR, "Making a Difference: Supporting Antiretroviral Treatment," <http://www.state.gov/s/gac/rl/fs/2006/67451.htm>.

¹¹ Given that some data have shown the potential for birth defects resulting from women who become pregnant while on ARVs that include efavirenz, this should be an area of particular concern for PEPFAR. Since efavirenz is part of the first-line regimen in many PEPFAR countries—where 60 percent of those on treatment are women, most of child-bearing age, in countries with high fertility rates and high rates of unintended pregnancies—PEPFAR has an ethical obligation to ensure that women receive appropriate counseling on fertility choices. See Mary Glenn Fowler et al., "The Interface of Perinatal HIV Prevention, Antiretroviral Drug Resistance, and Antiretroviral Treatment: What Do We Really Know?" *Journal of Acquired Immune Deficiency Syndromes* 34, no. 3 (November 2003).

The Case for PEPFAR Support to Integrated RH-HIV Programs

Increasing Access, Efficiency, and Cost Effectiveness;
Addressing the Shortage of Health Care Workers

“What we’re doing is like mopping the floor while the roof is leaking.”¹²

For PEPFAR, integrating reproductive health and HIV programs can expand entry points for accessing HIV/AIDS services; increase efficiency and cost effectiveness of programs; and help to address the shortage of health care workers. While in some cases, vertical, program-specific approaches may be useful as a way to maintain a clear focus, there is increasing concern that the creation of parallel programs within the broader health care system can lead to duplications, distortions, and disruptions in services.¹³

- RH/FP and HIV programs share a common target audience, especially in countries with generalized epidemics: women and girls of reproductive age. By increasing entry points along the life cycle of women and girls, PEPFAR can increase access to HIV prevention, care, and treatment services for vulnerable women and girls, while helping to ensure their dignity and safety.
- Integrated programs can reduce the stigma and discrimination associated with attending stand-alone HIV facilities.
- While reaching populations such as sex workers, adolescent girls, and injection drug users (IDUs) remains a challenge, integrated services have the potential to reach larger numbers of these target groups in need of both HIV and RH services.
- Integration can also help to address the shortages of health care workers, since most acutely affected countries cannot afford to develop parallel programs that duplicate human resource requirements. Although initial costs may be higher due to new training requirements, the investment will pay off in the long run. While there is always a risk of overburdening staff, program managers can be engaged to help providers organize their work more efficiently. Integration may be more efficient at reaching both HIV and RH goals since RH/FP providers and nongovernmental organizations are already equipped to offer services to women, and many are already reaching target populations, especially young women involved in unprotected sex who lack information and access to services. For example, RH/FP programs have years of experience in working with women and girls that can be adapted to HIV information and services, including the skills in counseling and testing, as well as education and STI management, which are essential for HIV-prevention information.¹⁴

¹² Interview with Dr. Ndugga Maggwa, director of field programs and technical services, FHI, Nairobi, Kenya, February 23, 2006.

¹³ Phyllida Travis et al., “Overcoming Health-systems Constraints to Achieve the Millennium Development Goals,” *Lancet* 364, no. 9437 (September 2004).

¹⁴ See Heather Boonstra, “The Role of Reproductive Health Providers in Preventing HIV,” *Issues in Brief*, Alan Guttmacher Institute/UNAIDS, New York, October 2005, <http://www.agi-usa.org/pubs/ib2004no5.html>.

- By preventing unplanned pregnancies, PEPFAR can reduce costs related to PMTCT services and ultimately the number of children orphaned by HIV and in need of care and support.¹⁵ According to the Policy Project, providing family planning at HIV treatment sites translated into a savings of almost \$25 for every dollar spent.¹⁶
- Integrated services that encourage male participation provide greater opportunities for communication about condoms between partners and thus assist young women in adopting contraception and dual-method use, meaning using both contraception and condoms. In vertical programs, men and women rarely access health care together or in the same place.¹⁷
- A 2006 study in Uganda found that providing ART, prevention counseling, and partner VCT was associated with reduced sexual risk behavior among HIV-infected Ugandan adults during the first six months of therapy. The study concluded that integrated ART and prevention programs may reduce HIV transmission in Africa.¹⁸

Meeting the Unmet Need for Contraception and HIV Outcomes

Meeting the huge unmet need for contraception also has important HIV outcomes. In addition to offering women and their families important benefits related to preventing early first births, lengthening birth intervals, and reducing infant and maternal mortality, providing contraception can prevent unintended pregnancies and mother-to-child transmission of HIV. In order to reduce HIV-infected births, infant and child mortality, children orphaned by AIDS, and maternal mortality, adding family planning and reproductive health to PMTCT, VCT, and ARV programs makes logical, programmatic sense.¹⁹

In sub-Saharan Africa, significant proportions of women have an unmet need for effective contraception; they are sexually active and do not want to get pregnant but are not using a method of contraception. This unmet need leads to high levels of unintended pregnancies, which in select African countries range from 31 percent in Senegal to 55

¹⁵ See John Stover et al., “Adding Family Planning to PMTCT Sites Increases the Benefits of PMTCT,” U.S. Agency for International Development (USAID), Washington, D.C., June 2004, http://www.usaid.gov/our_work/global_health/pop/publications/docs/familypmtct.html; and Heidi Reynolds et al., “The Value of Contraception to Prevent Perinatal HIV Transmission,” *Sexually Transmitted Diseases* 33, no. 6 (June 2006).

¹⁶ Stover et al., “Are Cost Savings Incurred?” The paper estimates the cost of PMTCT treatment to be \$3,500, which would then be multiplied by the number of infected births averted. Similarly, it uses the UNICEF estimated costs of support for orphans at \$224 to \$652 per child per year, assuming that each orphan living in families below the poverty line would need 11 years of support. Finally, the analysis is applied to the population receiving ART treatment or other HIV-related treatment under PEPFAR. This is compared to the cost of family planning services, which range from \$2 million in South Africa to \$3,000 in Guyana, with a median cost of \$120,000 per year. This translates into a savings of \$19 million in Uganda, with a median of \$3.4 million, depending on the contraceptive prevalence rate in each country.

¹⁷ Correspondence from Catherine MacPhail, Reproductive Health and HIV Research Unit (RHRU), University of Witwatersrand, Gauteng, South Africa, June 2006.

¹⁸ Rebecca Bunnell et al., “Changes in Sexual Behavior and Risk of HIV Transmission after Antiretroviral Therapy and Prevention Interventions in Rural Uganda,” *AIDS* 20, no. 1 (January 2006).

¹⁹ See Susheela Singh et al., *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care* (New York: Guttmacher Institute/UN Population Fund (UNFPA), <http://www.guttmacher.org/pubs/addingitup.pdf>).

percent in Kenya.²⁰ Some estimates of unmet need in sub-Saharan Africa are as high as 63 percent.²¹ Many of these women do not know their HIV status and risk passing the virus to their children. For these women, integration of services—including family planning, management of sexually transmitted infections, HIV prevention, and maternal health—can help to protect them and their families.

While not all HIV-positive women want to postpone having children, they should all have access to appropriate counseling to make informed choices about their reproductive health. Growing evidence indicates that the prevention of unintended pregnancies by improving access to contraception for HIV-positive women is a crucial strategy, but one that is undervalued. Too often, AIDS strategies focus on providing ARVs to prevent HIV transmission to the infant, but ignore the mother's needs.²²

- Data indicate the high unmet need for contraception among clients of HIV services. A study in Kenya, Zimbabwe, Haiti, and Tanzania found that more than half of the women accessing VCT services did not want to become pregnant in the next two years, but the majority of them were not using a contraceptive method.²³
- Two studies have demonstrated the role of FP in HIV prevention. A study in eight African countries found that a moderate decrease in the number of HIV-positive women becoming pregnant resulted in the same number of HIV-infected births averted as the current PMTCT efforts using nevirapine.²⁴ Another study found that adding FP to PMTCT services could avert 71,000 child HIV infections compared with 39,000 HIV-infected births averted with PMTCT only.²⁵
- In Uganda, the Ministry of Health estimates that over 1.4 million women would like to delay pregnancy, space their children, or stop childbearing, but are not using any contraception. Scale-up of HIV services offers an entry point for FP as well.²⁶

Reaching Women Already Infected and Addressing Fertility Choices of HIV-positive Women

Data increasingly demonstrate that some HIV-infected women, especially those on ARVs, as they begin to feel better and function more normally due to treatment, would like to become pregnant. In addition, married women who are HIV positive report strong family pressure to have children, especially if they have not disclosed their HIV status. With the knowledge that antiretroviral therapy can greatly reduce the risk of vertical

²⁰ Jacob Adetunji, *Unintended Childbearing in Developing Countries: Levels, Trends, and Determinants* (Calverton, Md.: MEASURE DHS, 1998).

²¹ UNFPA, "Linking HIV/AIDS with Sexual and Reproductive Health," <http://www.unfpa.org/hiv/linking.htm#practical>.

²² Heidi Reynolds and Rose Wilcher, "Best Kept Secret in PMTCT: Contraception to Avert Unintended Pregnancies," *Global AIDSLink*, issue 97 (May/June 2006).

²³ Ibid.

²⁴ Michael Sweat et al., "Cost-effectiveness of Nevirapine to Prevent Mother-to-child HIV Transmission in Eight African Countries," *AIDS* 18, no. 12 (August 2004).

²⁵ Stover et al., "Adding Family Planning."

²⁶ Delius Asiimwe et al., "Uganda TOO Final Report: Study of the Integration of Family Planning and VCT/PMTCT/ART Programs in Uganda," POLICY Project, Washington, D.C., December 2005, <http://www.policyproject.com/abstract.cfm/2749>.

transmission of HIV, more HIV-positive women may want to become pregnant.²⁷ This underscores the need for PEPFAR programs to support providers' ability to counsel on the risks and benefits of childbearing and to respect HIV-positive women's reproductive intentions and choices, including access to contraception and other reproductive health services.

Programs will have to address negative service provider attitudes toward positive women, especially those wanting children. As Noerine Kaleeba, the founder of TASO in Uganda, explained: "The common view is: you're HIV positive, don't you dare get pregnant; if you dared you're a murderer."²⁸ This point was reinforced by Promise Mthembu, global advocacy officer for the International Community of Women with HIV/AIDS (ICW), who stressed the need for comprehensive RH services where providers do not judge their clients and for safe spaces for young, positive women to access services.²⁹

- At the June 2006 PEPFAR meeting in Durban, South Africa, Steven Browning, U.S. ambassador to Uganda, reported on a study that found that women on ART who had stopped menstruating were surprised to learn that they were fertile again, but that 90 percent of those who had become pregnant did not want to have the child. Based on these findings, he urged PEPFAR to develop better strategies to help HIV-positive women prevent unwanted pregnancies and access contraception.³⁰
- A study in Uganda found that most people living with HIV/AIDS wanted integrated HIV-FP services and that they preferred to receive their FP services where they went for their HIV services. They reported a preference for providers who already knew them and appreciated their situations. In addition, many clients reported that they often spend an entire day in the HIV/AIDS centers and simply have no time to access other services elsewhere. Women specifically noted that integrated services would help them to change their partner's negative views on family planning since they could attend FP sessions together. Still, providers reported that uptake in contraceptives other than condoms continues to be low. This may be linked to a range of issues, including male dominance in sexual matters and fear of disclosure of HIV status, as well as provider attitudes toward HIV-positive clients who are sexually active.³¹
- A cross-sectional study of 1,092 HIV-infected men and women attending an AIDS support organization in Jinja, Uganda, found that 42 percent of participants were sexually active; 33 percent practiced pregnancy risk behavior, defined as having sex without contraceptive or condom; and 18 percent desired more children. Among those

²⁷ Diane Coopera et al., "Reproductive Intentions and Choices among HIV-infected Individuals in Cape Town, South Africa: Lessons for Reproductive Policy and Service Provision from a Qualitative Study," *Policy Brief*, Women's Health Research Unit and Infectious Diseases Epidemiology Unit, University of Cape Town, South Africa, and the Population Council, New York, September 2005, http://www.popcouncil.org/pdfs/Repro_intentions_PolicyBrief.pdf.

²⁸ Interview in Johannesburg, South Africa, February 27, 2006.

²⁹ Promise Mthembu, ICW, presentation at the FP-HIV Integration Working Group meeting, Washington D.C., May 19, 2006.

³⁰ John Donnelly, "Internal Criticism Voiced on US Plan for AIDS Relief: Ambassadors Cite Challenges," *Boston Globe*, June 18, 2006.

³¹ Asiimwe et al., "Uganda TOO Final Report."

practicing pregnancy risk behavior, 73 percent did not want more children and were at high risk for unwanted pregnancies. The study concluded that PMTCT and other HIV-prevention and care programs should ensure provision of family planning for HIV-infected populations who do not want to become pregnant.³²

Targeting Adolescent Girls

“We’re sitting on fire...it’s been a missing link.”³³

Reaching adolescent girls, including married adolescents, with RH and HIV information and services represents a critical challenge. In acutely affected countries, adolescent girls have poor access to confidential and affordable reproductive health and HIV services, making it difficult for them to protect themselves from HIV and unwanted pregnancy. This is an area that demands greater innovation and attention, both through facility-based approaches and other activities to reach young people. Evidence indicates that young people usually do not see themselves at risk and that few are aware of their HIV status.

- In sub-Saharan Africa, women ages 15 to 24 are infected at rates as much as six times higher than men and boys their age, underscoring the vulnerability of young women, which is often linked to unequal power relationships.³⁴
- A survey of almost 12,000 young people in South Africa found that just over two-thirds of South African women ages 15 to 24 were already sexually active and that 34 percent had been pregnant (33 percent of 15- to 19-year olds; 59 percent of 20- to 24-year olds). Given that rates of HIV infection in South Africa rise rapidly after age 15, high levels of unprotected sex put these young women at increasing risk of HIV infection. Accordingly, the study found that teenage pregnancy may be associated with outcomes that lead to HIV infection. The same risk behaviors are at the root of both teenage pregnancy and HIV infection, and they underscore the need to integrate services to better address the changing reproductive health needs of young women.

The study reports:

Our data indicate that beyond unprotected sex as the root cause of pregnancies and HIV infections, those behaviors that are likely to result in teenage pregnancy are also those that place young women at greater risk of HIV infection. Now, more than ever, there is a need to continue efforts to better integrate family planning and HIV prevention services and to involve young males in these decision-making processes. Although efforts are being made to better integrate these different services, our efforts thus far have not been adequate.³⁵

Helen Rees from the Reproductive Health Research Unit (RHRU) of the University of Witwatersrand stressed the importance of family planning in reaching young women:

³² Sylvia Nakayiwa et al., “Desire for Children and Pregnancy Risk Behavior among HIV-Infected Men and Women in Uganda,” *AIDS and Behavior* (May 2006).

³³ Interview with Dr. Robert Ayisi, Kenyan National AIDS and STI Control Program (NASCO), Nairobi, Kenya, February 23, 2006.

³⁴ UNAIDS, *2006 Report on the Global AIDS Epidemic* (New York: UNAIDS, 2006), p. 88, http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH04_en.pdf.

³⁵ H. Rees et al., “HIV, Contraceptive Use, and Pregnancy Among 15-24 year old South African Women,” paper presented at the 15th International AIDS Conference, Bangkok, Thailand, July 11–16, 2004.

“Ideally, we’d have comprehensive reproductive health services for women of all ages, but the chances of that are slim. The reality check is that the biggest return on investment and reaching young women is that we need family planning services.”³⁶

Preventing New Infections among Women and Girls

*“We’re losing here in South Africa. A lot more people are getting infected every day. We need new strategies.”*³⁷

Women make up nearly half of HIV infections worldwide and almost two-thirds of infections among young people. While HIV treatment has greatly expanded and now reaches 1.3 million people,³⁸ new infections continue to vastly outpace available treatment.³⁹ There is a compelling need to expand prevention strategies, and recent studies have demonstrated the important role of RH/FP programs in HIV prevention for women and girls.

The importance of women using dual protection—contraception and condoms—is essential; programs that help prevent pregnancy but do not also help women protect themselves from HIV are not enough. As Noerine Kaleeba put it: “When we send girls out with pills, are we saying ‘go get HIV infected?’ If she won’t get pregnant, where’s the incentive for protection? We need to work out a way of saying that we want to protect you against three things—pregnancy, STIs, and HIV.... Let them not go out of our door and into the hands of HIV.”⁴⁰

³⁶ Interview at Chris Hani Baragwanath Hospital, Soweto, South Africa, February 27, 2006.

³⁷ Interview with Steve Smith, PEPFAR coordinator, U.S. Embassy, Pretoria, South Africa, March 1, 2006.

³⁸ World Health Organization (WHO), *Progress on Global Access to Antiretroviral Therapy: A Report on “3 by 5” and Beyond* (Geneva: WHO, March 2006), http://www.who.int/hiv/fullreport_en_highres.pdf.

³⁹ Global HIV Prevention Working Group, *HIV Prevention in the Era of Expanded Treatment Access*, report of a working group convened by the Bill and Melinda Gates Foundation and the Kaiser Family Foundation, June 2004, <http://www.kff.org/hiv/aids/hiv061004pkg.cfm>.

⁴⁰ Interview with Noerine Kaleeba, Johannesburg, South Africa, February 27, 2006.

Promising Programs: Examples from the Field

An increasing number of programs are integrating RH/FP and HIV services for women and girls in affected countries. Some of these programs focus on integrating RH/FP into HIV; others focus on integrating HIV into pre-existing RH/FP programs; and still others focus specifically on reaching young people, including adolescent girls, with RH and HIV information and services. Up to now, there have not been comparative analyses of integrated programs versus vertical programs. The following section provides brief descriptions of some of the innovative initiatives in each of these categories.

Integrating Reproductive Health into HIV/AIDS Services

There is a logical link in addressing reproductive health concerns and health risks within the VCT setting, and it opens opportunities to speak about important issues. VCT sites are becoming places to determine one's HIV status, learn about HIV, and access RH/FP services. In addition, some VCT clients, such as married adolescents, men, and couples, may not necessarily be visiting family planning clinics, and VCT can help fill that gap.

While the implementation of integration is still in its early stages, a number of programs are exploring ways to make integration effective.⁴¹ Given that VCT clients are usually concerned that they had unprotected sex, with the possibility of unwanted pregnancy or having contracted an STI, and that family planning clients are sexually active and therefore at risk for HIV, VCT-FP integration offers them the services they need. In Kenya, for example, FHI documented that 32 percent of female VCT clients were at risk for unintended pregnancy.⁴² As VCT programs are being scaled up, this is an important moment to include integrated approaches in the design of policies and procedures.

FHI Program in Webuye Hospital, Western Province, Kenya

The Kenyan Ministry of Health, with support from FHI and other partners, is testing a national strategy for integrating family planning and VCT services. This followed a 2002 assessment that found that few VCT providers referred clients for family planning services, despite the fact that some VCT clients wanted to prevent pregnancies and that all VCT providers and most clients in the study supported integrating family planning services within VCT clinics.

In late 2004, the Ministry of Health, with support from FHI, AMKENI, and JHPIEGO, with PEPFAR funding, began integrating FP into VCT and ARV in over 60 centers, including the Webuye Hospital in Bungoma district in Western province. VCT sessions now include family planning information, with pills and condoms provided. Other family planning methods are available through referral to the maternal and child health (MCH) department in another part of the building. The program staff report

⁴¹See Kerry Wright Aradhya, "Integrating Family Planning into VCT services," *Network* 23, no. 3 (2004), http://www.fhi.org/en/RH/Pubs/Network/v23_3/nt2333.htm.

⁴² Heidi Reynolds et al., "Integrating Family Planning Services into Voluntary Counseling and Testing Centers in Kenya: Operations Research Results," Family Health International, Research Triangle Park, N.C., 2006.

increased uptake in services since they have been integrated, although they acknowledge that it is difficult to attribute the uptake solely to the integrated services.⁴³

The program staff reported that slightly more women than men are accessing VCT, more women are identified as HIV positive,⁴⁴ and that many of the women come for VCT out of concern about the behavior of their husbands or partners. As one VCT counselor put it: “There’s been a gap—they had no access to these services. So we give them two services at once, and we’ve laid two worries down in the same one hour about their health and their family. There’s a need for support of these services in VCT.”⁴⁵

Chris Hani Baragwanath Hospital, PHRU Wellness Program

The Perinatal HIV Research Unit (PHRU), a research unit of the University of the Witwatersrand, operates a “wellness” program for HIV-infected adults who are not yet eligible for ARV treatment. The program, which receives PEPFAR funding, provides comprehensive care and support for HIV-infected adults in facilities in Gauteng and Limpopo provinces. The aim of the program is to treat and prevent opportunistic infections, provide psychosocial support and advice on good nutrition and healthy lifestyle.

According to PHRU, about 70 percent of those in the Wellness Program are women, and 50 to 60 percent of them want family planning services from the program; the rest either get contraceptives elsewhere or currently do not have partners. While many of the women are theoretically using contraception, about 13 percent become pregnant. Since only a few want to become pregnant, there is a high rate of termination of pregnancy.⁴⁶

Reproductive Health Research Unit (RHRU) in Johannesburg General Hospital, South Africa

RHRU of the University of Witwatersrand established an ART clinic in the Department of Obstetrics and Gynecology at Johannesburg Hospital, funded by PEPFAR and the South African government. By setting up a pilot ART clinic within the Obstetrics Department of an antenatal clinic, the project is able to provide reproductive health and HIV services to their antenatal clients and to rapidly initiate pregnant women onto ARVs with close monitoring and support.

The program is designed to offer VCT to all the antenatal clients and, for those who are HIV positive, to bring the services they need to one site. According to Dr. Vivian Black, a physician with RHRU: “We try to capture the HIV-positive mothers who are not on treatment, so they can get contraception, condoms, pap smears, and encourage partner

⁴³ Interview at Webuye Hospital, Bungoma district, Western province, Kenya, February 21, 2006.

⁴⁴ Hospital records from January 2006, for example, indicate that of those tested, 159 were males and 168 were females. Of those, 22 males were positive, and 46 females were positive.

⁴⁵ Interview with Naseem Mohammed, nurse and VCT counselor, Webuye Hospital, February 21, 2006.

⁴⁶ Interviews at the Perinatal HIV Research Unit at Chris Hani Baragwanath Hospital with Glenda Gray, Busi Nkala, Primrose Mkhizee, Lerato Mohapi, Ntonski Bandezi, and Neil Martinson, Soweto, South Africa, February 27, 2006.

notification.”⁴⁷ The program puts a strong emphasis on dual protection. Since the program began in July 2004, some 450 women have been put on ARVs.⁴⁸

Patients are referred to the RHRU clinic if they are clinically eligible for ARVs; they are encouraged to disclose their status and to bring their partners, but it is not required. HIV positive women who want to become pregnant are also referred to the clinic for medical advice and assistance. While the number of such cases is still low, Dr. Black considers that they are “the tip of the iceberg” and that many more HIV-positive women want to become pregnant.

One 28-year-old patient in the clinic explained that she got sick in February 2004 and went for a TB test. Although that test was negative, she was then tested for HIV and was found to be positive. She described her experiences with disclosure: “I told my partner I was HIV positive when we met, but he didn’t care. He said that most of us are sick. I think he knew his status too. Then, when I was pregnant, his old girlfriend called me on my cell phone. She said ‘I’m HIV positive.’ She said ‘your boyfriend didn’t tell you, but you’re going to have a baby that has AIDS.’ She wanted to hate me because I was his new girlfriend. It was painful.”⁴⁹

Integrating HIV/AIDS into Reproductive Health Services

“With sexually active, well, young women in the peak incidence group, it’s criminal not to be offering them testing, while encouraging them to make other reproductive health decisions.”⁵⁰

Integrating HIV into reproductive health offers many benefits to clients, not least of which is that it can increase the opportunities for women to learn their HIV status and access services before they fall sick. Too often, people are referred for VCT only after they become sick, contributing to high morbidity and mortality rates.⁵¹ Integrating services may also increase uptake in family planning, which would help reduce vertical transmission. Finally, linking family planning and HIV services helps to address the sexual and reproductive health needs of people living with HIV and AIDS.

Using reproductive health, including antenatal clinics, as an entry point for HIV services increases access for women and girls by expanding the number of HIV-service delivery outlets. In Kenya, for example, 90 percent of women receive antenatal care from a trained medical provider, which therefore provides a good opportunity to reach large numbers of women with HIV information; 40 percent of women in Kenya deliver in a

⁴⁷ For example, in January 2006, the program had 328 patients, of whom 283 were counseled, 248 were tested, and 75 were HIV positive.

⁴⁸ Interview with Dr. Vivian Black, RHRU, Johannesburg General Hospital, Johannesburg, South Africa, February 28, 2006.

⁴⁹ Interview at Johannesburg General Hospital, Johannesburg, South Africa, February 28, 2006.

⁵⁰ Interview with Prof. Helen Rees at Chris Hani Baragwanath Hospital, February 27, 2006.

⁵¹ See comments from Dr. Joachim Osur of Family Health Options Kenya in “FP and HIV AIDS Integration Discussion: Week 2 of the FP HIV Integration Forum,” Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, Baltimore, Md., May 8, 2006, <http://www.fpandhiv.org/videoconference/forumday9.php>.

health facility, which provides an additional opportunity for HIV integration. Though only small numbers of Kenyan women receive postnatal care, some 75 percent of children under five years of age are immunized, which provides another opportunity to reach the mothers in a safe, nonstigmatizing environment.⁵²

Family Health Options Kenya (FHOK)

FHOK (formerly Family Planning Association of Kenya), an International Planned Parenthood Federation (IPPF) member association,⁵³ has introduced HIV prevention, care, and treatment into its RH program. Given that the program reached over 32,000 women with FP service in 2005, they have the potential to provide a useful entry point for HIV. As Dr. Joachim Osur from FHOK put it: “In an era of AIDS, you can’t give reproductive health services in the same way as we used to earlier on.”⁵⁴ He went on to describe how RH is linked to HIV prevention and access to services, with antenatal care linked to PMTCT, STI screening linked to VCT, FP and dual methods linked to VCT, and pap smears for HIV-positive women linked to their risk for cervical cancer, as well as the special risks faced by adolescent girls.

The FHOK model offers the opportunity to roll out HIV care through established RH clinics. They have the added advantage of existing community networks. As they readily point out, HIV care cannot be just hospital based—the community linkages are critical. The entry point can be FP, VCT, PMTCT, or medical treatment. FHOK is also able to reach newly married women with HIV information and services when they come for FP, antenatal, and postnatal care.

From June to October 2005, FHOK served over 6,000 clients with RH/FP services, of which over 2,000 received HIV services and 265 were identified as HIV positive.⁵⁵

The FHOK ARV program started in 2005, and they now have some 30 women on treatment in Nairobi and 73 total in their four sites. Other women have been identified as positive but not yet eligible for ARVs, and they are being followed by the clinic.

One woman living with HIV interviewed at FHOK described the importance of integrated services for her: “What is being done here is unique. The government isolates diseases, in parallel programs. You have to run to different places to get care. I come here and get FP, HIV—all my concerns under one roof. It also contributes to reducing stigma and discrimination.” Another positive woman, whose baby, named Hope, is exhibiting signs of HIV infection, explained how she finds the integrated clinic more supportive: “When I bring her here, she’s like any other child.”

⁵² Figures from Central Bureau of Statistics (Kenya), Ministry of Health (Kenya), and ORC Macro, *Kenya Demographic and Health Survey 2003* (Calverton, Md.: MEASURE DHS, July 2004), <http://www.measuredhs.com/pubs/pdf/FR151/09Chapter09.pdf>.

⁵³ The International Planned Parenthood Federation (IPPF), the largest organization working on sexual and reproductive health, has 150 member associations working in 167 countries; IPPF is also active in a further 15 countries where there are not currently member associations. (See <http://www.ippf.org/>.) Because IPPF advocates for liberalized abortion policies, the work of many of its member associations on unsafe abortion has suffered or been neglected as a result of the U.S. Mexico City policy, which denies reproductive health funding to foreign nongovernmental organizations (NGOs) that support, provide, or refer for abortions.

⁵⁴ Interview with Dr. Joachim Osur, FHOK, Nairobi, Kenya, February 22, 2006.

⁵⁵ Family Planning and HIV/AIDS Integration Working Group, “Integrating FP and ARV Programs,” meeting report, Washington, D.C., November 2005.

Population Council in Northwest Province, South Africa

This project, with PEPFAR funding, seeks to increase access to quality HIV and FP services, focused on integrating VCT into FP in Northwest Province. Given the relatively low uptake at stand-alone VCT sites, and that some 40 percent of RH clients present with STIs, the idea was to improve VCT access, increase use of dual protection, and keep quality FP services.

The pilot has set up two models, which differ in the degree of integration: high-integration clinics provide pre- and post-test counseling and rapid tests by FP providers in the FP counseling room; low-integration clinics refer FP clients for VCT services, on site but in a different room. In total, 141 nurses were trained in 12 clinics, and supplies and equipment were monitored and some clinics were reorganized.⁵⁶

In the Wonderkop Clinic in Rustenberg, a high-integration clinic, the staff reports that approximately 1,000 women come every month for family planning services. As the clinic nurse explained about the integrated program: “It’s more work, but it helps so many people. Before, they didn’t know their status. Now we can refer them to the wellness clinic and for ARVs.”⁵⁷

The preliminary findings of this pilot project include: improved provider discussion of STI and HIV risk factors; improved discussion of condoms and VCT; no decline in FP quality; and variable VCT activity, with high performers in both categories. To improve integration, the program identified the following priorities: adding job aids and operationalizing integration; extending staff rotation periods for integrated programs; ensuring adequate staffing; labeling consultation rooms with both VCT and FP, so it is not evident which services a client is going for; and keeping commodities for HIV and FP in one room. They also identified a number of challenges, including: increasing staff time with each client; clarifying roles between FP and VCT providers; strengthening post-VCT referrals (CD4, ARVs, PMTCT, wellness clinics); and training lay counselors, in addition to nurses, to provide FP services.⁵⁸

Family Guidance Association Ethiopia (FGAE)

FGAE is a nongovernmental organization in Ethiopia and an IPPF member association. In 2002, based on an assessment of clients’ needs and preferences, FGAE expanded its RH services to include HIV/AIDS. While RH services are usually used by women and girls, the HIV component has attracted men not usually targeted by RH programs. FGAE reports having had over 40,000 VCT clients in 2005,⁵⁹ making them the largest VCT provider after the Ethiopian government. Some 60 percent of their VCT clients are

⁵⁶ Interview with Saiqa Mullick, Population Council, Washington, D.C., May 18, 2006.

⁵⁷ Interview with Margaret Phatshwane, Wonderkop, professional nurse, Clinic, Rustenberg, South Africa, February 24, 2006.

⁵⁸ Presentation by Saiqa Mullick, “Increasing Access to Quality HIV and Family Planning Services: Results from Phase I of the VCT-FP Project in North West Province, South Africa,” Family Planning and HIV/AIDS Integration Working Group meeting, Washington, D.C., May 19, 2006.

⁵⁹ Between January and December 2005, FGAE tested 40,692 clients: 20,812 female, 19,880 male. Of those, 4,573 were HIV positive: 2,863 female, 1,710 male. Information provided by FGAE in Addis Ababa.

women, and most of them are young and single. FGAE does not provide ART yet, but it is working to secure resources to introduce ART in the near future.⁶⁰

FGAE has implemented different integration models: facility-level integration, where HIV and family planning are colocated in the same facility, and clients are referred to a different part of the facility for different services; room-level integration, where HIV and family planning rooms are rotated weekly to avoid the problem of clients being identified as seeking VCT services; and counselor-level integration, where health providers offer both HIV and family planning services in the same session.⁶¹

In 2005, FGAE also opened a rape center in its clinic in Addis Ababa, which is providing services to women and girls, including pregnancy tests, STI treatment, emergency contraception, HIV information and VCT, and referrals for legal assistance and social support. They report seeing some 100 clients per month, with the numbers rising.⁶²

The FGAE VCT clients differ from the Ethiopian general population in that they are slightly younger, more likely to be single, more educated, and more likely to be HIV positive. The high number of young, single clients in the FGAE population may be due in part to the youth outreach programs.⁶³

FGAE has a model clinic in Bahir Dar in the Amhara region, an area with very high HIV prevalence—23 percent, according to 2004 sentinel surveillance figures. The area also has the highest fertility rates in Ethiopia—5.9 children per woman—which indicates low use of contraception. The high HIV rates are due to many factors, including rural girls migrating to the city and becoming sex workers, few HIV/AIDS interventions working on prevention, and widespread poverty. The branch manager for the FGAE model clinic in Bahir Dar reports that since they integrated services, they have seen 2.5 times higher uptake in family planning clients, and 3 times higher uptake at the youth center (see below). Still, they acknowledge that it is hard to determine whether the rise in uptake is due directly to integration or to a combination of factors, including greater awareness and information dissemination.⁶⁴

Esselen Street Clinic, RHRU, South Africa

This project receives PEPFAR funding to focus on sex workers in the Hillbrow area of Johannesburg, a densely populated, inner-city location with high rates of crime and sex work, and a high ratio of males to females.

The project aims to reduce the rate of STI and HIV transmission by providing STI treatment services in ways that are accessible and acceptable to sex workers. The project includes a clinic and an outreach program that focuses on 13 “hotels” (brothels) mostly in Hillbrow, providing assessment, diagnosis, and treatment for sex workers and their clients. Services include FP, pap smears, and referrals for termination of pregnancy. The project encourages sex workers to access VCT and provides VCT at the brothels, as a

⁶⁰ Interview with Dr. Alem Assefa, HIV/AIDS program head, FGAE, Addis Ababa, May 8, 2006.

⁶¹ FGAE, “VCT/FP Integration: FGAE’s Experience.”

⁶² Interview with Dr. Meheret Elias, FGAE, Addis Ababa, May 8, 2006.

⁶³ Heather Bradley, “Educational Attainment and HIV Status among Ethiopian Voluntary Counseling and Testing Clients” (master’s thesis, Bloomberg School of Public Health, Johns Hopkins University, 2005).

⁶⁴ Interview at FGAE model clinic in Bahir Dar, May 9, 2006.

way to overcome stigma from service providers and to accommodate the sex workers' working times and constraints on getting to VCT sites. The project also provides CD4 screening and referrals for ARVs. To increase access to prevention services, the program distributes male and female condoms and information, education, and communication (IEC) materials. The project also provides RH and family planning services, including cervical cancer screening.⁶⁵

Pathfinder: Community Outreach in Ethiopia

In Ethiopia, Pathfinder deploys some 8,000 community reproductive health agents (CRHAs) in about 300 districts, covering four regions and almost half the country. Given that health coverage is so low in Ethiopia, this model allows CRHAs to go house to house in remote areas to reach women and girls with RH and HIV information and to identify sick people in households, including those who need VCT. On FP, the CRHAs provide pills and condoms, but refer women to health facilities for injectable or implanted contraceptive devices. On HIV/AIDS, agents provide prevention and care information and referrals for HIV services.⁶⁶

AMKENI in Kenya

In Kenya, AMKENI is a U.S. Agency for International Development (USAID) and PEPFAR-funded program through EngenderHealth with other partners. The program initially focused on reproductive health for women, especially family planning and safe motherhood, but it has since integrated programming on HIV/AIDS. The program aims to increase the use of sustainable, integrated, comprehensive services including HIV/AIDS prevention services at the community level. AMKENI operates in two Kenyan provinces (Western and Coast) and works with communities to increase healthy behaviors and to strengthen services. Using some 1,400 "animators" who are community volunteers, AMKENI reaches 90,000 facilities.⁶⁷

Preventing Mother-to-Child-Transmission (PMTCT)

PMTCT programs provide an essential entry point to address women's family planning needs and fertility intentions during antenatal and postnatal care. Too often, however, PMTCT programs miss this opportunity. Despite the fact that most PMTCT programs are offered within existing maternal and child health facilities, little family planning counseling appears to be provided, and the extent of integration varies widely.⁶⁸

It seems that little family planning is being offered because PMTCT services are largely limited to HIV testing in antenatal care and provision of ARVs to those who test positive. Family planning discussions are limited in antenatal care due to the fact that FP messages in this context do not result in contraceptive uptake, since women are focused on pregnancy and childbirth, not on preventing pregnancies. The ideal would be to

⁶⁵ Interview with Tiisetso Motloung, nurse and project coordinator for sex worker team, RHRU, Esselen Street Clinic, February 27, 2006.

⁶⁶ Interview with Tilahun Giday, country representative, Pathfinder International, Addis Ababa, Ethiopia, May 8, 2006.

⁶⁷ Interview with Anjala Kanethasan, AMKENI, Nairobi, February 23, 2006.

⁶⁸ Naomi Rutenberg and Carolyn Baek, "Field Experiences Integrating Family Planning into Programs to Prevent Mother-to-Child Transmission of HIV," *Studies in Family Planning* 36, no. 3 (September 2005).

provide FP services in the early postpartum period, but family planning programs have struggled for years to reach women with postpartum family planning services especially when few women deliver in health facilities. One service that women do use in high proportions in most countries is immunization care for their infants, but these services are not typically structured to identify women's family planning needs. Creative service delivery options are needed to reach all women with postpartum family planning services.⁶⁹

According to Dr. Robert Ayisi, program manager for PMTCT/STI/IDU for the Kenyan National AIDS and STI Control Program, "integration is the way forward." He explained that for the Kenyan government, primary prevention has to be the first part of the response, and bringing family planning forward helps prevent unwanted pregnancies. As he described it, "PMTCT is the entry point for comprehensive care for the mother, even including access to ART." He also noted that another entry point for care is pediatric care. "To follow up from baby A, in case she [the mother] seroconverts, before baby B comes. We want to know her serostatus before each pregnancy." In this way, the baby and the mother can be followed up through postnatal visits and continuing through child welfare clinics.⁷⁰

- In Ethiopia, through the Hareg Project, IntraHealth is receiving PEPFAR funding to take a broad-based approach to PMTCT, including a strong focus on the inclusion of family planning into PMTCT services as a primary HIV-prevention activity. By preventing unintended pregnancies and assisting HIV-positive or at-risk women in planning for future pregnancies, the program aims to reduce transmission of HIV from mother to child. By analyzing and learning from common gaps in services, including provider stigma as a barrier to uptake, IntraHealth is working to bring about overall improvement of maternal and child health services, including strengthened FP and sustained inclusion of PMTT services.⁷¹ IntraHealth is also working to address a major constraint to PMTCT, involving poor morale and motivation among health workers leading to high turnover rates.
- The World Health Organization (WHO) framework for PMTCT highlights the importance of FP in HIV prevention. The framework focuses on preventing HIV in young women, avoiding unintended pregnancies in HIV-positive women, providing ARVs to prevent vertical transmission (as well as safe delivery and support for safer infant feeding practices), and providing care and support to mothers and their families. However, PMTCT programs have traditionally focused on providing ARVs, while FP has been an underutilized intervention.
- Despite the importance and relative simplicity of providing PMTCT, few pregnant women are currently offered such services. According to the Joint United Nations Program on HIV/AIDS (UNAIDS), only 8 percent of women are covered with PMTCT; in sub-Saharan Africa, less than 6 percent of pregnant women were offered PMTCT in 2005.⁷²

⁶⁹ Communication from Heidi Reynolds, FHI, June 25, 2006.

⁷⁰ Interview in Nairobi, Kenya, February 23, 2006.

⁷¹ Interview with Cristina Ruden, IntraHealth, Addis Ababa, Ethiopia, May 10, 2006.

⁷² UNAIDS, *2006 Report on the Global AIDS Epidemic*.

Reaching Adolescent Girls

“We know the epidemic is targeting adolescents, but where are the programs? That’s where the epidemic is; that’s where you change behavior.”⁷³

Young women make up three-quarters of 15- to 24-year olds living with HIV in sub-Saharan Africa, and their numbers are increasing in every region of the world. RH/FP services offer an important entry point to reach adolescent girls with HIV information, counseling, and services. Time and again, girls report that they do not want to go to clinics out of fear of seeing their relatives and being chastised by the nurses. To reach them, alternative delivery points should be explored, including pharmacies. As Michelle Folsom of PATH in South Africa noted: “Girls want to avoid being stigmatized, to avoid wearing the scarlet ‘family planning’ or ‘ART.’”⁷⁴

A community animator with the AMKENI program in western Kenya described the importance for girls to get both RH and HIV information for prevention: “Girls have to protect themselves or two things will come out: either they’ll get pregnant, or they’ll get HIV.”⁷⁵ Dr. Maggwa from FHI echoed these realities when he said: “Adolescent girls get pregnant, are vulnerable, and have to suffer the consequences of unplanned and unwanted pregnancies. They are the least informed and have poor access to services.... The burden on them by HIV, by pregnancies themselves, is much higher, and it justifies focusing on the girl child at a much higher level of vulnerability.”⁷⁶

Family Health Options Kenya

FHOK is working to make its VCT sites youth friendly and to have youth resource centers attached to their clinics, linking RH and HIV information and services. Their outreach services include teams of young people who go into communities, visiting schools and churches. FHOK also provides outreach VCT services, and those who test positive are referred to the clinic. Outreach VCT services are offered in Nakuru, Eldoret, Kisumu, Mombasa, Nairobi, and Thika. They have found that about equal numbers of boys and girls are being tested in their youth-friendly sites, which they attribute in part to the attitude of the services providers and the fact that they stay open until 7 p.m.

The centers particularly target low-income girls in slum areas, many of whom are pushed by poverty and economic realities to engage in risky sex with older men. FHOK is working with the Ministry of Health to promote VCT and to enhance follow-up, particularly for girls 14 to 18 years old. In focusing on the “youth friendliness” of the clinic, FHOK tries to adjust waiting times, the clinic environment, staff attitudes, and prevention programs, while still providing VCT and ARVs. Overall, FHOK is finding that their integrated youth centers are getting good uptake in services. In their six centers over the past two years, they have counseled and tested some 9,000 girls.⁷⁷

One young woman, named Florence, described her experience of going for VCT at the Eldoret Center: “I was in a relationship before. I was forced into sex with my cousin

⁷³ Interview with Glenda Gray, PHRU, on February 27, 2006.

⁷⁴ Interview with Michelle Folsom, PATH, Johannesburg, South Africa, February 24, 2006.

⁷⁵ Interview with Ella Kedera, AMKENI field staff, Tigoi, Kenya, February 20, 2006.

⁷⁶ Interview in Nairobi, February 23, 2006.

⁷⁷ Interview with Edward Marienga, youth coordinator, FHOK, Nairobi, Kenya, February 22, 2006.

when I was 17. It happened at my home. I kept quiet when I learned my status, but became a peer educator and am working on home-based care in Eldoret. When I found out I was pregnant, I delivered at FHOK. So far, my baby boy—named Gift—is 2½, and seems fine.”⁷⁸

Family Guidance Association Ethiopia (FGAE)

FGAE youth centers in Bahir Dar and Nazareth offer diagnosis, treatment, information, counseling, and services on family planning, STIs, HIV/AIDS, emergency contraception, pregnancy tests, postabortion care, treatment of opportunistic infections, and other medical services. On HIV/AIDS, the centers offer VCT, and they have found that more girls than boys are accessing these services.⁷⁹ The centers also offer recreational and entertainment facilities and library services.

To address the problems of out-of-school youth facing poverty and unemployment, FGAE youth centers provide some skills-training programs, assertiveness training, and leadership training. The centers also sponsor post-test clubs for HIV-positive young people, as well as girls clubs, which are a way to overcome girls’ reluctance to come to centers dominated by boys. The girls clubs also reach out to vulnerable girls, including sex workers, house maids, and street children, with information about HIV/AIDS and family planning information.⁸⁰

loveLife in South Africa

loveLife is South Africa’s national HIV-prevention program for youth, promoting healthy living to reduce HIV infection and unwanted pregnancy among young people aged 12 to 17.⁸¹ loveLife combines national-scale clinical and community-based services and outreach programs with a sustained multimedia education and awareness campaign. loveLife includes more than 350 youth-friendly public clinics, 16 multipurpose youth centers (at least one in each of South Africa’s nine provinces), 3,500 schools, and 135 community-based organizations participating as loveLife “franchises” implementing loveLife programs locally.⁸² loveLife’s programs are managed by a national youth

⁷⁸ Interview at FHOK, Nairobi, Kenya, February 22, 2006.

⁷⁹ According to data from FGAE, between June 2002 and June 2004, a total of 15,028 young people were tested, of which 8,628 were female.

⁸⁰ Amare Bedada, FGAE executive director, “Youth Focused Programs: The Experience of Family Guidance Association of Ethiopia,” presented at World Bank meeting, “Taking Stock: Dialogue on Youth Focused Programs and Initiatives,” Addis Ababa, Ethiopia, June 2005.

⁸¹ loveLife was launched in late 1999 by a consortium of leading South African nongovernmental organizations in partnership with the South African government, major South African corporations including the South African Broadcasting Corporation, and with the support of private U.S. funders. loveLife has been funded by the South African government, the Kaiser Family Foundation, the Bill and Melinda Gates Foundation, the Nelson Mandela Foundation, the Global Fund, and more than 20 South African private corporations. The Global Fund, which accounted for one-third of its funding, recently withdrew its grant.

⁸² Key elements of loveLife include: community-level HIV-prevention education and youth mobilization programs (including 3,500 schools) led by national corps of 1,500 18- to 25-year-old groundbreakers and 5,000 volunteer peer motivators (*mpintshis* or buddies); a national adolescent-friendly youth clinic initiative (NAFCI), which has established youth-friendly HIV-prevention services in 350 government health clinics; a national network of youth facilities, Y Centers; loveLife games, the largest school sports competition in South Africa; and sustained multimedia HIV- and AIDS-education and awareness campaign.

volunteer corps of 1,700 18- to 23-year olds known as groundBREAKERS. A 2003 national survey of HIV prevalence and sexual behavior among 15- to 25-year-old South Africans found that 85 percent of respondents reported having heard of loveLife, and two-thirds of all South African youth reported awareness of four or more loveLife programs, with over one-third having participated in loveLife programs.⁸³

loveLife has reached a scale unmatched by other youth programs. By the end of 2005, loveLife was reaching over half a million young people a month through face-to-face interaction—mostly youth in urban informal settlements and on farms, or in rural areas with little access to HIV-prevention services. Each month, 300,000 young people seek information and counseling via loveLife’s toll-free helpline; over 2 million listen to loveLife’s 12 regional radio stations; and 750,000 print publications are distributed.⁸⁴

In the public clinics that are part of loveLife’s youth friendly program—the National Adolescent Friendly Youth Clinic Initiative (NAFCI)—far more girls than boys access services. Most girls access family planning services, but most are also referred to VCT by the family planning counselors. HIV prevalence among young girls runs from 7.3 percent among 15- to 19-year olds to 24.5 percent among 20- to 24-year olds, compared to 2.5 percent and 7.6 percent among males in each of these age groups.⁸⁵ Dr. David Harrison, CEO of loveLife, described the problems in addressing the disproportionate impact of HIV among young girls: “We have reached 95 percent plus on knowledge, yet there’s a massive explosion of HIV among 17- to 19-year-old girls. Why? We’re at the most intractable point of the epidemic, dealing with social norms and attitudes.... Condom use has improved, but we’ve done nothing yet to stem the explosion among 17- to 19-year-old women.”⁸⁶ He continued: “The link between teenage pregnancy and HIV—to try to break that explosion—that’s what we want to focus on, but it’s highly controversial terrain.”

- At the loveLife Orange Farm Y-Center, the staff has found that while they target 12- to 18-year-old girls and boys, the girls tend to be more responsive. As the regional campaign manager explained: “the issues we deal with affect them directly, like teenage pregnancy—the girls bear the results.”⁸⁷ The center has found that teenage pregnancy rates and STI cases in the area have gone down since loveLife was established, and that many girls were accessing the NAFCI clinics for contraceptives, including condoms. The center integrates HIV messages in all its programs, including sports and recreation. Nevertheless, uptake in VCT remains low.⁸⁸

⁸³ The study was commissioned as part of a larger evaluation of loveLife and conducted by the Reproductive Research Unit (RHRU) of the University of Witwatersrand with the Medical Research Council of South Africa. See RHRU, “HIV and Sexual Behavior among Young South Africans: A National Survey of 15-24 Year Olds,” <http://www.rhu.co.za/images/Docs/Fact%20Sheet.pdf>.

⁸⁴ Interview with David Harrison, CEO of loveLife, Johannesburg, South Africa, February 27, 2006; loveLife 2005 Monitoring Report.

⁸⁵ RHRU, “HIV and Sexual Behavior among Young South Africans.”

⁸⁶ Interview with David Harrison (see note 84).

⁸⁷ Interview with Mmana Bathobakae, Lekwa regional campaign manager for loveLife, Orange Farm, South Africa, February 27, 2006.

⁸⁸ Interview with Veronica Mochela, NAFCI regional coordinator, Orange Farm, South Africa, February 27, 2006.

- loveLife also has a training component focusing on building self esteem, personal motivation, and leadership skills. According to David Harrison, close to 75 percent of the “groundBREAKERS” get jobs, notably at the companies with which loveLife has established joint ventures. (This is notable because some 75 percent of 18- to 25-year-old South Africans are unemployed.) In particular, loveLife has been given a 26 percent shareholding in the publishing company Paar Gravure, which has also hired some of loveLife’s groundBREAKERS trained in printing.⁸⁹

loveLife workers described one case that involved a girl named Noluthando, whose parents had died. She was sexually abused by her uncle and forced to have sex with his friends; she was essentially forced to be a sex worker. This situation began when she was 10 years old, and she is now 16. She came to the loveLife Center, and eventually told a staff member what was happening. They realized she needed practical intervention, and referred the case to the police and department of social development. Noluthando was taken out of the home and placed with her grandmother, but she continues to come to the loveLife Center. As the manager explained: “When I spoke to her, she said life was a whole lot better. Now she can sleep and eat well. She was very reserved when she first came here; she thought she was worthless. She was 15 when she started coming here regularly.” loveLife also took her for an HIV test, and fortunately, she was negative.⁹⁰

Another girl was 15 or 16 years old when she was gang raped. She knew her attackers, and they threatened to kill her if she told anyone. According to the loveLife counselors, this broke her self-confidence, making her believe that she deserved it. Even her mother said it was because she wore miniskirts. Still, she never went for HIV counseling and testing. When she began coming to the loveLife Center, she was acting out, including sleeping around. Her mother eventually came to a meeting at the loveLife Center, and later the girl and the mother came for counseling. The girl became a volunteer at the center and finally went for VCT and learned she was HIV positive. loveLife referred her to the local government clinic for treatment, but she soon left for Pretoria.⁹¹

⁸⁹ Interview with David Harrison, February 27, 2006.

⁹⁰ Interview with Mmana Bathobakae, February 27, 2006.

⁹¹ Ibid.

Moving Forward: U.S. Policy Constraints

The United States has taken important steps toward the integration of RH and HIV services, but more is needed to create incentives for PEPFAR teams to support innovative integration approaches. In order to move forward, PEPFAR will have to identify some of the factors that constrain integration and make the necessary policy adjustments. Some of the key areas to be addressed involve broadening the concept of prevention, enlarging the exceptions under the Mexico City policy, and providing appropriate guidance for PEPFAR teams and partners on how to implement integrated programs.

PEPFAR programs generally do not address the linkages between HIV and reproductive health, just as they tend to avoid promoting reproductive health as part of HIV prevention.⁹² Where PEPFAR is moving ahead with integrated programming, it is often due to officials on the ground who are willing to support such programs and reach out to new partners.⁹³ Yet many involved in PEPFAR recognize they do not yet adequately address these linkages: “Every pregnancy of an HIV-positive woman is an at-risk pregnancy,” a senior administration official said. “We haven’t thought creatively about how to deal with that.”⁹⁴ In some PEPFAR countries, problems of integrating services are related to the nature of vertical programming. During a CSIS mission to Zambia in 2005, one U.S. embassy official described a “firewall” between HIV and reproductive health, inhibiting the important synergies between the two.⁹⁵

Some of the constraints on PEPFAR have been imposed by Congress, notably the earmark requiring that at least 33 percent of the prevention funds be spent on abstinence-until-marriage programs. However, other obstacles to integration come from PEPFAR country teams and OGAC itself. For example, some PEPFAR teams and partners simply avoid programming related to reproductive health issues, rather than risk jeopardizing their programs. One PEPFAR implementing partner described the perceptions about PEPFAR that inhibit innovation: “There are perceived restrictions in PEPFAR about what you can discuss with whom, so everyone is being very cautious.... People are afraid to discuss family planning, condoms, abortion—so many groups don’t address them at all.... The message isn’t out there, the guidance isn’t out.”⁹⁶

PEPFAR is also constrained by restrictions on funding non-AIDS-related contraception methods (i.e., PEPFAR will only pay for male and female condoms, not other forms of contraception). Given the shortages of contraceptive commodities in some PEPFAR countries, this is an area that deserves attention and highlights the importance of other RH and FP strategies for them.

⁹² See also Vanessa Brocato, *SIECUS PEPFAR Country Profiles: Focusing in on Prevention and Youth* (Washington, D.C.: Sexuality Information and Education Council of the United States (SIECUS), 2005), pp. 4–5, http://www.siecus.org/inter/pepfar/PEPFAR_Interior.pdf.

⁹³ Some country teams recognize the importance of reinforcing these synergies. For example, the Five-Year Strategy for PEPFAR in Kenya, *Strong Networks for a Sustained Response*, states that the U.S. government team is committed to work across sectors and program areas to build systems that promote sustainability. In fact, PEPFAR in Kenya is supporting work on integrating FP into VCT and strengthening PMTCT programs with some FP.

⁹⁴ Interview in Washington D.C., June 6, 2006.

⁹⁵ Fleischman, *Strengthening HIV/AIDS Programs for Women*.

⁹⁶ Interview in Nairobi, Kenya, February 22, 2006.

Narrow Prevention Approaches

In order to more effectively reach vulnerable populations of women and girls, PEPFAR's existing policy on prevention needs to be enlarged, both analytically and programmatically. PEPFAR's focus on the ABC approach to prevention,⁹⁷ with particular emphasis on A and B, has also been a constraint to RH-HIV integration. If PEPFAR prevention programs are overly focused on A-B approaches, this often leads women and girls who are sexually active to see no place for themselves in such programs, thus undermining prevention efforts.

Several studies have shown that focusing on abstinence until marriage inhibits young women who are sexually active from accessing useful prevention services.⁹⁸ In addition, the majority of women are infected within monogamous relationships. Among young women surveyed in Zimbabwe's capital Harare, and in Durban and Soweto, South Africa, 66 percent reported having one lifetime partner, and 79 percent had abstained from sex at least until the age of 17. Yet, 40 percent of these young women were also HIV positive, and most had been infected despite staying faithful to one partner.⁹⁹

The U.S. Government Accountability Office conducted a study on the challenges presented by the prevention spending requirements. Though the report noted important increases in PEPFAR prevention funding overall, it found that the abstinence-until-marriage spending requirements mandated by Congress have presented challenges for some PEPFAR country teams in designing their prevention strategies in ways that are integrated and responsive to local needs.¹⁰⁰ Among those areas negatively affected, the report lists PMTCT programs, programs promoting comprehensive messages to prevent sexual transmission of HIV/AIDS, and programs focused on prevention for HIV-positive people and high-risk groups such as sexually active youth, especially when it involves condom distribution.¹⁰¹

Policy Restrictions: The Mexico City Policy and the Prostitution Pledge

This is an important area where adjustments in U.S. policy approaches will be necessary to allow PEPFAR teams to promote effective integration strategies. Sensible exceptions to these policy restrictions would go a long way toward furthering RH-HIV integration by creating space for groups with different areas of expertise to come together and create more effective AIDS programs.

⁹⁷ ABC = Abstinence; Be faithful; Condoms.

⁹⁸ See amFAR, "Assessing the Efficacy of Abstinence-Only Programs for HIV Prevention Among Young People," Issue Brief No. 2 (April 2005), http://www.amfar.org/binary-data/AMFAR_PUBLICATION/download_file/37.pdf.

⁹⁹ UNAIDS, *AIDS Epidemic Update: December 2005* (Geneva: UNAIDS, 2005), p 9, http://data.unaids.org/Publications/IRC-pub06/epi_update2005_en.pdf.

¹⁰⁰ U.S. Government Accountability Office (GAO), *Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief* GAO-06-395 (Washington, D.C.: GAO, April 2006), <http://www.gao.gov/new.items/d06395.pdf>.

¹⁰¹ Susan A. Cohen, "GAO Report: Global AIDS Law's 'Abstinence-Until-Marriage' Earmark Shortchanges Other Key Prevention Strategies," *Guttmacher Policy Review* 9, no. 2 (Spring 2006), <http://www.guttmacher.org/pubs/gpr/09/2/gpr090219.html>.

The Mexico City policy¹⁰² prevents any foreign nongovernmental organization (NGO) from receiving U.S. family planning funds if it performs or advocates for abortion. In August 2003, a presidential memorandum was issued clarifying that HIV/AIDS assistance was exempt from these restrictions. Accordingly, if a foreign NGO is receiving U.S. family planning assistance, it has to comply with the Mexico City policy; if the organization is receiving only HIV/AIDS funding, it is not subject to these restrictions.

This policy has serious implications for RH-HIV integration, since it often precludes organizations with years of experience in reproductive health from bringing their expertise into an integrated program approach.¹⁰³ While such groups could work on the HIV side of a project, they cannot work on the RH-FP piece. Given the important overlap between the two fields, there are serious concerns that this policy is contributing to a weakening of reproductive health systems in HIV-affected countries, which are vital avenues for reaching women and girls. Mark Dybul, then-deputy U.S. global AIDS coordinator, addressed this issue in a letter to IPPF: “[I]n an integrated program, different organizations may be responsible for different types of activities, as not all organizations necessarily do both voluntary family planning and HIV/AIDS activities. Any partner that receives funds solely for HIV/AIDS is thus not subject to the Mexico City Policy.”

In late 2005, the PEPFAR team and USAID in Kenya issued an integrated request for application (RFA) for a five-year, \$193-million program called Population and Health Integrated Assistance (APHIA II).¹⁰⁴ According to the RFA, the activities are expected to improve and expand facility- and community-based HIV/AIDS, reproductive health,¹⁰⁵ and family planning programs, and selected maternal and child health services.

¹⁰² The Mexico City policy was announced at the Mexico City population meeting in 1984 during the Reagan administration. The policy mandates that no U.S. funding can be provided to any foreign nongovernmental organization that performs abortions. In 1993, President Clinton ended the policy by executive order. In January 2001, President Bush reinstated the ban for all USAID population programs.

¹⁰³ A study by Population Action International found that two key Ethiopian organizations—the Family Guidance Association of Ethiopia (FGAE) and Marie Stopes International Ethiopia (MSIE)—refused to abide by the conditions in early 2002. As a result, FGAE lost 35 percent of its budget, while MSIE lost 10 percent, forcing them to scale back services. Even though FGAE does not perform abortions—they are illegal in most cases in Ethiopia—it is an IPPF affiliate and advocates for liberalized abortion policies. In addition, the Mexico City policy exerts a chilling effect on programs: Population Action International (PAI) states that “a well-known U.S.-based NGO” wanted to include FGAE sites as part of an HIV/AIDS project but decided against it on the assumption that FGAE was ineligible for participation. See the Global Gag Rule Project, *Access Denied: U.S. Restrictions on International Family Planning: The Impact of the Global Gag Rule in Ethiopia* (Washington, D.C.: Global Gag Rule Project, 2003), http://www.globalgagrule.org/caseStudy_ethiopia.htm.

¹⁰⁴ The RFA is designed to use multiple sources of funding, including GHAI (Global HIV/AIDS Initiative funds, for PEPFAR activities), Population funds (FP/RH), and Child Survival (CS) funds (child survival, malaria, and other infectious diseases). While integrating services, the programs are still required to report separately on the use of each funding stream and its restrictions. While HIV/AIDS funds are overwhelmingly dominant, reproductive health and family planning have been given a higher priority in Nyanza and Eastern Provinces.

¹⁰⁵ The RFA states that reproductive health, reproductive health care and reproductive health services refer to voluntary family planning and any combination of the following: HIV/AIDS-related counseling, services, and care; maternal/newborn services; postabortion care; counseling and treatment for sexually transmitted infections; prevention of gender-based violence. They specifically exclude provision or promotion of induced-abortion services.

HIV/AIDS services and activities are the primary component, but integrating these services with TB, RH/FP, and maternal and child health services is required. Unfortunately, due apparently to the mistakes of a contract officer, the RFA incorrectly stated that all participating organizations would have to comply with the Mexico City policy, causing the RFA to be withdrawn and reissued. Nevertheless, the RFA signaled an important recognition that HIV should be linked to RH/FP.

HIV/AIDS funding is subject to a different restriction—the prostitution pledge. In 2003, Congress required that foreign NGOs seeking U.S. HIV/AIDS funds must pledge that they do not support “the legalization or the practice of prostitution.” This requires organizations receiving U.S. funds to pledge their opposition to prostitution and sex trafficking in order to continue their HIV work. In 2005, the Bush administration expanded this to apply to U.S. organizations as well. Under this requirement, recipients of U.S. funds are forced to adhere to official U.S. policy even in their privately funded speech regarding the most effective ways to engage high-risk groups in HIV prevention. The pledge requirement also acts as a constraint on integration, since many organizations working closely with sex workers are reluctant to sign out of concern about increasing their stigma and isolation, which in turn could increase barriers to accessing HIV services.¹⁰⁶

Lack of Guidelines on Integrated or “Wraparound” Programs

A major problem in promoting integrated programs has been the lack of program guidance from OGAC to its country program managers and implementers, since guidance is one of the key ways in which OGAC can provide direction to the field. In order to encourage national teams to move forward with integrated programs, OGAC should provide both support and authorization to the field. This includes assistance for country teams in determining realistic targets and providing technical assistance to implement the new programs. Without such guidance, the lack of clarity often leads to excessive caution.

In a February 2006 letter to Steven Sinding, director general of IPPF, Mark Dybul explicitly stated that FP and antenatal care clinics are important entry points to reach women, and he encouraged “wraparound” activities:

Evidence shows that, particularly in high HIV-prevalence settings, voluntary family planning and antenatal care clinics can be important venues for reaching

¹⁰⁶ In 2005, two U.S. organizations—the Alliance for Open Society International (AOSI) and Pathfinder International—brought a lawsuit against the U.S. government opposing the pledge, stating that it imposed restrictions on their privately funded speech by forcing them to adopt the government’s viewpoint in order to remain eligible for funds. On May 9, 2006, a federal judge ruled that these restrictions on the privately funded speech of groups participating in the federal government’s international HIV/AIDS program violate the First Amendment. On May 19, in a suit brought by DKT International, a second federal judge ruled unconstitutional the government’s policy of forcing U.S. groups to denounce prostitution as a condition for receiving funds for international AIDS work. While the two rulings apply only to the plaintiffs in each case, they provide an important precedent for other U.S.-based groups receiving U.S. HIV/AIDS funds. (See Global Health Council, “Council Update on Second Ruling Against the Anti-Prostitution Pledge,” press release, May 19, 2006, http://www.globalhealth.org/assets/press/app_update_051906.pdf.) Nevertheless, foreign NGOs are not entitled to constitutional protections and would still have to comply with the pledge provisions in order to receive U.S. HIV/AIDS funding.

women with HIV prevention, treatment, counseling and testing, and other interventions or referrals. The Emergency Plan has communicated to countries and partners the importance of voluntary family planning as a “wraparound” intervention. We have made our staff aware that voluntary family planning clinics and programs are an important HIV/AIDS care-delivery point, and play a key role in reducing morbidity and mortality from HIV/AIDS.

However, there is a lack of clarity about what precisely “wraparound” entails, and how it differs from “integration.” Indeed, some PEPFAR partners have been told in no-uncertain terms not to use the term “integration.”¹⁰⁷ It seems that PEPFAR interprets integration to imply a commingling of funds, which runs counter to the restrictions and reporting requirements attached to the different funding accounts. The wording of the Kenyan RFA—which does not refer to “wraparound” but describes integrated services—clearly states that since the financing will come from multiple U.S. sources,¹⁰⁸ the funding had to be accounted for separately:

While integrating services, recipients must maintain the ability to report separately on the use of each stream funding, abiding by restrictions in the Foreign Appropriations Act (FAA), and by the Office of the Global AIDS Coordinator. Each geographic region has a different mix of funds. In all regions, Global HIV/AIDS Initiative (GHAI) funds are predominant. In Nyanza and Eastern Provinces, FP/RH have a higher priority.¹⁰⁹

Yet interviews with U.S. officials and PEPFAR partners made clear that this remains an area of considerable confusion and misinterpretation. It is incumbent on OGAC to clarify policies and procedures for integrated or “wraparound” programs. It is also necessary to provide guidance and technical assistance in how to set up the mechanisms necessary to meet the reporting requirements. This is an imperative that goes beyond RH and family planning, to encompass programs focusing on food and nutrition, violence against women, economic empowerment, and other relevant areas.

Obstacles to Making Necessary Linkages with Other Development Programs

Obviously, PEPFAR cannot fund all health and development programs. There is also a critical need for national governments and donors to increase support for national RH, STI, and family planning programs, which are also entry points for HIV services. Yet without investments in preexisting reproductive health services and promoting linkages with HIV services, PEPFAR is missing a critical opportunity to reach women and girls with life-saving HIV information and services. In South Africa, the PEPFAR team described FP as a vehicle for getting people into HIV counseling and testing, not a question of improving FP quality or access. “That is not what PEPFAR is about,” the PEPFAR coordinator stated.¹¹⁰ However, by focusing narrowly on the VCT angle,

¹⁰⁷ Interview in Addis Ababa, Ethiopia, May 10, 2006.

¹⁰⁸ The U.S. funding streams include GHAI (Global HIV/AIDS Initiative funds, for Emergency Plan activities), population funds (FP/RH), and child survival (CS) funds (child survival, malaria, and other infectious diseases).

¹⁰⁹ Request for Applications (RFA) Number 623-A-06-009, Issuance Date: November 18, 2005.

¹¹⁰ Interview at U.S. embassy in Pretoria, South Africa, March 1, 2006.

PEPFAR may miss the opportunity to build capacity and create a more sustainable AIDS program.

In some countries, PEPFAR teams have recognized the importance of these services in reaching their goals, and have linked to other U.S. government-supported family planning programs to ensure that HIV-positive clients receive access to family planning information and services.¹¹¹ In Kenya, for example, USAID/Kenya's Strategic Objective 3 focuses on reducing fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services.¹¹² The potential for integration to increase access and effectiveness was summed up in the recent integrated RFA in Kenya: "HIV/AIDS, TB, FP/RH and other services are inherently mutually supportive and synergistic. The close links between positive reproductive health behaviors, prevention of HIV and STIs, and child spacing, for example, should not be underestimated."

¹¹¹ See Office of the U.S. Global AIDS Coordinator, *The President's Emergency Plan for AIDS Relief: Second Annual Report to Congress*, February 2006, <http://www.state.gov/s/gac/rl/61286.htm>.

¹¹² The agency's performance goal under its health strategic goal is: Improved global health, including child, maternal, and reproductive health, and the reduction of abortion and disease, especially HIV/AIDS, malaria, and tuberculosis.

Recommendations for Strategic Integration

The United States has an important opportunity to enhance the sustainability of PEPFAR by promoting greater integration of RH-HIV services. This approach serves to meet PEPFAR's goals and to improve the quality of PEPFAR's programs, while also addressing the compelling needs of women and girls in an era of AIDS. With the creation of the interagency technical working group on gender, PEPFAR now has a mechanism for examining innovations, developing guidance, and commissioning evaluation. This is also an area that the U.S. Congress will need to address as it looks toward future U.S. HIV/AIDS policy beyond PEPFAR's first phase, from FY 2003–2008.

PEPFAR should implement proactive strategies to move forward with RH-HIV integration, and it can begin in four key priority areas:

1. Communication with PEPFAR country teams—

- OGAC should formulate written instructions and guidance to the PEPFAR country teams and partners outlining the importance of programs working to integrate RH and HIV and providing information about how to meet the reporting requirements for different funding streams in integrated programs.
- OGAC should solicit from PEPFAR country teams successful examples of integration and wraparound services. The coordinator's office can help document successful or innovative programs, encouraging information to be shared widely.
- OGAC should support evaluation/collection of strategic information on integrated programs to inform scale-up of programs.

2. Incorporate RH/FP components into existing HIV programs, and HIV into existing RH/FP programs—

- PEPFAR should expand work with HIV-positive women to support their fertility decisions and respect their reproductive rights, including: determining clients' desires within the context of VCT, PMTCT, and ART services; identifying operational barriers and gaps in providing FP services within HIV services; providing informed-choice counseling.
- PEPFAR programs should include family planning and reproductive health as part of a minimum package of HIV services, and collocate services wherever possible.
- OGAC should encourage ART treatment programs to incorporate FP components during scale-up, rather than adding them later, and it should proactively provide information on FP methods, backed by guidelines and protocols. Working with country teams and in-country partners, OGAC should ensure that ART protocols include FP, including supervision and logistics management, determining which contraceptives are provided at ART sites and which through referrals, and what counseling would include. OGAC should also ensure that adequate counseling and access to FP and RH services are available at ART sites.
- PEPFAR should support training for VCT providers and for ARV providers to include additional training in FP and RH; at the same time, FP providers should receive basic training in HIV and VCT.

3. Reach and solicit input from those most affected—

- PEPFAR country teams should include women's health advocates and networks of women living with HIV/AIDS in programming and resource allocation decisions.
- PEPFAR teams should expand youth-friendly health services for young people, including adolescent girls. Criteria for youth-friendly services should include: involving young people; ensuring that services are affordable and provided at convenient times; inclusion of skills training and assertiveness building for prevention; and training for service providers in how to treat young people in a respectful and nonjudgmental way.
- PEPFAR programs should ensure that health workers' and clients' needs are being solicited and evaluated, in order to continually improve services and efficiency.

4. Make the case for integration to U.S. policymakers—

- A growing body of evidence points to the important benefits of integrating HIV services with FP and RH services: in expanding entry points and reaching those most at risk, in reducing mother-to-child transmission of HIV/AIDS, in efficiently using existing infrastructure and health personnel, and in contributing to long-term, sustainable national HIV and health services responses.
- OGAC should bring to the attention of Congress, the administration, and the U.S. public this growing body of evidence supporting integrated strategies and build support for a streamlined approach that successfully addresses both reproductive health and HIV imperatives, to the benefit of both.
- PEPFAR should broaden its approach to prevention beyond ABC to include reproductive health and family planning integration.
- OGAC should request that President Bush issue a new presidential memorandum under the Mexico City policy, clarifying that RH/FP organizations can receive U.S. funding in integrated RH-HIV programs for work related both to RH/FP and to HIV/AIDS.

