AIDS, SEX & REPRODUCTION

Integrating HIV/AIDS and Sexual and Reproductive Health into Policies, Programmes and Services

Setting the agenda

'Reproductive rights and AIDS are closely connected. Women have the right to decide about their own sexuality.
To protect themselves against AIDS needs to be an inalienable part of this right. This includes no forced sex, and the right to use a condom'.

Agnes van Ardenne, Minister for Development Cooperation

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Introduction

One-third of all countries have no policies to ensure access for women to sexual and reproductive health services, prevention and care; more than one-third of countries badly affected by HIV/AIDS have no strategies in place to care for AIDS orphans; two-thirds of all countries fail to provide legal protection for vulnerable groups against discrimination; and only one in nine people in sub-Saharan Africa wanting to know their HIV status has access to testing.[1]
Within this context the need for more integrated sexual and reproductive health and HIV/AIDS policies and services is obvious. To be more effective, to reach more people and thus to save more lives. The Dutch government has strong international policies on both subjects. We therefore see the Dutch EU presidency during the second half of 2004 as an ideal opportunity to set the agenda for an integrated HIV/AIDS sexual and reproductive health programme and follow-up during 2005.
The HIV/AIDS pandemic is currently receiving a lot of attention – and rightly so. Its urgency led to demands for new programmes and extra budgets. But given the fact that (worldwide) 80% of HIV is sexually transmitted and a further 10% perinatal or during breastfeeding, the fight against AIDS is far too often approached as if it is barely related to sexual and reproductive health. Resources and campaign-like programmes to fight HIV/AIDS should strengthen existing reproductive health programmes, but instead they are frequently frustrating them. While behavioural impact, reaching target groups at risk and cost-efficacy can be increased by using existing resources and structures, too often the projects to fight AIDS undermine and delay the establishment of effective national public health systems. In order to be effective, the challenge should be to fight HIV/AIDS in such a manner that it leads to strengthening sexual and reproductive health as an inextricable part of a coherent overall health system.
It is crucial to achieve, both effectively and timely, the common goals of various UN conferences ICPD (International Conference on Population and Development) 1994, Beijing 1995, UNGASS (UN General Assembly Special Session) on Aids 2001 as well as the commitments made by the European countries (Dublin Declaration, 2004) in providing education and services, reducing HIV infection rates and maternal mortality, plus promoting contraceptive and condom use among the sexually active population.
Poor sexual and reproductive health accounts for a substantial share – nearly one-fifth – of the global burden of disease. AIDS is the fastest growing cause of death for the poor. The impact falls hardest on the most disadvantaged groups, especially women and children. Of all human development indicators, those for reproductive health reveal the largest gaps between low income and developed countries and the starkest inequities between rich and poor people within countries. The HIV/AIDS pandemic has shifted the burden of disease and disability, both overall and within the area of sexual and reproductive health. In other words, HIV/AIDS has become another major cause of sexual and reproductive ill health worldwide[2].
Understanding the full benefits of sexual and reproductive health services in relation to HIV/AIDS requires looking beyond medical outcomes to broader individual, family and societal benefits. Sexual and reproductive health services contribute to economic

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[1] HIV report by WHO, April 2004

[2] UNFPA, Adding it up, 2004

Joint document of SHARE-NET, WPF and STOP AIDS NOW!

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'At the societal level, AIDS is changing views about sexuality, sexual behaviour and procreation, and intensifying concerns about human rights. At the level of the individual and the family, AIDS is complicating sexual relationships and threatening the ability to safely conceive and bear children. For those engaged in service delivery, AIDS is changing priorities, increasing the need to address the other sexually transmitted infections, influencing recommendations on contraceptives, and frustrating abilities to counsel clients seeking advice on issues as far-ranging as infant feeding and partner relations'

I. de Zoysa, WHO, Geneva

growth and equity, and also contribute towards improving women's social position and increasing their community and political participation.
A conservative coalition is currently trying to undermine the Cairo Programme of Action by constantly equating sexual and reproductive rights with the promotion of abortion. On the first day of his presidency, President Bush reinstated the Mexico City Policy (also known as the Global Gag Rule). This policy means that no American money can go to organisations referring women for abortion, advocating (broader) legalisation of abortion, or who offer abortion counselling and services, even if these organisations implement such activities with their own financial resources. This means that services that provide sexual counselling, testing, family planning, prevention etc. cannot do their important work. This frustrates the fight against sexual ill health and thus the prevention of HIV/AIDS.
The Bush administration is promoting abstinence-only policies, i.e. to educate youngsters only about abstinence, or at best, to promote the ABC method: abstinence, be faithful or, if you are not strong enough to comply with A and B, you can use condoms. With regard to AIDS prevention programmes, the US maintains its position that at least one-third of the financial resources need to go to abstinence-only programmes although all research points out that this does not protect young people against HIV or unwanted pregnancy. All these policies prevent the start of many projects that provide information and education, mother-and-child health, family planning, prevention of HIV and other STIs (sexually transmitted infections). These policies are therefore more likely to increase the number of unwanted pregnancies, unsafe abortions and HIV infections rather than decrease them.
This document has been drawn up to expand knowledge and understanding about the necessary integration of HIV prevention, treatment and care of people living with HIV/AIDS, plus sexual and reproductive health and rights (SRHR).
The following chapters briefly explain the concepts of gender and sexuality as they are at the basis of our sexual and reproductive health and susceptibility to HIV/AIDS. Subsequently we will review the main international agreements made with respect to these subjects. We will also describe a rights-based context that we think needs to be upheld in order to ensure effective integration. We then discuss current threats and opportunities on integrating both fields. Finally, we end this document with recommendations on how to ensure effective integration of SRHR and HIV/AIDS.

'Only by addressing people's sexual and reproductive needs in a holistic manner can we work together to roll back the devastation caused by the HIV virus'.

Steven Sinding, Director General of IPPF

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
EU	European Union
FP	Family Planning
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
GIPA	Greater Involvement of People with HIV/AIDS
HAART	Highly Active Anti Retroviral Therapy
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
MTCT	Mother to Child Transmission
MTCT+	Mother to Child Transmission, including continuing treatment for the mother
NGOs	Non Governmental Organisations
OVC	Orphans and Vulnerable Children
PEP	Post-exposure Prophylactics
PEPFAR	President's Emergency Plan for AIDS Relief (President Initiative/Bush Grant)
PLWHA	People Living with HIV/Aids
PMTCT	Prevention of Mother to Child Transmission
PoA	Programme of Action (ICPD)
RTI	Respiratory Tract Infection
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Gender and sexuality

In a plenary speech at the AIDS Conference in Durban in 2000, Geeta Rao Gupta – president of the International Centre for Research on Women (ICRW) – spoke of the four Ps of sexuality:
(1) practices, (2) partners, (3) pleasures/ pressures/pain and (4) procreation. The first two, practices and partners, refer to how and with whom you have sex, while the others refer to underlying motivations or results. However, all of these are affected by inequity and deny women's sexual and reproductive wellbeing, mainly because of what Geeta Gupta referred to as the fifth P of sexuality – power. Power influences all sexual interactions, how the four dimensions of sexuality are expressed and experienced, and who determines the rules of the game. Understanding power relations and its social context is central to understanding sexual health.

It is well known that sexual and reproductive health need our full attention, particularly in the AIDS era. It is agreed that increased infection risks not only arise out of physical vulnerability, but also out of a social one. Power determines one's control over whether, when, where, with whom and how sex takes place. In most societies, men determine whether sex is safe or unsafe, forced or consensual, pleasurable or painful and offer the possibility of procreation (or not). A social change in sexuality is needed more than ever before, to prevent people from dying of poor sexual health and to prevent HIV infection from spreading.

Consequences

Gender is acknowledged as a key determinant influencing sexuality and sexual health. In practically all cultures women have a lower status than men, while men have a lead over power relations. Sociocultural norms that undervalue women also concurrently undervalue women's access to and control of productive resources such as education, income, land and credit. In view of this, gender inequity determines their access to information, commodities, services and options, which in turn determine their health, including their reproductive and sexual wellbeing.

As a result, choosing to have (or not have) sex or use condoms has social meanings, consequences and implications for one's public and private identity.[3] In many societies there is a culture of silence that surrounds sex, dictating that 'good' women are expected to be ignorant about sex and passive in sexual interactions. Married women must submit to any and every sexual request by their partner, while for unmarried girls traditional norms of virginity are often prevalent. In contrast, most societies expect men to find sex wherever and whenever they can. For men, in fact, cultural beliefs promote variety in sexual partners as being essential to men's nature as 'men', and that periodic sexual release is imperative for good health. Yet these stereotypical gender roles often reproduce and encourage discrimination and violence against women[4].

As a result there is an inherent contradiction in, for example, asking women to ensure the use of condoms or discouraging penetrative practices, let alone refuse sex, when their culturally legitimised role in most cultures is one of passivity. This highlights the relevance of engaging gender in formulating and providing sexual health education, as the latter often has little or no relationship to the real choices and pressures around sexual health. Merely concentrating on the biology of human reproduction does not take into account the context in which sexual behaviour takes place nor the personal and social consequences of such behaviour.

Managing the vulnerability of young women in sexual health and HIV education may also mean addressing young men and the notions of gender and sexual identity through which they understand their experiences. Everyone must understand the importance of responsibility, of protecting themselves and those they love. Women must be able to refuse sexual contact, even with their husbands if necessary. But men must also examine their behaviour and change it where necessary. Only then can social changes in sexuality be achieved, leading to a better sexual and reproductive health and reducing women's susceptibility to HIV.

'Gender' refers to how people are expected to think and act as women and men because of social constructions, in contrast to biological differences. People are born female or male, but learn to be girls and boys who grow into women and men. They are taught what for them are the appropriate behaviour and attitudes, roles and activities, and how they should relate to other people.

This learned behaviour is what makes up gender identity and determines gender roles. Gender roles vary widely within and between cultures, and are affected by the values of society made explicit through law, religious and cultural practices. In addition gender roles change over time and over an individual's life stages.

[3] Impact of HIV and sexual health education on the sexual behaviour of young people: a review update, WHO/GPA

[4] Norwegian Working Group on HIV/Aids and Gender, *HIV/Aids*, p. 1-20

International context

Governments have signed a range of international agreements committing them to respect, protect and fulfil the rights of women and girls. These obligations have been reinforced by commitments made by governments in a range of international and regional forums, including during the ICPD and UNGASS events on HIV/AIDS. More recently, European countries made further commitments regarding reproductive health care in relation to HIV/AIDS as part of the Dublin Declaration.

ICPD

In 1994, the International Conference on Population and Development (ICPD) in Cairo was widely recognised as a landmark in the history of the United Nations. Many years of experience by various organisations in this field cumulated in a specific plan to provide sufficient reproductive health care worldwide by the year 2015. The consensus brought together different angles and approaches, the right to family planning and women's rights, population policy and sustainable development. Its Programme of Action (PoA) placed reproductive health and rights at the heart of the development agenda in a human-rights-based, practical approach.

Beijing

In 1995, the Fourth World Conference on Women succeeded in bringing about a new international commitment to the goals of equality, development and peace for all women everywhere, and moved the global agenda for the advancement of women into the 21st century. The Beijing Declaration and the Platform for Action, adopted unanimously by representatives from 189 nations, constitute a powerful agenda for women's empowerment and gender equality. The commitments made reflected the understanding that women's equality to men must be a central component of any attempt to solve the world's social, economic and political problems.

UNGASS on HIV/AIDS

By June 2001, the United Nations General Assembly Special Session on HIV/AIDS declared HIV and AIDS to be a global emergency requiring immediate action. UNGASS also declared that 'women and girls are disproportionately affected by HIV/AIDS' and committed UN member states to a set of actions to reduce the impact on women and girls, and to promote and protect their human rights. The UNGASS Declaration makes clear that investment in sexual and reproductive health is a major foundation for both HIV/AIDS prevention and treatment.

Millennium Development Goals

In 2000, the UN countries agreed to another broad set of targets – the Millennium Development Goals – that set international development priorities for years to come. 'Halting and reversing the spread of HIV/AIDS' was explicitly mentioned as a goal in this declaration. While sexual and reproductive health was not specifically included as a goal itself, improvements in sexual and reproductive health will be vital for achieving all of the Millennium Development Goals. World poverty cannot be cut in half without guaranteeing reproductive health to the female half of the population.

Dublin Declaration

In February 2004 the EU issued a declaration indicating how Europe will fight HIV/AIDS. The language in the declaration is powerful, althouh the emphasis is mainly regional, focusing on Europe and Central Asia. The declaration acknowledges that respecting the right to reproductive and sexual heath, access to sexuality education, information and health services as well as openness about sexuality, are fundamental factors in the fight against the AIDS pandemic. The declaration also recognises that focusing on the role of men and boys is essential in combating HIV/AIDS and in promoting gender equality.

'Emphasizing that the overwhelming majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding; that both sexual and reproductive health initiatives and HIV/AIDS initiatives must be mutually reinforcing; that both HIV/AIDS and sexual and reproductive ill-health are driven by many common root causes, including gender inequality, poverty and social marginalization of the most vulnerable populations; and that stronger linkages between sexual and reproductive health and HIV/AIDS will result in more relevant and cost-effective programmes with greater impact';

The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health 2004

Rights-based approach

As we move towards integration and collaboration between sexual and reproductive health services and HIV/AIDS services we should seek to ensure that the rights-based, community-led approach that has characterised effective action on sexual and reproductive health and HIV/AIDS to date is upheld. A rights-based approach to sexual and reproductive health and HIV/AIDS insists on the protection, empowerment, and equality of all human beings in all aspects of their lives, including their sexuality. In other words, it provides the necessary elements to meet the sexual and reproductive health needs of a sexually active population.

The International Planned Parenthood Federation (IPPF), the world's largest NGO in the field of sexual and reproductive health and rights, has developed a charter based on 12 rights. This represents the application of internationally agreed human-rights language to sexual and reproductive health and rights issues, and demonstrates the legitimacy of sexual and reproductive rights as key human-rights issues. It has been designed as a tool to help policy-makers and NGOs to hold governments accountable for promises they have made to uphold human rights in general, and sexual and reproductive rights in particular. We have taken the liberty of including the examples that are relevant to HIV/AIDS.

THE RIGHT TO

Life – to protect all persons, particularly women, whose lives are endangered by pregnancy and/or HIV and AIDS.

Liberty and Security of the Person – to protect all persons, particularly women at risk from coercion, genital mutilation or subject to forced pregnancy, sterilisation or abortion.

Equality and to be Free from all Forms of Discrimination – to protect the rights of all people, regardless of race, colour, sex, sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status, to equal access to information, education and services related to development, and to sexual and reproductive health and treatment – free of stigma.

Privacy – to a degree of privacy, and to confidentially with regard to personal information given to service provides, for all clients of sexual and reproductive health-care information, education and services as well as all clients of testing and treatment services.

Freedom of Thought – to access education and information related to their sexual and reproductive health free from restrictions on the grounds of gender, sexual orientation, thought, conscience and religion.

Information and Education – to access full information on the benefits, risks and effectiveness of all methods of fertility regulation and STI/HIV/AIDS prevention, in order that any decisions they take on such matters are made with full, free and informed consent.

Choose Whether or Not to Marry and to Plan and Conceive a Family – to protect all persons against any marriage entered into without the full, free and informed consent of both partners.

Decide Whether or When to Have Children – to protect the rights of all persons to reproductive health-care services that offer the widest possible range of safe, effective and acceptable methods of fertility regulation, are accessible, affordable, acceptable and convenient to all users, irrespective of their HIV status.

Health Care and Health Protection – of all persons to the highest possible quality of health care, including emergency services related to sexual reproductive health, and the right to be free from traditional practices that are harmful to health.

Benefits of Scientific Progress – of all persons to access available reproductive health-care technology, including gender-specific prevention needs, which independent studies have shown to have an acceptable risk/benefit profile and where to withhold such technology would have harmful effects on health and wellbeing. For example, Mother-to-Child Transmission programmes, including treatment for the mothers (MTCT+).

Freedom of Assembly and Political Participation – to form an association that aims to promote sexual and reproductive health and rights and/or an association of people living with HIV/AIDS.

Freedom from Torture and ill Treatment – to protect children, women and men from all forms of sexual violence, exploitation and abuse.

Original source: IPPF Charter on Sexual and Reproductive Rights; International Planned Parenthood Federation, London, 1996 (reprinted 2003).

Current situation, threats and challenges

Although the control of HIV/AIDS was identified as a central component of the reproductive health agenda during the ICPD (1994), several factors caused these two fields to grow apart during the following decade. A strong resistance arose among SRH service providers to become involved in HIV/AIDS work, due to a strong HIV/AIDS stigma. On the other hand, HIV/AIDS activists were disinclined to work with family planners as, at that time, HIV/AIDS was still primarily associated with gay sex and injecting drugs. They often preferred to establish independent services to address HIV/AIDS care and prevention.

However, times have now changed. Nowadays the average life expectancy in some countries of Sub-Saharan Africa has fallen by 15 years as a result of AIDS. School systems are deteriorating as teachers fall ill. Social and economic activity is set back as young workers in their most productive years become sick and die, and the health sector is under enormous strain as hospitals are overwhelmed with AIDS patients and nurses, doctors and other health-care workers fall ill themselves.
The epidemic has already claimed the lives of over 20 million people, with 3 million deaths in 2003 alone. Nowadays more than 40 million people worldwide are living with HIV and AIDS. The AIDS epidemic is a compelling public health and development crisis. On top of all this: of all the human development indicators, those for reproductive health reveal the largest gaps between low income and developed countries and the starkest inequities between rich and poor people within countries. Sexual and reproductive ill health accounts for 20% of the global burden of disease and 32% of the burden among women of reproductive age (15-44) worldwide. Of that figure HIV/AIDS accounts for 6% (out of the 20) and 14% among women aged 15-44. Again it is felt that these indicators demand for a much more integrated approach and upscaling of efforts. The WHO and UNFPA were consulted on the linkages between sexual health and aids programmes in May 2004. The Dutch Minister for Development Cooperation decided to put both subjects into a combined agenda during the EU presidency in the second half of 2004.

Existing health programmes in countries where HIV is raging are under more stress than ever before. Due to the urgency of the epidemic, and the public pressure to do a better job to fight HIV/AIDS and make treatment available on a larger scale, larger HIV/AIDS-specific programmes have finally started. However, if the total picture of health care at large, and sexual and reproductive programmes in particular, is not considered carefully, this could lead to pulling away (human) resources from the primary health-care structure, and will eventually lead to erosion of the overall health-care structure. The other way around, human resources are already decreasing on a larger scale due to losses from AIDS itself, and if immediate action to fight HIV and AIDS is not taken, this will also lead to a further erosion of overall health care.
A growing shortfall in the availability of the supplies needed for HIV/AIDS prevention, contraception and other vital sexual and reproductive health-care services is threatening the wellbeing of men and women in the developing world. For contraceptives alone, UNFPA estimates that costs increased from US$ 222 million in 1992 to US$ 572 million in 2000, and will rise to US$ 1.25 billion in 2015. Yet the percentage of these costs borne by donors has declined from 37% in 1992 to just 27% in 2000. Similarly, UNFPA estimates that between 2000 and 2015 the costs of condoms needed for the prevention of STIs, including HIV/AIDS, will rise from US$ 239 million to US$ 557 million. In 2000, donors provided barely 12% of the condoms needed in developing countries and Eastern Europe to have a significant impact on the spread of HIV/AIDS. Several donors have shown their concern and a willingness to help when called upon, such as the governments of the UK and the Netherlands. But too many others are constrained by politics or a lack of awareness of the seriousness of the crisis. However, the supply issue is not just a donor problem. Many recipient countries need to change their policies, practices and systems and improve their logistics capacity[5].

Looking at the shifts in population and health spending with a particular focus on reproductive health and HIV/AIDS, it is significant that actual funding for reproductive health has declined considerably. On the contrary, between 1994-2001 funding for HIV/AIDS services increased by 300%.

In Sub-Saharan Africa:
- 58% of people living with HIV/AIDS are women; 67% between the ages of 15-24
- Young women between 15-24 years are 2.5 times more likely to be HIV infected than men

Worldwide:
- Pregnancy-related problems are the main cause of death for 15-19 year-old girls
- More than 5 million girls aged 15-19 seek abortions each year

While public funds from both national and international sources, including those for sexual and reproductive health services, are under stress, the urgency and public pressure to respond to the AIDS pandemic has led to the creation of new funds such as the *Global Fund to Fight AIDS, Tuberculosis and Malaria* (GFATM), *MAP* by the World Bank, *the Bush Grant*, *the Clinton Foundation*, and campaigns such as the '*3 by 5 Initiative*', led by WHO. Despite explicit agreements that the budget, for example of the Global Fund, should be additional to existing health-care donations, not all donor countries act accordingly.
There should never be a situation where there is less availability of condoms or other contraceptives due to more availability of treatment.
Successful integration can be achieved through genuine institutional collaboration by actors at both the HIV/AIDS and SRHR level. In other words, SRH services should be linked more specifically into the guidelines of new HIV/AIDS initiatives and vice versa. This will also result in cost sharing, capitalising on existing infrastructures and (human) resources and reaching wider audiences while becoming responsive both to clients' needs and to public health. ◄

[5] *Fact Report, number 2 in a series; Supply Initiative*

Policy and services

As previously mentioned, an integrated approach is needed in order to successfully fight sexual and reproductive ill health and the AIDS epidemic. This means: taking care of and treating the sick and suffering, preventing new infections and sexual health problems, finding ways to optimise enjoying sexuality without problems and eradicating AIDS in the future. HIV is primarily spread through sexual transmission and should therefore be part of a comprehensive SRH response. However, when seen in the context of the long history of family planning and population programmes, the question of how to integrate HIV/AIDS prevention, care and treatment services with sexual and reproductive health policies, programmes and practices is relatively new. Considering the urgency of the AIDS epidemic, it is a question that also needs to be addressed immediately.

Integration has to take place at various levels, with actors needing to work together in policy and programme development, and service provision. Integration and collaboration should be realised in a rights-based, community-led manner. These integrated services also need to be accessible, available and affordable. There is one more reason to integrate HIV/AIDS into existing services: its potential to mitigate the stigma related to HIV/AIDS. Primary health-care facilities as well as SRH facilities can offer greater privacy and confidentiality and less stigma than dedicated HIV/AIDS facilities. Integrating HIV/AIDS and SRH programmes and services where possible will ultimately result in more efficient and effective responses to sexual and reproductive ill health, including HIV/AIDS.

To prevent new infections, sexual health education has to make young people aware of the pressure of gender roles, their socialisation, their rights in self-determination and support them in taking a stand for themselves. Sexual health education also offers the unique possibility to boys and girls, men and women, of integrating the prevention of HIV/AIDS and reproductive health in such a way that 'safe sex' not only means 'safe' because it prevents diseases but also because it prevents unwanted pregnancy. Safe sex also stands for consensual sex, sex free of coercion, which will prevent STIs (incl. HIV) and unintended pregnancy, as well as the trauma of being forced into sex. Besides sexual health education, high-quality sexual and reproductive health services should be accessible for all, including unmarried young men and women, should be user- and youth-friendly, involve men and be supportive to people with a different sexual orientation such as gay men and lesbian women.

Better-integrated renewed and vigorous efforts are needed to promote and accelerate education and prevention interventions on sexual and reproductive health and HIV/AIDS. Successful programmes should be gender-specific, emphasise mutual responsibility and provide prevention methods.

Where medicines are available, voluntary counselling and testing (VCT) is conditional in the fight against HIV/AIDS. If tested positive people need counselling in how to live with HIV/AIDS and all related conditions, be they social, sexual or health-related, and eventually prepared for treatment. If tested negative, people need counselling on how to remain that way. Partners should be tested as well, without intruding on their privacy. If VCT is part of an HIV/AIDS structure, it should include counselling on SRH issues and behaviour change.

VCT programmes need to be scaled up and integrated along with reproductive health services. For example, the one-year incident pregnancy rate among HIV-positive women participating in a voluntary and counselling programme was 22% before family planning was offered, and plummeted to 9% after these services were introduced. By preventing unplanned pregnancies, family planning services can sharply increase the number of HIV infections averted in infants[6]

Treatment programmes are only appropriate if they include counselling with regard to safe sex, sexuality, relationships and family planning. Care for the sick and dying plays a major role in the fight against HIV/AIDS. However, caring for the caretakers should also be a part of all programmes.

A preventive vaccine is needed to eradicate the disease altogether. This will take time, but the experience gained with other diseases clearly shows the need. It means a strong demand for research, which is also needed for developing new prevention methods that can at least be controlled by both partners. Women have very little say in the use of male condoms, which have to be used on men. In the case of the female condom, women primarily control its use. The development of microbicides (a range of compounds – gels, creams or rings – that will substantially reduce transmission of STD including HIV when applied in the vagina) could, for the first time, offer women a prevention method over which they have personal and direct control. Another benefit of microbicides is that many women wish to be able to conceive and bear children, and about half of the microbicides currently under research would allow conception. It is anticipated that a microbicide could be available within 10 years, should sufficient funding allow.

A potential complete sexual and reproductive health package including HIV/AIDS should entail:

- All education efforts and services should be working towards reducing stigma and discrimination related to HIV status, sexual orientation and gender.
- Prevention of unwanted pregnancies, STIs/RTIs and HIV.
- Behaviour change through information, education and communication and counselling.
- Antenatal care, skilled attendance at delivery and postnatal care including prevention of MTCT.
- Safe abortion services, management of abortion complications and provision of post-abortion care, including for HIV-positive women.
- Adolescent sexual and reproductive health services, without parental consent.
- VCT including counselling on sexuality issues
- Condom promotion and distribution as well as female-controlled prevention options.
- Diagnosis and treatment of STIs and HIV, including treatment with anti-retrovirals.
- Prevention and appropriate treatment of sub-fertility and infertility.
- Care and support of infected and affected people, including providing them with sufficient knowledge to prevent infection.
- Prevention and management of sexual violence and harmful practices involving men and the community
- Participation by target groups in programme design and implementation, including greater involvement by PLWHA.
- Provide knowledge and support for breastfeeding.

[6] *A. Guttmacher: whatever happened to Family Planning*

Recommendations

To ensure the integration of SRH and HIV/AIDS services, governments should reinforce:

The relevant international agreement, particularly the ICPD Programme of Action and their 'plus 5 reviews', Beijing Platform of Action, Millennium Development Goals, UNGASS Declaration on HIV/AIDS and Dublin Declaration on Partnerships to fight HIV/AIDS in Europe and Central Asia

in order to:

- **Assure sufficient quality of sexual and reproductive health services, the prevention of HIV, and the care and treatment of people living with HIV/AIDS – at the levels of services, policies and national action plans – and an effective integration of both.**
- **Ensure an efficient and effective international response to fight HIV/AIDS and sexual and reproductive ill health, and accordingly mitigate its impacts on society (e.g. household, national and international level); plus strengthening existing health systems.**
- **Develop a strong collective voice and commitment in the international policy and political community, in order to counteract the negative effects of the current US position.**

To be more specific:

1. Within the framework of development cooperation, donors and government programmes should be forced to enact and implement appropriate programmes and policies that protect the rights of women and young girls.

2. Information and education on sexuality, reproduction and HIV/AIDS should be gender-specific and explicitly accessible for women, boys and girls – as well as for key populations in a marginalised position such as sex workers and street children – in need of information.

3. In order to avoid further development based on two separate structures, connecting HIV/AIDS prevention and sexual and reproductive health should be conditional on receiving new funding. In so far as separate programmes are carried out, integrating either HIV/AIDS or SRH into the existing programme should be a reason to receive additional funding.

4. Where possible, *existing* sexual and/or reproductive health counselling facilities should incorporate voluntary counselling and testing. *New* counselling and testing facilities should be integrated within comprehensive health services that promote confidentiality and mitigation of stigma.

5. Existing sexual and reproductive information and counselling need to be scaled up and new developments on HIV/AIDS trials and treatment need to be included.

6. Reproductive health-care services for women living with HIV/AIDS and their babies should be governed solely by each woman's fully informed and unpressured choice.

7. Comprehensive sexual and reproductive health services should be made compatible to the needs of both sexes and should be readily available to both sexes, of all ages, both married and unmarried and without parental consent. Accordingly, specific measures should be taken to make VCT confidentially available for one's partner.

8. Access to AIDS treatment should be equal for both women and men.

9. Commodities such as male and female condoms and safe maternity kits should be made generally available as soon as possible, including over-the-counter availability for both sexes.

10. Donor countries should make bold and long-term research investments into female-controlled prevention methods such as microbicides, and in preparing for its use in resource-poor settings.

Illustrating the subject; five examples

The following five cases illustrate practices of integrated HIV/Aids and Sexual and Reproductive Health programmes.

Integrating HIV prevention into sexual health curricula for young people

In 2002, based on behaviour change and adolescent development theories, WPF (World Population Foundation) developed an outline for comprehensive sexual health curricula, which integrates a rights-based approach. This outline proposes a logical sequence of sexual health issues to be composed in an educational programme and formulates objectives for each issue at various levels (knowledge, attitudes, social norms and skills). The outline is meant to provide a basis for developing a cultural, country and target group specific curriculum, which prevents sexual health problems and promotes self-reliance of young people.

The outline guides adolescents in forming a realistic self image, building self esteem, accepting changes in puberty and coping with gender roles, as well as becoming more independent and autonomous, building relationships and deciding on (and negotiating) sexuality in sexually active relationships by proposing alternative options for safe and consensual sexual behaviour, including abstinence from sexual intercourse.

The next step in this outline concerns the support of adolescents in preventing both unintended pregnancy and STIs, including HIV. The final step is to guide adolescents in coping and finding support in the event of sexual health problems and to anticipate, avoid and cope with sexual harassment and abuse.
The systemic integration of objectives on sexual and reproductive rights throughout the entire outline is meant to empower adolescents in goal-setting, decision-making, communication, negotiation and using health services and products appropriately.

WPF uses this outline to offer young people the tools for learning to make their own informed decisions to enjoy sexuality whenever they are ready to do so, and to prevent sexual health problems by promoting safe sexual behaviour, i.e. safe in preventing unintended pregnancy, safe in preventing STIs (including HIV) and safe because it is consensual and free from coercion and abuse.

Up to now the outline has been used in the Vietnamese curriculum for re-education schools, the CD-ROMs on sexual and reproductive health and rights for Uganda and South African secondary schools and for the theory-based and evidence-based development of curricula in Tanzania and in the South African provinces of Limpopo and Western Cape.

Including HIV Counselling and Testing in Sexual and Reproductive Health Programmes

Addressing a critical need in responding to HIV/AIDS, the International Planned Parenthood Federation (IPPF) and the United Nations Population Fund (UNFPA), have published new guidelines for programme planners, managers and service providers on integrating HIV voluntary counselling and testing (VCT) services into reproductive health settings.

VCT provides an effective means of preventing HIV transmission and an important entry point for treatment of HIV-related illnesses, prevention of mother-to-child transmission, tuberculosis control, and psychosocial and legal support. Yet, all too often, VCT has been introduced in isolation from services that meet people's overall sexual and reproductive health needs.

Results from pilot projects in two distinct regions – at two sites in Côte d'Ivoire and two in India – indicate that integrating VCT into sexual and reproductive health services has exponential benefits: it reduces stigma associated with HIV/AIDS, strengthens awareness of healthy sexual behaviour, and increases access to and utilisation of services. Using existing resources and infrastructure also results in considerable cost savings.

The new guidelines reflect the experiences gained from these sites, as well as those from sites in Kenya, Rwanda and Ethiopia. These were developed in collaboration with a broad range of partners, and draw on international literature of best practices.

The guidelines provide practical information to both public and non-governmental providers on integrating VCT for HIV/AIDS within sexual and reproductive health services, using a stepwise approach that shows how to effectively plan, implement, monitor and evaluate an integrated service.

Linking HIV prevention and reproductive health provides an opportunity to reach the millions, especially women, who are vulnerable to infection. In addition, stigma and discrimination that act as barriers to VCT and effective prevention should be overcome.

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Sexual reproductive health and HIV/AIDS integrated programme for youth

Following the ICPD, the Government of Mozambique started several initiatives to address the needs of youth, including an integrated plan of action to support the development of adolescents and youth. An outcome of this plan was the launch of a multi-sectoral adolescent sexual and reproductive health (ASRH) project called 'Geração Biz'.

Geração Biz believes that ASRH issues should involve the entire community. The mobilisation of all sectors is thus necessary to truly impact change. Young people are not just seen as the beneficiaries of ASRH projects and programmes; they are also equally involved as partners in the design and implementation of activities.

Many young talented people are involved as peer educators passing on their knowledge, commitment and enthusiasm, strongly believing in their own control over the future, aware of their sexual and reproductive rights, HIV infection risks, and their needs if they are HIV positive. HIV/AIDS issues cannot be isolated from the broader spectrum of sexual and reproductive health matters, and therefore they are fully integrated into Geração Biz.

KENWA (Kenya Network of Women with AIDS)

KENWA (Kenya Network of Women with AIDS), one of the counterparts of STOP AIDS NOW! partner Hivos, is a grassroots community-based organisation created and run by women living with HIV/AIDS in Kenya. KENWA started in 1993 as a meeting group of five HIV-infected women who had been rejected by their families due to their HIV status.
Because of the sexual connotation of HIV/AIDS and the fatal character of the disease, many myths and half-truths are circulating and are thus contributing to the misconception of HIV/AIDS. Women in particular lack adequate knowledge and negotiation skills to prevent HIV/AIDS infection.
KENWA regards HIV/AIDS as an issue that exceeds the scope of health care. The organisation defends human rights and the practical and strategic interests of women living with AIDS. Its various drop-in centres therefore offer training on decision-making and negotiation skills regarding sexuality and reproductive health, as well as training on social skills for disclosing HIV status.

Quality of Sexual Reproductive Health and HIV/AIDS Programmes under pressure in Namibia - a voice from the field

Ombetja Yehinga Organisation, a Namibian NGO aimes to create awareness of HIV/AIDS among young people. The organisation specialises in the use of the arts to create awareness of HIV/AIDS and other related social issues such as gender, sexuality, and children's rights.

Until recently, Ombetja Yehinga was receiving financial support through various channels, including USAID/Family Health International. The EU support to Namibian NGOs has stopped the argument that the income per capita in Namibia is too high, yet does not take into account the fact that 10% of the population own the vast majority while 90% live in poverty. Ombetja Yehinga and other NGOs are therefore becoming predominantly dependent on financial aid from the United States. Presently they see themselves confronted with further changes in the political climate as US donor funding is channelled through PEPFAR (the President's Emergency Plan for AIDS Relief). This has severe consequences for NGOs in the field of sexual and reproductive health and HIV/AIDS as it means they must compromise on the content of their programming in order to obtain funding, while at the same time reality urges prompt action based on real-life facts.

Going carefully through PEPFAR guidelines and listening to comments, several issues of concern arise:
Prevention of HIV infection should focus on condom distribution to high-risk populations. 'High-risk groups' are prostitutes, sexually active discordant couples, substance abusers and others. These 'others' are not defined but, during meetings with USAID, it was clearly stated that young people are not considered a high-risk population, which is dubious in a country with a zero-prevalence of 22%.
Sex education at school should focus on abstinence and behaviour change for the youth, delaying first sexual intercourse and secondary virginity (having been sexually active and then abstaining again). A USAID representative stated that: 'schools and condoms cannot be associated in one sentence'.
Even though it is not in the guidelines, recipients of the funds were informed that all publications/IEC material by NGO's receiving money from PEPFAR would have to be reviewed by Johns Hopkins University before release. This is a very unhealthy situation, as informative material should be reviewed by the relevant national institutions. Organisations are not allowed to even talk about abortion, let alone lobby for it. ◄

STOP AIDS NOW! is a partnership between Aids Fonds, Hivos, ICCO, Memisa (Cordaid) and Novib. They joined forces to increase and improve the Dutch contribution to the worldwide response against the devastating impact of HIV/AIDS, from awareness and combating stigma to access to affordable treatment. We need to do more, do it better and faster! STOP AIDS NOW! therefore raises funds, involves the Dutch public and advocates both in the Netherlands and in Europe.

WPF (World Population Foundation) is a Dutch non-profit organisation aiming at the improvement of sexual and reproductive health and rights in developing countries. WPF supports local organisations to enable men, women and young people to decide freely and responsibly on their sexual lives and the number and spacing of their children by giving them the information and means to do so. WPF advocates in the Netherlands, Europe and around the world for supportive policies and resources. Every human being has the right to a safe and voluntary sex life.

Share-Net is a network of 30 Netherlands based organisations and experts working in the field of Sexual and Reproductive Health and AIDS. Share-Net seeks to contribute to improve the international sexual and reproductive health and rights situations as well as the HIV/AIDS condition, guided by principles of human rights, equity, equality and empowerment. Share-Net is involved in capacity building, knowledge-exchange and advocacy activities.

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