

**All-Party Parliamentary Group on
POPULATION, DEVELOPMENT AND REPRODUCTIVE HEALTH**

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The Missing Link!

Parliamentary Hearings Linking Sexual & Reproductive Health and HIV/AIDS

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Introduction

At the International Conference on Population and Development (ICPD) in Cairo in 1994, 179 countries reached a consensus on what the aims of international policy on Sexual and Reproductive Health should be:

'In the light of the urgent need to prevent unwanted pregnancies, the rapid spread of AIDS and other sexually-transmitted diseases, and the prevalence of sexual abuse and violence, Governments should base national policies on a better understanding of the need for responsible human sexuality and the realities of current sexual behaviour.'

[Programme of Action paragraph 7.38]

Sexual and Reproductive ill health accounts for one-third, of the global burden of disease, amongst women of reproductive age, and one-fifth of the burden of disease among the population overall.

HIV/AIDS indirectly accounts for many maternal deaths and is the direct cause of death of many individuals and their family members.

HIV/AIDS is overwhelmingly transmitted by unprotected sex – particularly in the poorest countries.

Regrettably, Sexual and Reproductive Health specialists have not taken a leading role in the fight against HIV/AIDS and many donor countries have prioritised HIV/AIDS at the expense of Sexual and Reproductive Health.

The failure of both the Sexual and Reproductive Health and donor communities to work together, in the struggle to overcome HIV/AIDS, is the reason for this report. Why did this happen? What can Sexual and Reproductive Health bring to the fight against HIV/AIDS given that current international and national efforts have failed to prevent the epidemic?

In the UK Parliament, the All-Party Parliamentary Group on Population, Development and Reproductive Health (APPG on PD&RH) is open to Parliamentarians from both Houses. It has been in existence for over twenty years and has played a prominent part in the establishment of similar groups in Europe, Asia and Americas.

The Group has always believed that part of its role is to influence policy, a recent example of which was a report on Female Genital Mutilation, which had a considerable impact, including new legislation in the U.K.

Our activities have also raised the profile of Reproductive Health in the Department for International Development (DfID). As a result there has been an important enhancement of the partnership between the HIV/AIDS and the Reproductive Health teams within DfID, as demonstrated in the recent DfID policy papers.

The APPG on PD&RH decided to investigate what happened to the link between Sexual and Reproductive Health and HIV/AIDS and what has been missed as a result?

On the tenth anniversary of Cairo, the International Conference on Population and Development in 1994, the group conducted research, held Parliamentary Hearings and heard evidence from experts from both specialties.

There are many reasons why the separation occurred:

- HIV/AIDS first achieved prominence when intravenous drug users and men having sex with men were the main high-risk groups;
- The focus of the developed world was on the search for drugs to keep HIV positive people alive;
- Many in the Sexual and Reproductive Health world were slow or unwilling to embrace the complicated problem of HIV/AIDS;
- The development of separate donor funding streams for HIV/AIDS and Sexual and Reproductive Health; and
- The antipathy of the Bush Administration in the United States toward Sexual and Reproductive Health choices.

The fight against HIV/AIDS continues in the developing world, and there is an imminent danger to the people of China, the Indian sub-continent and Eastern Europe.

A major audience for our report are fellow parliamentarians in other countries. It is crucial that parliaments, as the focal point of civil society, are active in debate and policy making in these areas.

If sustainable development is to mean anything, people must be healthy enough, to benefit from it and not have their lives cut off, prematurely, through a lack of choice and services.

We must strengthen the links between Sexual and Reproductive Health and HIV/AIDS funding, policies and services.

This report represents the results of our investigation.



Christine McCafferty MP
Chair All Party Parliamentary Group on
Population, Development and Reproductive Health

Acknowledgement

The UK All Party Parliamentary Group on Population, Development and Reproductive Health warmly thanks hearing committee members, the Chair Tony Worthington MP treasurer of the UK All Party Parliamentary Group on Population, Development and Reproductive Health (APPG on PD&RH), Neil Gerrard MP and Chair of the UK All Party Parliamentary Group on AIDS (APPG on AIDS), Nigel Tarling (International Family Health), Ros Davies (Interact World-wide), Dr Alice Welbourn (International Community of Women Living with HIV/AIDS), Simon Wright (ActionAid), Ann Mette Kjaerby (Parliamentary and Policy Advisor to APPG on PD&RH) and Edwige Fortier (Policy Advisor to APPG on AIDS) for their support, commitment and work on the UK Parliamentary Hearings and Reports.

Special thanks goes to the experts from Non Governmental Organisations (NGOs), academic institutions, health clinics and hospitals, United Nations Organisations (UN Organisations), the Department for International Development (DfID), Ministries of Health (MoH), the World Bank, the Global Fund to fight HIV/AIDS, TB, and Malaria (Global Fund), and the European Commission (EC) who all provided written and oral evidence at the Hearings.

Expert witnesses included Dr Steven Sinding and Kevin Osborne from the International Planned Parenthood Federation (IPPF), Dr Susannah Mayhew from the London School of Hygiene and Tropical Medicine (LSHTM), Sandra Kabir from the International Council of Management of Population Programmes (ICOMP), Ms P. Kousalya, Dr Alice Welbourn and Gcebile Ndlovu from the International Community of Women Living with HIV/AIDS (ICW), Sujit Ghosh from the HIV/AIDS Alliance, Dr Sunil Sawant from CSM Hospital Kalwa, India, Dr Bernadette Ssebadekka from the Family Planning Association of Uganda, Ms Usasinee Rewthong from the NGO Coalition on AIDS, Thailand, Steve Kraus from the United Nations Population Fund (UNFPA), Gillian Holmes from the Joint United Nations Programme on HIV/AIDS (UNAIDS), T. Farley and Dr Francis Ndowa from the World Health Organization (WHO), John Worley and Robin Gorna from DfID, Dr Baige Zhao from MoH, China, Yogan Pillay from DoH, South Africa, Dr Siripon Kanshana from Ministry of Public Health (MoPH), Thailand, Elizabeth Lule from the World Bank, Dr Richard Feachem from the Global Fund and Angeline Eichhorst from the EC.

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We particularly want to express our appreciation to Tony Worthington MP for his inspiration behind the Hearings and to Ann Mette Kjaerby for her professional knowledge and organisational skills.

A. Relationship between Sexual and Reproductive Health and HIV/AIDS: Current situation

1. Our working theory that the fight against HIV/AIDS has been damaged by the failure to link Sexual and Reproductive Health services with HIV/AIDS services was confirmed by the written and oral evidence

HIV/AIDS is most often transmitted through unprotected heterosexual sex and the majority of people infected are women who are often unable to protect themselves. We believe that many hundreds of thousands of people, particularly women, have become HIV positive and died from pregnancy related complications because of the failure of the developed world¹ to recognise the link between Sexual and Reproductive Health (SRH) and HIV/AIDS. If we approach the HIV threat confronting China, the Indian sub-continent, and Eastern Europe on the same basis, the epidemic could take the same disastrous direction as Africa. With just one percent of its population infected, India has 5.1 million HIV positive--only South Africa has higher total numbers of HIV positive people. Russia faces one of the world's fastest growing rates of infection as the World Bank projects that, by 2020, the number of HIV positive people in Russia could range between 5.4 million and 14.5 million.

Reproductive Health needs of people and of countries are constantly changing and after two decades of implementing HIV/AIDS programmes, it is clear that business as usual will not curb the spread of HIV/AIDS. Both Reproductive Health and HIV/AIDS need multi-sectoral approaches. Countries can no longer afford to pass up missed opportunities to address the range of unmet Reproductive Health including HIV/AIDS needs of clients. Linking Reproductive Health and HIV services can be an efficient way to promote wanted, healthy pregnancies, improve child health and prevent diseases including HIV/AIDS.

Written evidence to UK APPG on PD&RH Hearings April 2004 by World Health Organization (WHO)

2. Why is there a 'missing link' between Reproductive Health and HIV/AIDS?

The approach to HIV/AIDS adopted by the donor world for the developing world was heavily influenced by the initial pattern of HIV/AIDS in the developed world. The principal casualties of the epidemic were seen as men having sex with men, sex workers and intravenous drug users.

The response of the developed world through the pharmaceutical industry was to find drugs that would help keep people infected with HIV alive for longer. Another reason why the links between SRH and HIV/AIDS failed to develop was that many people and organisations in Reproductive Health were slow or unwilling to recognise that HIV/AIDS was an area in which they should be working. It is a long step from the traditional family planning setup to realise that men or intravenous drug users have Reproductive Health issues too. But HIV/AIDS is overwhelmingly a sexually transmitted infection and there are many areas where reproductive health workers must be involved.

Sexual health services were not really a concern of donors or governments until the HIV/AIDS epidemic emerged in the mid 1980s. The separation from 'reproductive

health' was largely a function of the epidemiology in western nations where HIV was prevalent among the homosexual and drug-using communities and was therefore never regarded as a 'reproductive health' issue. In developing countries, particularly in Africa, the HIV epidemic has always been a heterosexual epidemic that is intimately linked to Sexual and Reproductive behaviours. The result has been separate national bodies dealing with HIV (and sometimes Sexually Transmitted Infections (STIs)) and with Family Planning (FP)/Maternal and Child Health (MCH), separate donor programmes and funding streams and separate policies and technical, clinical protocols. International donors have still not woken up to the inappropriateness of this separation in developing countries. The separation is widening and today the immense surge of interest in HIV/AIDS and establishment of the Global Fund, threatens to re-stigmatise condoms through their promotion for illicit sex (i.e. where abstinence and being-faithful are 'not possible'). This will exacerbate the isolation of HIV/AIDS programmes and services from the reproductive needs of sexually active adults and the sexual health needs of fertile men and women, which may ultimately work against preventive efforts for HIV/AIDS. This in turn mitigates against international goals of poverty reduction.

Written evidence to UK APPG on PD&RH Hearings April 2004 by Dr Susannah Mayhew, London School of Hygiene and Tropical Medicine (LSHTM)

3. HIV/AIDS prevention still paramount

The discovery of anti-retroviral therapy (ART) has been wonderful news in both the developed and developing world. Their availability at a more reasonable cost now provides hope where once there was none. The provision of anti-retroviral drugs has also ensured better knowledge of HIV/AIDS prevalence and has made it easier to plan public policy in health and beyond. We also recognise that there is much more to learn about ART and its importance in prevention.

It is important that the discovery of ART does not distort our response to HIV/AIDS as anti-retroviral drugs do not cure. Prevention of HIV is paramount. If HIV/AIDS is to be brought under control, then we must concentrate on the search for methods of prevention, which have been neglected by the donors in their search for effective treatment. Whilst the fall in price of ART will keep many in the developing world alive, the sustainability of such provision is highly doubtful if, by our policies, we continue to fail to prevent many more millions of people becoming HIV positive.

Condom distribution is astonishingly cost-effective, costing just \$3.50 per year of life saved. In contrast, antiretroviral therapy cost almost \$1,050.

PLANetWIRE Clips [PLANetWIREClips@ccmc.org]

4. Post-Cairo letdown

The year 1994 was a high point when, at the International Conference on Population and Development (ICPD) in Cairo, delegates from 179 states achieved consensus on sensitive SRH issues, defining a Programme of Action on Population and Development for the next 20 years. But, since 1994, concern about HIV/AIDS has been steadily mounting and those who have been active in the Sexual and Reproductive Health and Rights (SRHR) field have been disturbed by a

sense of apathy, particularly by the donors. It was as though the consensus achieved at Cairo was the achievement and that SRH problems were no longer so worrying. Continued fertility decline in the developing world also led to a false sense of security. Yet, never has there been a greater need for strong SRH services as the largest cohort in history reaches reproductive age.

'Injecting drug users also have Reproductive Health issues; they are both fathers and mothers. Often when intravenous drug users become pregnant they feel that this is the time now to sort themselves out.'

Robin Gorna and John Worley, Department for International Development (DfID)

5. Funding Failure

Funding targets set in 1994 for Sexual and Reproductive Health and Rights have not been met. The United Nations General Assembly Special Session (UNGASS on ICPD+5) stated that by 2010 at least 95% of young men and women should have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Such targets now seem fanciful because of funding shortfalls. In fact, the problem is far worse as SRH and HIV/AIDS services are in competition because of the way that health services and development funding are organised. The Group received evidence from Dr Ssebdukka of Uganda who was asked why Reproductive Health indicators remained obstinately unsatisfactory in Uganda, although the country is seen as a success story in HIV reduction.

'I think reproductive health was not given the attention it deserved right from the beginning... a number of things go on under HIV and hardly anything under Reproductive Health and this is clearly reflected in our statistics.'

A further bitter blow was the Millennium Development Goals (MDGs) which failed to mention Sexual and Reproductive Health and Rights, although it is impossible to achieve most of the MDGs without comprehensive Sexual and Reproductive Health services.

Reductions in maternal and infant mortality, equality in education, gender empowerment and indeed, combating HIV/AIDS, are unattainable without adequate SRH services.

6. The neglect of Vaccines and Microbicides

Economic incentives drove the pharmaceutical companies to invest their research resources where returns were likely to be highest – the long-term treatment of people living with HIV/AIDS in the developed world who could afford to pay. Less money was allocated to the search for a vaccine whose ultimate success would eliminate the need for drugs. Almost no money has been invested in microbicides research, a technology giving women a protective method that is more under their control.

The Group commends DfID for allocating public money into research on both vaccines and microbicides.

7. Donors guilty of separating Reproductive Health and HIV/AIDS

SRH and HIV/AIDS tend to be put in separate departments in both the structure of government health departments and in the structure of donor agencies. HIV/AIDS and Reproductive Health staff find it difficult to talk to each other let alone plan, implement, monitor and evaluate programme work together. Donors fund HIV/AIDS projects OR Reproductive Health projects, often actually putting these complimentary fields in competition.

The consequence of the division between SRHR and HIV/AIDS can be damaging. The presence of donor money for HIV/AIDS will utilise the tiny supply of medical personnel and pull from other parts of the health system such as Reproductive Health. An African country may spend as little as \$2 – \$10 per capita on health per year and have an acute shortage of trained doctors and nurses – themselves depleted in numbers by AIDS. Even if the cost of anti-retroviral drugs came down to one dollar per person per day, how can that country afford those drugs? It is vital that donors work cooperatively making the links between Reproductive Health and HIV/AIDS to ensure the development of a sustainable health system.

'Although Reproductive Health services are critical to prevention of HIV/AIDS, the existing infrastructure, logistics and information systems and skills in Reproductive Health programmes to address this have not been adequately exploited. This was a missed opportunity and a costly mistake in the early 1990s.'

Elizabeth Lule, the World Bank (WB)

8. The Global Fund to fight AIDS, Tuberculosis and Malaria

The historical separation of STI/HIV and MCH/FP services divorces service provision from the reality of people's reproductive lives. This separation has become further polarised with the establishment of the Global Fund despite clear political and financial commitment given at the Cairo Conference for the expansion and integration of Sexual and Reproductive Health services, and widely accepted inappropriateness of separate services to deal with Sexual and Reproductive behaviours that are profoundly linked.

There are strong epidemiological, cost-benefit and rights-based rationales for providing holistic Sexual and Reproductive Health services and integrating a variety of components to reach different target populations.

Written evidence to UK APPG on PD&RH Hearings April 2004 by Dr Susannah Mayhew, LSHTM

In 2002, with the support of the G8 and the United Nations, the Global Fund was established to tackle the scourges of HIV/AIDS, Tuberculosis (TB) and Malaria. There have been concerns from SRH Non Government Organisations (NGOs) that it has not been possible for them to obtain funding from the Global Fund (through the Country Coordinating Mechanisms), although their programmes include strong HIV/AIDS components. This issue was raised with

Dr Feachem, Executive Director of the Global Fund at the Parliamentary Hearings. Dr Feachem said that, *'Proposals or projects have to very much centre on the battle against HIV/AIDS and it is essential that any proposal for funding come from the national plan of the country involved.'* It is therefore crucial for countries to convincingly link Reproductive Health and HIV/AIDS and the Global Fund will look sympathetically at such a project or proposal. We welcome this clarification by the Executive Director of the Global Fund and would urge him to make clear that the Global Fund shares the growing global consensus, that it is important to exploit the beneficial links between HIV/AIDS and SRH.

'Treatment is a very clear cut case, there is nothing at the treatment end that is controversial, but once you go to prevention, sexual behaviour, and rights in that area, and provision of condoms, it becomes so politically sensitive and emotionally sensitive. It is a difficult vehicle to ride.'

Angeline Eichhorst, European Commission (EC)

9. The divisive impact of U. S. policy

The most powerful example of the donors' failure to recognise the linkage between SRHR and HIV/AIDS is the United States "President's Emergency Plan for AIDS Relief" (PEPFAR). Whilst we applaud the \$15 billion that has been pledged for work in HIV/AIDS, we are critical of how this programme has been formulated and is being applied:

- The United States unilaterally decided which countries were to benefit without consultation with those countries. The Zambian Health Minister said that his government did not have a formal meeting with the American Ambassador until 15 months after Zambia's role had been announced.
- The American programme emphasises abstinence and puts the lowest priority on condom use, the only known safeguard for the sexually active.
- The programme takes insufficient regard for the lack of power women and girls have in negotiating sexual matters.
- The programme emphasises the use of American-produced anti-retroviral drugs when simpler generic drugs are being produced more cheaply, thus saving more lives. (CIPLA of India's Triomune 3-in-1 pill costs as little as \$140 a year per patient compared to \$562 for the American brand name versions.)
- The programmes take no account of the impact that their sheer scale will have on the embryonic health systems in sub-Saharan Africa. When countries have a shortage of doctors and nurses (due to AIDS-related deaths and emigration to wealthier countries), it is inevitable that the remaining staff will be attracted to the resources of the well funded American programme at the expense of the rest of the health system.
- Other donors have not been consulted making it difficult for them to rebalance their aid programmes to meet the countries' overall health needs.
- Finally, the American programme denies the linkage between SRH and HIV/AIDS. Prevention of mother to child transmission of HIV, control of sexually transmitted infections, and contraceptive supply (particularly condoms) makes obvious the importance of links between Sexual and Reproductive Health and HIV/AIDS services.

10. The U.S. attempt to undermine Cairo and UNFPA

On his first day in office, President Bush reintroduced the Mexican City Policy (also called the Global Gag Rule) denying funding to foreign organisations which engage in public abortion policy debates or perform legal abortions. Bush has been actively seeking to undermine the Cairo consensus since he came to office. All funds to the United Nations Population Fund (UNFPA) have been removed on the unsubstantiated ground that UNFPA supports the Chinese one child family policy. This is in direct contradiction to the findings of the American Government's own investigation team and the findings of a UK Parliamentary team. The UK group, after visiting China, concluded that: *'UNFPA is a force for good in China.'* Funds have also been cut for the International Planned Parenthood Federation (IPPF) and a programme involving Marie Stopes International collapsed when the United States withdrew funding. Happily, the European Union and other Governments including the British Government have come some of the way toward restoring these funds.

At the very time that the rest of the world is recognising the great importance of strengthening the links between Reproductive Health and HIV/AIDS, the most powerful nation in the world is seeking to impose on recipients of American aid a dogmatic approach which severely inhibits the building of such links. (This was a prominent theme in our Hearings as well as in all the regional UN and NGO ICPD+10 conferences and the 2004 HIV/AIDS conference in Bangkok.)

We deeply regret the undermining of the ICPD rights based approach by this attitude. We ask the United States government to reconsider its withdrawal of funding for UNFPA, recognising that good Reproductive Health services will lead to women and girls being able to make mature and appropriate choices about intercourse and childbearing. Abstinence will always play a part in the fight against HIV/AIDS, but it is folly to seek to restrict access to the only means by which couples can have sex and receive a dual protection against HIV/AIDS and unwanted pregnancy.

11. Divided Donors

Better coordination amongst donors and with national governments is paramount for success.

Many of the countries facing the most severe crises of poverty, high rates of HIV prevalence and severe SRH needs are not in control of their own fate. Their problems are poverty driven and they are dependant on the policies of the donor countries and the International Financial institutions. *'They are not in control of their own policy making'* said Elizabeth Lule of the World Bank. Yogan Pillay of the South African Department of Health said, *'The problem with funding for HIV/AIDS is that it is often targeted to things like anti-retrovirals. Most donors want to know "If we give you x amount of money how many patients will that buy anti-retrovirals for" forgetting that there is a range of infrastructural issues which need to be funded for that drug to be delivered.....It is certainly an emerging and fairly big problem'*. The donors, acting in an uncoordinated way, must take a large share of the responsibility for stimulating vertically funded services that do not link and do not adequately fund the infrastructure that is necessary to deliver programmes and services.

'Everyone wants to take the lead on HIV but nobody wants to talk about sex.'

Dr Siripon Kanshana, Ministry of Public Health (MoPH), Thailand

B. The case for linking Sexual and Reproductive Health and HIV/AIDS

12. Integration or Linkage of services?

Many have advocated that Sexual and Reproductive Health and HIV/AIDS programmes should be integrated, but as the work on this project advanced, it became apparent that the term 'linked' services was preferable.

Yogan Pillay of South Africa said that linking...'*often means the multi-skilling of a single nurse who is the sole health professional in an area. In another case, it may simply mean very well planned and implemented referral systems.*'

'Integration provides an important opportunity to make the best use of whatever limited contact people have with health services.'

Robin Gorna and John Worley, DfID

If one considers the continuum of care required for HIV/AIDS and also the growing demand for Reproductive Health services, strengthening the linkages between Reproductive Health and HIV programmes is likely to promote client satisfaction, efficiency, and effectiveness by reducing duplication of services: reducing administrative and overhead costs, maximising the utilisation of scarce human and financial resources by sharing facilities and rationalizing staff responsibilities, and minimise missed opportunities. Greater efficiency may be achieved through better coordination, using the same infrastructure and sharing facilities, minimising administrative duplicated tasks, and training workers to perform multiple tasks. From the client's perspective, integrated or linked services may reduce out of pocket payments and other costs for transport and other opportunity costs.

Written evidence to UK APPG on PD&RH Hearings April 2004 by Elizabeth Lule, WB

There will always remain a need for some separate services for HIV/AIDS prevention, treatment and care and SRH prevention, treatment and care. This, however, does not excuse the separated (and often duplicated) financial, logistics and procurement structures in many countries.

There are attempts in the countries surveyed to provide more integrated services because of:

- the gains for patients through a 'one stop' service;
- better use of staff resources;
- the recognition of the futility of a disintegrated approach to issues like mother to child transmission;
- commodity supplies; and
- the recognition that stigma will be better overcome in more integrated settings.

There is also clear recognition of the areas where integration is not appropriate such as the specialised care and support for people with advanced AIDS. But our respondents were quite clear that the need for a better linked approach was very strong and this was confirmed by the work of Dr Mayhew and her LSHTM colleagues (see next section). But a linking of services has proved very difficult for a variety of reasons. Our respondents mentioned above all the shortage of human resources, and lack of equipment and medicine in the clinics. There is also poor governance; disruptive and counterproductive donor behaviour; difficulties in finding the right administrative and professional structure; and inappropriate staff attitudes. While these have inhibited progress, we found no evidence that supports the present separated services. We urge all countries and donors to plan their Reproductive Health and HIV services in a more closely linked way.

'Let us not forget that many men that have sex with men also have Reproductive Health issues: for instance they also often have sex with their wives and female partners and they are fathers!'

Dr Alice Welbourn, ICW

13. Linking Sexual and Reproductive Health services and the services combating HIV/AIDS

Dr Mayhew of the London School of Hygiene and Tropical Medicine put it best:

Three primary rationales can be identified:

a. Epidemiological and clinical reasons

The Reproductive Health services have traditionally and rightly been responsible for the treatment of sexually transmitted diseases. According to Grosskurth, sexually transmitted infections can increase the risk of HIV transmission 9 fold and can make STIs more difficult to treat. Anti-AIDS related services to treat STI infections among sex workers have had some success but one needs to have access to women and youth in less 'high risk' sections of the population. It makes sense that there should be totally linked services to counteract the threat of STIs worsening the AIDS problems. Another example of where the services should be closely linked is that HIV positive women and sex workers will have Reproductive Health needs which they are unlikely to have met if their only contact is with services that have an exclusively anti-AIDS focus.

b. Cost-effective, rational use of resources

More close linked or integrated services are needed on cost effective grounds, particularly in countries with rudimentary services and grave shortages of staff. Countries who have uncoordinated services and donors who are not team players are wasting resources' (and again Dr Mayhew quotes extensively from research which indicates this.) For example, 'Prevention strategies that many Family Planning clinics already conduct are recognised as low cost interventions with potentially large savings for STI and HIV control programmes where they influence safer sexual behaviour and prevent infections and their expensive treatment costs.' They should be expanded – not competed with. Work that empowers women to exercise choice in terms of family size is also work to counteract behaviour that would prevent the contraction of HIV/AIDS. These two strands of work belong together – not in separate departments.

c. Human rights issues

The Cairo and Beijing conferences both argued for rights based holistic services. 'There are particularly powerful rights based arguments for ensuring adequate knowledge, information, choice and access to services that allow adolescents and young adults to make appropriate decisions regarding their Sexual and Reproductive intentions.'

The gains that Dr Mayhew points out for more linked services were confirmed by the survey we conducted of donors, Ministry of Health (MoH) officials, health managers and service providers.

In an ideal world the following would be the case:

If a woman is pregnant and suspects she may be HIV positive, she would want to have voluntary counselling and testing. She would want to have ante and post natal care along with treatment with antiretrovirals during a safe delivery and possibly after. She would want to be supported by a midwife and her family in her decision to breastfeed or not. Her husband would want to be tested and treated if found positive. They would like a supportive relationship with staff at the local primary health care centre and not have to travel long distances and interact with strangers for different health services. They would want these services to be available locally, preferably at one location. Both wife and husband would want their children taken care of by the family and community if one or both died from HIV/AIDS.'

Written evidence to UK APPG on PD&RH Hearings April 2004 by Sandra Kabir, International Council for Management of Population Programmes

New DfID policy on Sexual and Reproductive Health and Rights

Those working on Sexual and Reproductive Health and AIDS need to cooperate on policy-making and service delivery. The UK is firmly committed to the ICPD Programme of Action. There are four main ways in which DfID will work with country governments and partners to achieve these international goals for Reproductive Health for all by 2015:

- Advocate internationally and nationally for policies, plans and resources that address people's rights to Sexual and Reproductive Health, and continue to address controversial issues such as safe abortion and harmful and coercive practices.*
- Improve access to comprehensive services that are responsive to the rights and needs of poor people and other vulnerable groups.*
- Address social, cultural and economic barriers, using a rights-based approach, and tackle factors outside the health sector.*
- Support research, monitoring and evaluation and apply knowledge and lessons learnt in policy and planning.*

Sexual and Reproductive Health services are integral to HIV prevention, building on family-planning promotion and behavioural change. Similarly AIDS services offer an important opportunity to increase access to Sexual and Reproductive Health services, including for women and men affected by HIV.

Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world, July 2004

C: Areas where the work of Sexual and Reproductive Health and HIV/AIDS should be linked

14. Working with Women

Not only do women face more danger from HIV/AIDS, they have fewer defences. The International Community of Women Living with HIV/AIDS has this to say:

'Society has constructed profound psychological and social differences based on gender, yet the response to HIV/AIDS fails to recognise these differences. Women are still seen primarily in the reproductive role, whilst men are seen as the monetary providers, and thus retain physical, social, legal, religious and medical control over women's lives...Women carry a "triple jeopardy" of AIDS; as people infected with HIV, as mothers or children infected and as carers of partners or parents with AIDS (or, in the case of increasing numbers of grandmothers, as carers of orphans). Care, traditionally one of women's many responsibilities within a family, is provided free but has a hidden cost. When women care for others, their labour is lost, this has a huge impact on the wealth and therefore the health not only of themselves but also of the whole household. In the case of girls they are often removed from school to care for sick relatives. This is also a huge economic and social loss, both for them and for their future families. HIV/AIDS is thus contributing to the acceleration of feminised poverty across the world.'

Women have to be given the right to choose what happens to their bodies and isolating Reproductive Health and HIV/AIDS inhibits the broad-based human rights approach that is necessary to overcome the fight against poverty.

'Women's lack of socio-economic power is perhaps the greatest catalyst for the spread of HIV.'

ICW

We support the joint report by UNAIDS/UNFPA/UNIFEM:

'Women and HIV/AIDS: Confronting the Crisis' broadly summarised as follows:

- **Prevention:** ensure that adolescent girls and women have the knowledge and means to prevent HIV infection.
- **Treatments:** ensure equal and universal access to treatment.
- **Care giving:** recognise and support home-based caregivers of patients with AIDS and orphans.
- **Education:** promote girls' primary and secondary education and women's literacy.
- **Violence:** promote zero tolerance of all forms of violence against women and girls.
- **Women's rights:** promote and protect the human rights of women and girls.

15. Women who are HIV positive

It is particularly important that we use a rights based, non judgemental, holistic approach with women who bear the brunt of stigma and isolation, especially sex workers and women who are HIV positive. UNAIDS have estimated that about 2.5 million women who become pregnant each year are HIV positive. However, most women have not been tested for HIV and are consequently unaware of their HIV status. A large number of these will be married and have acquired the virus from their husbands. Some of the most powerful evidence we received came both in person and in written form from women who are HIV positive.

HIV/AIDS challenges us to face up to the greatest taboos facing all our humanity around the world – sex, death and gender.

*'Oh! This one is infected! Women, HIV and Human Rights in the Asia Pacific Region'
from the International Community of Women with AIDS.*

This is what ICW had to say about HIV positive women:

'Women's lower social, political and economic status is fundamentally linked to negative health outcomes, particularly in relation to HIV/AIDS but also to Reproductive ill health.

Coupled with their greater vulnerability to becoming infected, women are significantly more likely than men to experience AIDS-related discrimination after becoming infected. The response to HIV/AIDS to date has failed to address adequately women's inability to prevent themselves from becoming infected, resulting in a thriving epidemic and huge populations of HIV positive women who live in unsafe and undignified conditions. Because of this imbalance of power, public health interests are usually determined by men, driven by economic rationalism and often override women's rights. Interventions always target women in relation to either men or children and do not recognise women as separate entities. These interventions are also very often judgemental. The great achievement of ICPD at Cairo was the declaration and acceptance that control of fertility was a matter of universal Sexual and Reproductive Rights particularly for women. We have to cling fiercely onto the concept of Sexual and Reproductive Health Rights. ABC messages of "abstain, be faithful or use condoms" fail to recognise the context of women's lives. Most women have no control over when, with whom and in what circumstances they have sex.'

'Integration of Reproductive Health and HIV services is desperately needed in order to have women accessing ARVs as opposed to only men who often control the financial resources.'

Gillian Holmes, UNAIDS

It is vital to an effective response that these women's full Sexual and Reproductive Health and Rights needs are met. They should be given the choice whether to have children or not. This choice must be made within a framework of whether there is access to safe abortion. Access to safe abortion should be legal in order for women to decide whether to continue with a pregnancy

or not free of coercion. It is vital that women and their children have access to social support. Work place HIV/AIDS and gender policies are also of paramount importance in combating stigma and discrimination. In addition, there is a need for more research on ART as little is known about the long term impact of the therapy on women and children. We have been greatly impressed by the work being done by organisations such as the International Community of Women Living with HIV/AIDS in forcing their perspectives onto the policy agenda and demonstrating the importance of not tackling HIV/AIDS within a narrow treatment of infectious disease framework.

16. Working with Young People

Of the five million new people living with HIV world wide each year, half of them are under the age of 25. 6000 young individuals per day are newly infected with the virus. Early sex is often a reflection of the lack of power and choice that young women have. Simply put, unprotected early sexual intercourse will make the Millennium Development Goals unattainable. A recent survey carried out by UNFPA showed that only 34% of countries have plans and programmes for providing Sexual and Reproductive Health services to adolescents. Governments are not involving young people in their planning and lack of political will to do so continues to be a major constraint.

'For me the big issue is how you reach young girls and young boys. Certainly young boys do not use Reproductive Health services in virtually any country. Young girls also do not have easy access to Reproductive Health services. . . We are moving into a very brave new world talking about sexuality education for girls and boys who are not yet ten but unless we reach these populations, as I say, we are going to have real problems stemming the epidemic particularly with the rates of inter-generational sex we are seeing in some parts of Southern Africa.'

Gillian Holmes, UNAIDS

An example of an effective programme was brought to us by Dr Feachem who talked about the Love Life programme in South Africa:

'Well, I visited some of those and I have seen the way they create settings where teenagers feel very comfortable and where the staff are teenager attuned; it is not a severe matron, who would want to make you run out of the door or not talk to. This is a very hip group of people who meet on their own terms, sit around and play pop songs. It is in a youth culture frame. It is exactly what we need.'

Gillian Holmes from UNAIDS said:

'AIDS education is a battle against ignorance, misinformation and myths. . . we must use all avenues of education engaging the strengths of community institutions, such as schools, local governments, churches and mass media. Uganda's effectiveness in reducing its HIV prevalence over a period of ten years was largely due to preventive education campaigns that mobilised leaders at all levels and in all sectors. Massive education campaigns also helped Brazil and Thailand make strong strides towards managing their epidemics.'

Dr Feachem of the Global Fund said of the prevention stage:

'Particularly when you focus on HIV and Reproductive Health in young women and girls, where a lot of attention should rightly be focused, there is such a synergy of messages and intervention. We all collectively want later sexual activity, and less sexual partners and we want safer sex and those are in the interests of Reproductive Health, all sexually transmitted diseases and HIV in particular.'

Overwhelmingly, our witnesses and evidence demonstrated the need for dedicated youth-centred services with education and counselling combining SRH and HIV/AIDS. (But an example of a genuine, integrated approach is very difficult to find.) We ask developing countries and donors to view this issue of linked approaches for young people as a matter of priority. All developing countries should be assisted in developing programmes that reach out to young women and men before they are sexually active, that prepare them both for fulfilling and responsible Sexual and Reproductive lives and equip them to avoid HIV/AIDS.

'This is a political issue. The young are not the problem. The barrier to providing services to young people is largely the resistance of governments and conservative societies.'

Dr Steven Sinding, IPPF

'Women and young people are especially vulnerable to HIV/AIDS. Young people are in the precarious position of being the most vulnerable to infection and hard hit by HIV and STI. Half of all new infections occur in young people aged 15-24 – about 5 young people per minute. Young girls are worst affected. . . [and]. . . account for 62% of the 11.8 million young people living with HIV/AIDS. Women are more than four times more vulnerable to HIV infection than men and young women less than 20 are up to 10 times more vulnerable.'

Elizabeth Lule, WB

17. Working with Men

While much integration has focused on STI/HIV and MCH/FP services reaching largely married, fertile women, specialist SRH services for adolescents and for men have been neglected. Without adequate services for men, the effectiveness of women's Sexual and Reproductive Health services is limited. Adolescents are socially and biologically the most vulnerable group to STI/HIV infection and unwanted pregnancy, yet there is little real commitment to providing integrated services that foster open dialogue on sexual issues. Commitment to providing integrated SRH services for men and adolescents as well as women is therefore necessary.

Written evidence to UK APPG on PD&RH Hearings April 2004 by Dr Susannah Mayhew, LSHTM

Men have been called the “final frontier” for education on sex and family planning. Reproductive Health has been largely associated with clinics and women with young children. In most countries, men are seen as not being comfortable in this female territory and similarly the staff associated with family planning clinics are often reported not to be comfortable in outreach work to men. Furthermore, almost throughout the world, there has been an unwillingness by political and medical leaders to tackle the issue of male sexual behaviour. There is the framework, mostly of a primary health care service which must be built on for prevention, promotion and counselling work with men. Dr Zhao of China informed us what needed to happen in male education:

‘In addition to conventional methods such as training sessions, wall newspapers, posters and exhibitions, new methods like face to face counselling, peer education, community services and voluntary participation have been introduced and have begun to change people’s behaviours. Public education approaches have evolved from group education to individualised activities. Content has shifted from focusing merely on Reproductive Health knowledge to integration with practical knowledge and skills. In addition, the rank of advocates has expanded from Government departments to non-governmental organisations and social workers as well.’

Both developing countries and donors must tackle the badly neglected area of prevention and counselling for men, ensuring the development of successful and sustainable services in both Reproductive Health and HIV/AIDS.

‘In the struggle against HIV/AIDS, men are having terrible difficulties, as men are often meant to be mature and powerful. In many societies men are expected to have had many sexual experiences and partners. There is a lot of pressure from within communities in relation to male behaviour which needs addressing in order to curb the HIV/AIDS epidemic.’

Ana Luisa Liquori, MacArthur Foundation, Mexico and Geeta Rao Gupta, International Center for Research on Women (ICRW)

18. Mother to Child Transmission of HIV/AIDS

One of the most tragic aspects of the HIV/AIDS epidemic is where pregnant women transmit the HIV virus to their children, so that not only the mother but her child faces the prospect of life with HIV/AIDS.

Of the 14,000 new HIV infections that occur daily, more than 1,600 occur among infants either during pregnancy, at childbirth or during breastfeeding. In 2001 alone, WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) reported that 800,000 children became infected with HIV.

Prevention of Mother to Child Transmission (PMTCT) provides a stark instance of the perils of treating Reproductive Health services and HIV/AIDS services as separate services. The UN General Assembly Special Session on AIDS in 2001 committed itself to considerable reductions in PMTCT infection rates. It said that the proportion of infants infected by HIV/AIDS must be reduced by 20% by 2005 and 50% by 2010, utterly unattainable targets unless there are very considerably improved linkages between Sexual and Reproductive Health and HIV/AIDS.

There are four main interventions for PMTCT:

1. Prevention of HIV infection in women;
2. Prevention of unintended pregnancy in HIV-positive women;
3. Prevention of HIV transmission from HIV infected pregnant women to their infants through anti-retroviral drugs, safe delivery practices and infant feeding counselling and support; and
4. Treatment, care and support for HIV infected women and their families.

A programme that is set up to focus strongly on HIV/AIDS is likely to centre on approach 3 – having found a woman who is pregnant and is HIV positive, the team will provide appropriate anti-retroviral treatment for her and her child. And yet, approach 3 will do nothing to stop the flow of infected mothers and also takes no account of the severe effects of a positive diagnosis on the mental health of a pregnant woman.

Current estimates from the WHO forum in Glion estimate that implementing the third PMTCT element alone will reduce HIV in infants by between 2% and 12% in many countries. The more effective ways of reducing the proportion of HIV infected infants are by preventing HIV infection in women (Approach 1) and by preventing unintended pregnancy in HIV infected women (Approach 2). These two could reduce the proportion of HIV infected infants by 35-45% in the countries that were studied, a very powerful argument for stronger links between SRH services and HIV/AIDS services. This especially as the majority of people do not actually think themselves at risk of HIV/AIDS and the majority of people do not actually know their HIV status.

At the WHO convened high level meeting at Glion in Switzerland, recommendations on PMTCT policies and programmes were developed. The meeting commented critically on the failure to develop potential linkages, which would make a substantial impact on the HIV/AIDS epidemic (see Box)

The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children, May 2004

We, the undersigned, call upon governments, parliamentarians, UN agencies, donors, civil society, including NGOs and community-based organisations, to:

1. Policy and Advocacy

- a. Increase awareness, understanding and commitment to the four elements of PMTCT.
- b. Commit to developing and implementing policies that strengthen the linkage between family planning and PMTCT.
- c. Formulate legislation and policies that support the rights of all women, including HIV-infected women, to make informed choices about their reproductive lives.

2. Programme Development

- a. Strengthen commitment to achieving universal access to reproductive health services, including family planning, and recognize and support the contribution of these services to HIV/AIDS prevention efforts.
- b. Ensure access for all women to family planning information and services, within both PMTCT and voluntary counselling and testing (VCT) services.
- c. Ensure that psycho-social counselling and support services are available to women seeking to be tested for HIV and for women infected with HIV.
- d. Operationalise the linkage between family planning and PMTCT (through training, ensuring the supply of ARVs, contraceptives, HIV testing kits, pregnancy testing kits, male and female condoms, and establishing referral systems and tracking mechanisms)
- f. Ensure that condoms are available and distributed at family planning, PMTCT and VCT settings, together with the information and counselling necessary for their correct and consistent use.
- g. Promote and facilitate the participation of men, both as individuals and as a partner in a relationship, in PMTCT programmes.
- h. Ensure the participation of young people in the design of programmes addressing their special needs in the prevention of MTCT.

3. Resource Mobilisation

- a. Allocate the necessary funds for the implementation of all four elements of PMTCT, including family planning.
- b. Improve cooperation and coordination among donors to support and strengthen the linkage.
- c. Rectify the severe funding shortfall for the provision of Reproductive Health supplies, including contraceptives and condoms, and invest in the logistics systems in countries to improve their ability to procure, forecast and deliver those supplies.

4. Monitoring and Evaluation and Research

- a. Build on existing data to develop and improve monitoring and evaluation mechanisms for programmes linking family planning to PMTCT services, including measurement of the reduction of numbers of women and infants infected with HIV.
- b. Continue innovative operations research to identify the most effective and efficient strategies and technologies to support linkages between PMTCT and family planning programmes.

'There is simply not enough interest in the maternal mortality package to make it happen. In HIV, you get the whole group together, the private sector, pharmaceutical industry, researcher, foreign office, security people, everything comes together on HIV, but you simply do not have that on Reproductive Health issues.'

Angeline Eichhorst, EC

19. Leadership: Governments, Parliamentarians, Civil Society, and Multilateral Organisations

Much has been said about the importance of leadership in counteracting HIV/AIDS. For example, contrast President Museveni of Uganda who led the fight against HIV/AIDS from a very early date and the former President Moi of neighbouring Kenya, who could hardly bring himself to speak about the subject. While Museveni's leadership made a real difference, Kenya drifted as the HIV incidence rose (and continues to rise today).

And yet from Dr Ssebdukka, from Uganda... 'despite the relative success with HIV infections, Uganda's Reproductive Health indicators such as rates of infant mortality, maternal mortality, and high birth rates remains obstinately disappointing'.

The evidence continues to support the case for closely linked services, particularly at the prevention, educational and counselling stages, which will reduce HIV/AIDS infection rates as well as greatly improve maternal and child health. Leaders must realise there is no hope of reaching the Millennium Development Goals unless a higher focus is given to the linkages between SRH and HIV/AIDS.

Poverty Reduction Strategy Papers (PRSPs) allow a country ownership of policies and include civil society while developing a policy framework. Unfortunately, there is little sign that many of our fellow parliamentarians are taking a lead role in developing policy. One of the consequences of the way in which donors and countries operate is that the relationship is between donor and governments and that parliamentarians – at the apex of civil society as the people's elected representatives- are left out or do not insist upon becoming involved and relevant.

The recently published Cardoso Report, set up by Kofi Annan and overseen by former President of Brazil Fernando Henrique Cardoso to look at the relationship between UN organisations and Civil Society, found:

'More systematic engagement of parliamentarians, national parliaments and local authorities in the United Nations would strengthen global governance, confront democratic deficits in intergovernmental affairs, buttress representative democracy and connect the United Nations better with global opinion. The Panel's proposals are designed to encourage national parliaments to give more attention to United Nations matters, to evolve more appropriate engagement for those members of Parliament who come to United Nations events and to link national parliaments more directly with the international deliberative process, particularly by experimenting with global equivalents of parliamentary select committees.'

We recommend that the United Nations takes these steps to improve its links with parliamentarians to be better able to contribute to policymaking and to build up a genuine sense of ownership of policy. We must equip parliamentarians in countries with fragile democracies to build up their skills in policy areas.

What we say about parliamentarians and their needs should also be said about civil society as a whole and it is essential that vigorous local NGO's are nurtured. Many SRHR and HIV/AIDS NGOs exist and have been working intensively over the last decade to improve SRH & Rights and HIV/AIDS policies, programmes and services at all levels. The failure to put a woman's face on AIDS has led to the policy weaknesses and donors must redouble their efforts to build local involvement and influence as part of the key to ending stigma and discrimination.

'I am still amazed that in a number of countries where they are engaged in a national poverty strategy, how frequently the UN system seems to be disengaged from that process. As Reproductive Health people we should be insisting that those national poverty strategies are carrying our Reproductive Health messages, our Sexual Health messages and our HIV/AIDS messages. We cannot sit by and watch that ship pass in the night.'

Steve Kraus, UNFPA

20. The review of the Millennium Development Goals

There can be little doubt that Reproductive Health has fallen off the international priority list since the consensus at Cairo and one of the reasons is the failure to mention Reproductive Health in the Millennium Development Goals. Earlier we pointed out that many of the MDGs, such as reduction in infant mortality rates and maternal mortality rates, empowerment of women, universal primary education and especially falling rates of infection with HIV/AIDS, can only be achieved with an enhanced commitment to SRHR.

In 2005, the world community is going to assess progress towards the MDGs. World's leaders need to recommend changes that would stress the importance of Sexual and Reproductive Health in the achievement of the MDGs and to the gains that would be made to promote the greater linkage of Reproductive Health and HIV services.

We urge the UN General Assembly, the G8, The World Bank, The Global Fund, all relevant UN organisations, The European Union, New Partnership for Africa's Development (NEPAD) and all partners in development to affirm their support for the inclusion of SRH & Rights within the MDGs.

'The Millennium Development Goals should be incorporated with the ICPD Programme of Action and the Millennium Development Goals should be tied with Reproductive Health issues in future international documents.'

Dr Zhao, Ministry of Health (MoH), China

21. Welcome to the UNFPA and UNAIDS Partnership in the New York Call to Commitment

In June 2004, UNFPA and UNAIDS convened a high level global consultation in New York. The resulting New York Call to Commitment included participants such as Ministers, Parliamentarians, Ambassadors (including the British Ambassador to the UN), leaders of other UN organisations, Government officials (including DfID), community and non-governmental leaders, young people and people living with HIV/AIDS.

These powerful voices in the field came together prior to the Bangkok Conference on AIDS to make this strong statement, that substantial change was needed to conquer HIV/AIDS.

It expressed 'profound concern that far too many policies, programmes and initiatives addressing Sexual and Reproductive Health or HIV/AIDS have failed to take account of these linkages; and that as a result, the global community has been thus less effective than it could have been in responding to these shared challenges and opportunities.'

We commend the New York Call to Commitment (see Box for full text).

The New York call to commitment: Linking HIV/AIDS and Sexual and Reproductive Health

1. Reaffirming the development goals as contained in the Millennium Declaration adopted by the United Nations General Assembly at its fifty-fifth session in September 2000, and in the road map towards the implementation of the Millennium Development Goals and the goals set by the other United Nations international conferences of the 1990's;
2. Recognizing that these development goals will not be achieved without ensuring universal access to Sexual and Reproductive Health services and programmes and without an effective global response to HIV/AIDS;
3. 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 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;
4. Expressing profound concern that far too many policies, programmes and initiatives addressing either Sexual and Reproductive Health or HIV/AIDS have failed to take account of these linkages; and that as a result, the global community has thus been less effective than it could have been in responding to these shared challenges and opportunities;
5. Agreeing that the strengthening of the policy and programme linkages between HIV/AIDS and Sexual and Reproductive Health is essential for either effort to be successful, and for both efforts to contribute, as they must, to the achievement of the Millennium Development Goals.

We have agreed upon the following actions and call on others to do likewise:

6. Reaffirm the linkages between HIV/AIDS and Sexual and Reproductive Health, and their inter-relationships with broader issues of public health, development and human rights, as agreed by the international community in a series of commitments including:
 - The 'Programme of Action' adopted in 1994 at the Cairo International Conference on Population and Development (ICPD), and the Key Actions for the Further Implementation of the Programme of Action of the ICPD adopted in 1999;
 - The Beijing Declaration and Platform for Action of September 1995, and the Political Declaration and Further Action and Initiatives to Implement the Beijing Declaration and Platform for Action of June 2000;
 - The United Nations Millennium Declaration of September 2000 and the Millennium Development Goals; and
 - The 'Declaration of Commitment on HIV/AIDS' agreed by acclamation at the United Nations General Assembly Special Session on HIV/AIDS in June 2001;
7. Promote the greater and more effective involvement of potential beneficiaries, especially people living with HIV and young people, in the design, governance and delivery of Sexual and Reproductive Health and HIV/AIDS initiatives;

8. Transform existing Sexual and Reproductive Health and HIV/AIDS policies, programmes and services to ensure:
 - That Sexual and Reproductive Health, HIV/AIDS and integrated initiatives are all built on a fundamental commitment to respect, protect and promote human rights;
 - That the creativity and capacity of communities and of nongovernmental organizations are fully engaged towards the achievement of these goals;
 - Recognition of, and response to, the Sexual and Reproductive Health needs and human rights of people living with HIV;
 - Special efforts to reach priority populations most under-served by current efforts, including poor women, young people and marginalized populations;
 - That family planning and voluntary counselling and testing are included in prevention of mother-to-child transmission programmes, as endorsed in the "Glion Call to Action";
 - Provision of an essential package of Sexual and Reproductive Health information and services to all people reached by HIV/AIDS programmes;
 - Provision of an essential package of HIV/AIDS information and services to all people reached by Sexual and Reproductive Health programmes; and
 - Adequate, accessible, affordable and acceptable supplies of essential HIV/AIDS and Sexual and Reproductive Health related commodities, including male and female condoms and STI diagnostics and drugs;
9. Reinvigorate our efforts to ensure that young people around the world have access to age-specific, gender sensitive and culturally appropriate Sexual and Reproductive Health and HIV/AIDS education and services;
10. Mobilize the necessary resources to support dramatically increasing linkages between HIV/AIDS and Sexual and Reproductive Health programmes and services;
11. Ensure that the linkages between HIV/AIDS and Sexual and Reproductive Health are addressed within existing national development plans and budgets including health sector reforms, poverty reduction strategy papers (PRSPs), sector wide approaches and UN system instruments such as the Common Country Assessment and Development Assistance Framework;
12. Promote a coordinated and coherent response to HIV/AIDS that builds upon the principles of one national HIV/AIDS framework, one broad-based multi-sectoral HIV/AIDS coordinating body, and one agreed country-level monitoring and evaluation system; promote attention to Sexual and Reproductive Health priorities within this effort; and promote strategies which ensure that HIV/AIDS and Sexual and Reproductive Health programmes contribute to the overall strengthening and sustainability of health systems;
13. Above all, encourage all interested and concerned parties to reach out to their colleagues, to advocates, and to leaders around the world, emphasizing the global emergency created by HIV/AIDS and Sexual and Reproductive Health; the urgent need for much stronger links between Sexual and Reproductive Health and HIV/AIDS policies, programmes and services; and the centrality of these intersecting efforts towards the achievement of the Millennium Development Goals.

22. Human Resource crisis

There is a severe shortage of health staff in developing countries. UNAIDS reports that in some countries the size of the health force must triple or quadruple if universal coverage of anti-retroviral treatment is to be achieved. In countries most affected by HIV/AIDS, vacancy rates for doctors, nurses and other health staff are extremely high. In 2001, for example, Malawi had only filled half its public sector nursing posts. Gcebile Ndlovu of Swaziland said,

'Human resources are our biggest challenge...we have had funding from the Global Fund, but there is no human resource to utilise that funding to get the services that the people need the most to them.'

These figures are dramatic, but they do not take into account the impact of HIV/AIDS upon the medical profession itself. Neither do they take into account the imbalance of medical staff that prefer urban areas to remote rural ones.

'In Zambia, out of more than 600 doctors trained since independence, only 50 remain in the country. More than 50% of physicians trained in Ghana during the 1980s practise abroad. United Nations Conference on Trade and Development (UNCTAD) estimated that 56% of all migrating physicians flow from developing to industrialised countries, while only 11% flow in the opposite direction.'

Elizabeth Lule, WB

In addition, there are substantial but surmountable issues relating to management and staff attitudes. Management systems should be set up with clarity and additional staff training given on the importance of non-judgmental attitudes. Ian Askew and Marge Berer say, *'At present, there is a severe lack of capacity in health departments and there are considerable doubts raised by the World Bank and other agencies about how countries will cope with the extra funds scheduled to go into AIDS work from the Global Fund and the United States. One of the issues that will need to be tackled is the one of staff attitudes and competencies. Often Sexual and Reproductive Health services are seen as working with married women on family planning issues. For many staff, working with HIV positive clients may be very difficult if they share the stigmatising attitudes prevalent in many societies.'* UNAIDS refers to the power of stigma and discrimination which directly hamper the effectiveness of HIV/AIDS responses, stopping people coming forward for Voluntary Counselling and Testing or preventing the use of condoms. We call on the WHO and other relevant organisations to work with countries to address these capacity, managerial and staff attitude issues.

'We have the health worker now who usually tells the patients what to do, they do not listen to what they ask, they just tell them what to do, they say "take this, take that" and that is it. That is how it was. Now it is much better because of the training in two way communication.'

Dr Kanshana, MoPH, Thailand

'Previously all the programmes that the Government implemented were all vertical, now they have become horizontal... My experience over the last 2 and a half years was on a pilot project integrating the voluntary testing and counselling centre with family planning services which is very good. We implemented in 2002... so now we link many programmes on Reproductive and Sexual Health together with other services; they are not separate. We have voluntary counselling and testing services, mother to child transmission centres, an integration of all the services you get at the hospital now. An integrated service is more effective than individual services, that is my experience.'

Dr Sawant, CSM Hospital Kalwa, India

23. Contraceptive Supply

Another area hampered by the present divide between SRHR and HIV/AIDS services is that of contraceptive supply and condom supply in particular. Condoms are cheap (\$0.03 per condom to the donors), mass produced, low tech contraceptives which allow safer sex as well as protection from pregnancy. Condoms provide a unique dual protection for many couples. In Thailand, strong support from political leaders, adequate public financing and the promotion of condom use as part of a safer sex campaign helped reduce the number of new HIV infections to about 20,000 down from a peak of 143,000 in 1991. This kind of leadership is needed to build up the demand for condoms. Yet as DfID says,

'Millions of women and men are unable to access the contraceptives and related services they need to plan when and if to have children. Bridging the current gap and meeting future increases in demand will make a huge difference to people's lives. It will lower reliance on abortion, which for many women is the sole means of regulating fertility. The number of couples wanting contraceptives is predicted to rise from 525 million couples in 2000 to 742 million in 2015.'

According to the UNFPA, every one million dollars spent on contraceptives saves the lives of 800 women and 11,000 infants; prevents some 14,000 deaths of children under 5; averts 360,000 unwanted pregnancies; prevents 150,000 unwanted pregnancies; and prevents 150,000 addition induced abortions.

UNFPA predict that 'the need for condoms for the prevention of HIV/AIDS and other sexually transmitted infections will rise from 8 billion in 2000 to 12.8 billion in 2005 and 18.6 billion in 2015.'

At the WHO symposium on Prevention of Mother to Child Transmission of HIV/AIDS in Glion this year, the UNFPA informed us that donor support only met 20% of the total commodity required – and that the gap between need and supply widens each year. Yet the volume and reliability of the supply of condoms has been erratic and controversial. Donors need to address the shortage of all Reproductive Health commodities including issues around the entire supply chain. There is a damaging divide between the HIV/AIDS and Reproductive Health world and there could be a single focus on the supply of condoms.

This is an area where the UK has a creditable reputation, paying for almost half of the one billion condoms distributed in the developing world. (This has been especially important as U.S. policy changes have meant a major decrease in their contraceptive commodity distribution.) The UK International Development Under-Secretary of State, Gareth Thomas MP still feels the need to do more saying, *'That is not enough if we are to make an impact in preventing the spread of HIV/AIDS.'*

We call upon UNFPA, UNAIDS, WHO, the World Bank and other donors to devise a system for the supply of contraceptives on a scale that meets the ICPD goal of universal access to Sexual and Reproductive Health care (and does so in a way that bridges the divide between Sexual and Reproductive Health care services and HIV/AIDS services).

BISHOP OF MOZAMBIQUE BLESSING OF THE CONDOMS

'God clearly tells us that we must protect life at all costs. To not do so is committing a serious sin against God.

A is for abstinence – many of you cannot live by this advice. Let us be realistic, few if any of you can abstain.

Which brings us to B, be faithful – some of you are faithful... many of you are not.

So that leaves us with C... condoms. Now many of you believe that condoms are a crime against God... that wasted semen is a sin and I am here today to tell you otherwise.

You see, if you are HIV positive and you have unprotected sex and you infect someone, you have, in the eyes of God, committed murder. Or if you are HIV negative and you have unprotected sex with someone who is infected, and they infect you, you have, in the eyes of God, committed suicide.'

'So my Children, wearing a condom is not a sin... not wearing one IS! Can't argue with that logic! Sunday church services will never be the same as now every Sunday, part of the Celebration is the blessing of the condoms.

That's right, the BLESSING OF THE CONDOMS!'

PLANetWIRE Clips

24. What is happening with the Female Condom?

Steve Kraus of the UNFPA raised with us the issue of the female condom (one of the few witnesses who did so). This is intriguing since the female condom ought to be invaluable in the fight against HIV/AIDS as it is the only means that many women have to protect themselves against HIV infection that is to some extent under their control. Why does the female condom have such a low profile? Why is it so unpopular? Is it because it is too expensive? Is it because too little research money has been allocated to develop, promote and advocate for the further development and dissemination of female condoms? We recommend to WHO and the donors that the female condom be better promoted and made more widely available and affordable.

'When I was a programme manager in Zimbabwe, the UNFPA came in as the provider of condoms for family planning. Then when HIV and STI came we had the World Trade Organization (WTO) coming in with condoms for STI and HIV prevention. One could not use UNFPA condoms for STI prevention.'

Dr Francis Ndowa, WHO

25. Some factors that predispose to HIV/AIDS infections

High rates of reproductive tract infections (RTI) or sexually transmitted infections make it easier for an individual to become infected by the HIV/AIDS virus.

For example, in our evidence from China, we heard that 27.6% of the women from the general population in Shenzhen province and more than half of the sex workers suffered at least one type of reproductive tract infection. If the virus was to become endemic in China as is feared, then the high prevalence of reproductive tract and sexually transmitted infections would mean quicker spread of the HIV/AIDS virus. The population of China and elsewhere should routinely be offered reproductive tract and STI testing when seeking contraceptive services. Such preventive work is highly unlikely to be incorporated into a free-standing, vertically organised HIV/AIDS programme.

Frequent reference is made in the literature to the costs and difficulties of diagnosis and testing, especially given the stigma surrounding HIV/AIDS. As treatment improves, with the greater availability of anti retroviral therapy, it becomes even more important to identify people who are HIV positive. Setting up separate testing facilities for HIV purposes and Reproductive Health purposes is difficult to justify. We ask the WHO what is needed to improve the quality, response time, local installation and lower the cost of diagnosis and test with regard to HIV, STI and RTI infections. Is this an area where the private sector should be increasing its research involvement? What could be the role of the private foundations?

Another factor which appears to affect the incidence of HIV/AIDS is the level of male circumcision. In a paper by Cameron and colleagues in *The Lancet* in 1989, it has been suggested that the rate of male circumcision in a country is related to the incidence of HIV/AIDS. For example, countries like Botswana, Zimbabwe, Namibia and Zambia where 20% of the male population are circumcised have very high rates of infection. In contrast, countries like Nigeria, Ghana, and Sierra Leone where over 80% of their male population circumcised have much lower rates of infection. A recent *Lancet* article (Halperin and Bailey) also found that lack of male circumcision is one of the main causes of regional discrepancies in rates of HIV infection. We call upon the WHO to respond on this issue: Is the prevalence of HIV/AIDS related to the rate of male circumcision and, if so, what action does it propose to take to use this information in the battle against HIV/AIDS?

26. The Organisation of Services

We strongly support the "three ones" strategy spearheaded by UNAIDS, and endorsed by DfID – that there should be:

- One national HIV/AIDS strategy
- One national AIDS Commission
- One way to monitor and report progress

It has been very striking to us that all the agencies and people we have consulted have been very strongly in favour of much better integration or linkage between Reproductive Health services and HIV/AIDS services but nobody is clear on how to proceed.

In Tanzania, for example, there are three Directorates of Services in the Ministry of Health (Preventive, Curative and Human Resources Development) (Oliff et al. 2003). The National AIDS Control Programme (NACP) is part of Epidemiology and Disease Control under Preventive Services, along with TB and malaria control. Where, in this case, does TB and malaria care for HIV positive pregnant women fit? HIV/AIDS-related treatment is surely curative, but NACP is under Preventive Services. What about PMTCT – does that come under safe motherhood or NACP? Reproductive and Child Health Services (RCHS) is also under Preventive Services and is defined only as family planning, safe motherhood and child health – how, therefore will STI services be integrated? Will they be moved from NACP, or will be in both places? Answers to these questions are important because they define drug and contraceptive supply structures, technical supervision, training responsibility and more.

The organisation of Ministries of Health is complex and Sexual and Reproductive Health services cut right across the traditional divisions of preventive and curative, yet, as has been demonstrated, they are inextricably linked. To separate the preventive and curative components of Sexual and Reproductive Health would be to decrease the effectiveness of both.

Written evidence to UK APPG on PD&RH Hearings April 2004 by Dr Susannah Mayhew, LSHTM

EXPERIENCE FROM SOUTH AFRICA

The Constitution provides for three spheres of government – each with some responsibility for health service delivery. These are the national, provincial and local spheres. Historically, and to some extent currently, health services are duplicated in some areas with both the provincial Department of Health and municipalities providing primary health care. In a few extreme instances one would find a provincial clinic coexisting with a municipal clinic in the same building. The latter would provide immunisation and family planning whilst the former will provide a range of curative services. Fortunately, these extreme cases have been integrated into one service.

The reason for this level of fragmentation and duplication was that these levels of governments were not forced to co-operate and that each had its own funding and governance authority.

In some ways the provision of services related to the HIV epidemic has also fragmented services provided by the provincial Departments of Health. At national and in each provincial Department units have been established which are responsible for HIV and AIDS. Programmes that were initiated early on included a range of prevention programmes, including abstinence, being faithful to one's partner and use of condoms. Others included early and complete treatment of sexually transmitted infections, Voluntary Counselling and Testing, the Prevention of Mother to Child Transmission and post exposure prophylaxis (PEP) for both needle stick injuries and rape survivors. However, all of these programmes were planned and managed

from the units responsible for HIV and AIDS. Very little was done to integrate these programmes into the maternal child and women's health unit (which also deals with reproductive health issues). The rationale for this was similar to the establishment of all vertical programmes – easier to fund and manage!

Yogan Pillay, DoH, South Africa

As DfID said, 'There is no blueprint for integration or how a better linked set of services should be delivered because every country has different needs, values and differing structures. Also we gain the impressions of desperately stretched services that are put under even greater difficulty in delivering by the multiple demands from powerful or cash-bearing outsiders, the donors.'

We recommend the following principles that have emerged from our Hearings:

- a. The top leadership of the country at national and local level should make it clear that they recognise and support the crucial linkages between Reproductive Health and HIV/AIDS services.
- b. Donors should recognise just how damaging it is to the development of services meeting the needs of clients, if they vertically fund services that inhibit and disrupt links between the services. They should fully commit themselves to multilateral programmes that regard SRH services as having complementary needs to HIV/AIDS services and thus release the economies of scale that would come from joint planning. We commend DfID for its initiatives to display such better linkage and UNFPA and UNAIDS for giving global leadership in this respect.
- c. We recognise that there are areas of both services where it would be inappropriate to insist on closer integration, where common sense shows that there is no advantage to this (e.g. areas such as palliative care for people living with AIDS).
- d. The priority must be to the provision of local services rather than to dramatic, back-to-the-drawing-board restructuring. All new services must be drawn up with the goals of very close linking of SRH and HIV/AIDS services at the local level, building on existing infrastructures and services. This report has indicated key areas such as HIV prevention, behaviour change communication on safer SRH behaviour, prevention of Mother to Child Transmission, diagnosis, testing and treatment of sexually transmitted infections, Voluntary Counselling and Testing, and contraceptive provision especially condoms for dual protection.

27. The need for an Holistic Approach

We repeatedly hear that "HIV/AIDS is much more than health". This is equally true of Sexual and Reproductive Health. Sexual and Reproductive ill health and HIV/AIDS are the biggest threats to development in sub-Saharan Africa, devastating workforces and destroying families. We must emphasise HIV/AIDS prevention and improved maternal and infant health. The future focus must be on prevention as the worst is still to come. Even the present low rates of HIV infections in China, India and Eastern Europe will bring far more deaths and devastation to individuals, communities and societies than have occurred in Africa. One point of optimism is that these countries have generally much stronger health care systems than sub-Saharan Africa. Dr Sinding, Director General of IPPF said in Glion, "We need to break the policy knots so that we can link together better."

If we fail to have well developed linkages between such obviously contiguous areas as Sexual and Reproductive Health and HIV/AIDS, then it will prove impossible to take an holistic approach to all the other areas where HIV/AIDS is having a crippling impact on development.

Hilary Benn MP and Secretary of State for International Development:

'Sexual and Reproductive Health and AIDS are inextricably linked. By taking action on one, we know we are also helping to tackle the other.'

Far too many poor women in developing countries live with painful, disabling and hidden injuries or illness because they are denied their rights to Sexual and Reproductive Health. 529,000 women die each year from pregnancy and childbirth related illnesses. Last year over 1 million women died of AIDS. In sub-Saharan Africa teenage girls are five times more likely to contract HIV than teenage boys. This announcement of £80m over the next four years for the United Nations Population Fund (UNFPA), coupled with the commitments in DfID's Sexual and Reproductive Health and Rights paper, will contribute to more effective HIV prevention work among young people and women, as well as improved access to and use of male and female condoms and better integration of Sexual and Reproductive Health services and AIDS programmes.'

Guardian Article, July 7th 2004

Acronyms and Abbreviations

ABC	Abstain, Be Faithful and use Condoms
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
ART	Anti-Retroviral Treatment
APPG on PD&RH	All Party Parliamentary Group on Population, Development and Reproductive Health
CCMs	Country Coordinating Mechanisms
CDC	Center for Disease Control
CIPLA	CIPLA Pharmaceutical company
DDI	Didanosine
DfID	Department for International Development
DoH	Department of Health
Dr	Doctor
EC	European Commission
E.G.	Exempli gratia, meaning “for example”
FGM	Female Genital Mutilation
FP	Family Planning
GF – Global Fund	The Global Fund to fight HIV/AIDS, TB and Malaria
G8	Heads of state or government of the major industrial democracies: France, US, Britain, Germany, Japan, Italy, Canada, Russia and the European Community
HIV	Human Immunodeficiency Virus
ICOMP	International Council of Management of Population Programmes
ICPD	International Conference on Population and Development
ICPD +5	International Conference on Population and Development 5 year Review
ICPD +10	International Conference on Population and Development 10 year Review
ICRW	International Center for Research on Women
ICW	International Community of Women Living with HIV/AIDS
I.E.	Id est, meaning “that is,” or “in other words”
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
IV	Intravenous
LSHTM	London School of Hygiene and Tropical Medicine
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MoH	Ministry of Health
MoPH	Ministry of Public Health
MP	Member of Parliament
MTCT	Maternal to Child Transmission of HIV/AIDS
NACP	National AIDS Control Programme
NEPAD	New Partnership for Africa’s Development
NGO	Non-Governmental Organisation
PEP	Post-Exposure Prophylaxis
PEPFAR	President’s Emergency Plan for AIDS Relief
PMTCT	Preventing Mother to Child Transmission of HIV/AIDS

PoA	Programme of Action
PRSP	Poverty Reduction Strategy Papers
RTI	Reproductive Tract Infections
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TB	Tuberculosis
UK	United Kingdom
US	United States
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCTAD	United Nations Conference on Trade and Development
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNIFEM	United Nations Development Fund for Women
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organisation
WTO	World Trade Organisation

Notes