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SRH-HIV Convergence Newsletter

The PATH Convergence Project

INSIDE:

- **Introduction to the PATH Convergence Project**
- **SRH-HIV Convergence: A Literature Review**
- **Report on State-Level Meetings about Convergence**

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The Convergence project is supported by the William and Flora Hewlett Foundation, the David and Lucille Packard Foundation and by DFID. It is a research and advocacy project to promote and determine the feasibility of HIV and SRH service convergence in four states in India – Andhra Pradesh (AP), Uttar Pradesh (UP) Maharashtra and Bihar.

The overall goal of the PATH Convergence Project is to contribute to a reduction of HIV and unintended pregnancy by strengthening and promoting SRH and HIV convergence. The project objectives are to increase accessibility to SRH and HIV services for populations at risk of HIV and unintended pregnancy by (i) strengthening the awareness of policy makers about the need for SRH and HIV convergence and (ii) strengthening the understanding of service providers about how best to implement convergence for populations at risk. This is being done by conducting a diagnostic assessment of convergence in one district in each of the four states - Srikakulam in AP, Lucknow in UP, Nashik in Maharashtra and Patna in Bihar. Dialogue and discussion about realistic options for convergence will then be facilitated at national and state/district level. Where requested, PATH will assist service providers to monitor and evaluate selected convergence pilots to learn lessons for replication and scale up.

PATH is currently working with populations at risk of HIV and unintended pregnancy to design and conduct a comprehensive mapping of current SRH and HIV services in each study district. The extent and nature of HIV and SRH service provision to populations at risk will be identified - covering all relevant government, NGO and private providers. Following this, Provider concerns and training needs related to SRH and HIV convergence will also be identified and attitudes of policy makers (national, district and panchayat leadership) towards con-

vergence of SRH and HIV services will be explored. Interviews will also be held with key donor and UN staff.

After analysis, findings will be verified with key stakeholders and feedback workshops held at district/state and national level. District assessment reports will be produced and disseminated as will a national convergence report on the information generated from all four states. It is expected that these reports will include documentation of current policy and program practice regarding linkages and gaps between SRH and HIV/AIDS services for at risk populations; identification of feasible options for converging HIV, contraception, and abortion information, counseling, services, and/or referral into currently vertical programs; and information about where convergence is not appropriate.

Concurrently, PATH will initiate state and national level policy work. This will involve continued dialogue among stakeholders who have indicated an interest in contributing to the development of supportive advocacy and policy at state and national levels. A desk review of global research on convergence is being conducted and a dynamic review will be disseminated at district/state and national level meetings. To maintain interest and momentum amongst key stakeholders whilst assessments are carried out at district level, regular newsletters with information and updates on convergence will be widely circulated.

The PATH Convergence Project began with a national consultation with a group of national and state-level NGOs and donors around issues of SRH-HIV convergence. PATH seeks to build on this work and facilitate this group to develop into a national forum to further the convergence agenda in India. Additional national meetings will therefore be used to forge a multi-sectoral working group which will include the donor community and which will take forward the convergence agenda in India. PATH will facilitate this working group, assist in defining its role and the specific tasks it will undertake. It is anticipated that the working group will leverage additional funding support for convergence in India,

Evidence on convergence from four states ... will also provide a more powerful platform for advocacy at the national and state level

The PATH Convergence Project

support the development of policy around convergence and help guide service providers.

Following the assessment, policy briefings and guidelines for implementing convergence will be developed and final district/state and national workshops will be held to assist policy makers and service providers plan next steps around convergence.

It is envisaged that this work will generate feasible models of convergence that can be scaled up. From the study, recommendations will be made for selected convergence options to be implemented. Criteria for selecting these convergence pilots will include low cost, ease of implementa-

tion and benefit to people at risk of HIV and unintended pregnancy. Where service providers are able to act on these recommendations, PATH will assist to monitor and assist for funding for convergence pilots selected for implementation. PATH will draft reports detailing lessons learned by the end of the project period for replication and scale up.

It is anticipated that over time, findings from this project will contribute to increased awareness of and access to more holistic sexual and reproductive services for those at risk of HIV and unintended pregnancy, including sex workers and people with HIV.

SRH-HIV CONVERGENCE: A DRAFT LITERATURE REVIEW

Abstract

The HIV/AIDS pandemic has compelled the fields of sexual and reproductive health (SRH) and HIV/AIDS to better leverage their strengths. This paper reviews the literature and explores possibilities for convergence in the SRH and HIV fields. Integrated access to essential SRH care in HIV prevention, care, and treatment programs, and appropriate forms of prevention and treatment of HIV/AIDS in SRH services are highlighted. The feasibility of convergence is outlined through an examination of the potential opportunities and existing barriers to different types of linkages between SRH and HIV services.

Summary

Converging SRH and HIV referrals, communications, and services can provide opportunities for increased value to clients, providers, and programs. This includes, amongst others, strengthening the prevention of unintended pregnancy and HIV infection, expanding target population reach, and increasing program efficiency. Existing barriers to convergence that have been identified include weakened health systems, vertical programs, and administrative bureaucracies. Successful convergence necessitates strengthened commitment by governments, donors, NGOs, and civil society alike to identify and scale up effective models.

Introduction to Convergence

The AIDS epidemic has emphasized the urgent need for the HIV/AIDS field and SRH field to better coordinate efforts to prevent sexual transmission of HIV, apply gender perspectives to HIV/AIDS programs, and provide SRH services to HIV positive couples (Kaufman and Messersmith, 2005). Such coordination can create a synergistic impact by leveraging the strengths of both fields in policy and service provision (WHO, 2004). Further, the fields of SRH and HIV have much in common. Sexual and reproductive health and HIV services require access to the same population – i.e., people who are sexually active. In addition, providers of these services require similar skills for addressing the needs of their clients and both aim at modifying sexual behavior. Condoms and other barrier methods are common technologies available for the prevention of HIV/AIDS, sexually transmitted infections (STIs), and also for the prevention of unwanted pregnancies. Finally, since HIV/AIDS and STIs can seriously affect the health of the mother and newborn child, their diagnosis and management during pregnancy is particularly important (Pachauri, 1994).

As the interrelationships between HIV and other STIs have become increasingly clear, there has also been a growing concern to find ways to integrate these programs. Moreover, a strong case is made for convergence of HIV/AIDS and STI prevention efforts with those of programs designed to address other SRH needs of women and men, such as family planning (FP) and maternal and child health (MCH). As will be discussed in subsequent sections, converging SRH and HIV services may lead to many opportunities for increased value to clients, (e.g., through support for dual protection¹ among couples); to providers, (e.g., by enabling staff to offer more convenient, comprehensive services to expanded population groups); and to programs (e.g., through benefits of enhanced cost-effectiveness and efficiency in service delivery).

The term 'convergence' is beginning to be widely used in the context of SRH and HIV services both by the national AIDS control organization (NACO) and the ministry of health and family welfare² (MoHFW) in India. In international fora, there is

disagreement about whether this should mean services just having links with one another, or a full integration of SRH and HIV services. From what is already known, it is likely that the type of convergence of these two programs will vary depending on the context. There is, therefore, an urgent need to research the opportunities and challenges, benefits and barriers in convergence of SRH and HIV programs and to develop practical models for convergence in different contexts.

Types of Convergence

The operational meaning of the term "convergence" is dependent upon the nature and content of the particular HIV and SRH components that services want to link to or integrate. Convergence can mean mutual referrals between SRH and HIV services. It can also mean providing HIV communications within an SRH setting and vice versa [e.g. behavior change communication (BCC), interpersonal communication (IPC), and counseling]. At a more comprehensive level, HIV and SRH services (as well as referrals and communications) can be converged with one another [e.g., by providing anti-retrovirals (ARV) through antenatal and post-natal care].

Broadly, three types of convergence have been identified by WHO (1996) – convergence of different health services (horizontal and vertical integration), convergence of management, administrative, and support functions, and convergence of activities of different sectors – as outlined below³.

Horizontal integration of services could entail:

- Converging existing health programs (e.g., FP and MCH).
- Adding new health programs to existing ones (e.g., converging HIV/AIDS prevention with FP). For example, projects in the Philippines, Bangladesh, and Indonesia have successfully integrated STI services into FP services, and thereby increased treatment of STIs and clinic attendance (Murthy, 2005).

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1. Dual protection is protection against both unintended pregnancy and STIs, including HIV. For sexually active individuals, a condom is the only device that is effective for dual protection. Dual protection can also be achieved by using condoms with another method of contraception, referred to as dual method or double protection. Source: <<http://glossary.ippf.org/GlossaryBrowser.aspx>> [Accessed March 4, 2006].

2. Source: Ministry of Health and Family Welfare <<http://mohfw.nic.in/Convergence%20plan%20between%20NACP%20and%20DOHFW.htm>> [Accessed March 6, 2006]

3. Adapted from WHO (1996)

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Types of Convergence

Vertical integration of services could entail:

- Integrated provision of different health services at primary, secondary, and tertiary administrative levels.
- Provision of health services to integrated population groups (e.g., provision of FP to adolescents, in addition to adults).
- A combination of the above. For example, the governments of Pakistan, China, Sri Lanka, and Indonesia have sought to provide reproductive health (RH) services through multiple delivery points (e.g., primary health clinics, FP/MCH clinics, and reproductive tract infection clinics), with implementation varying across the kind of clinics (Sayeed, 1999).

Convergence of management, administrative, and support functions. This could involve convergence of planning, budgeting, information systems, human resource development, and research. Administrative convergence may occur at national, provincial, district, local, or other levels. It may be accompanied by merger of different health departments (e.g., family welfare with public health departments).

Convergence of activities of different sectors. This may involve either the integration of activities of differ-

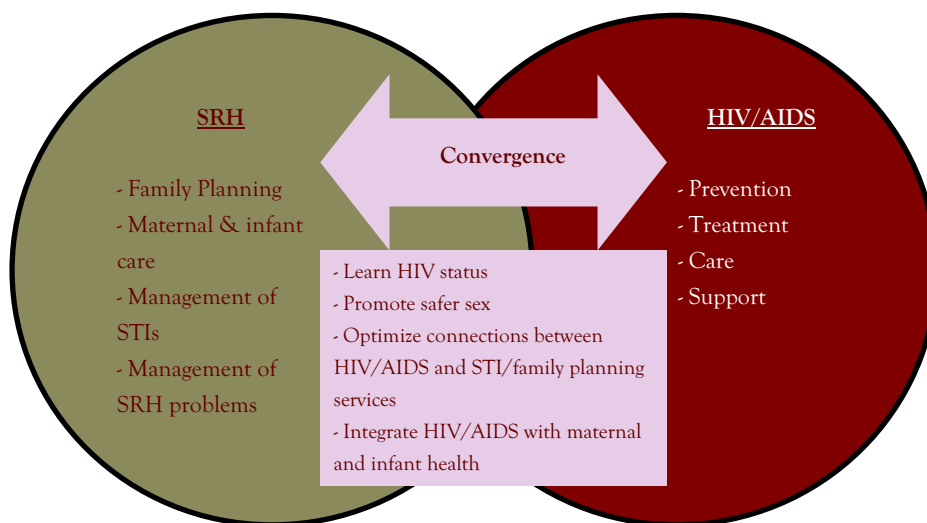
ent sectors within health services (public and private health sector) or across sectors (health, water, housing, social welfare etc.). For example, health reforms in the Philippines have promoted inter-sectoral (e.g., health, water, roads, and bridges) planning at district level in the context of decentralization. However, evidence from the Philippines example suggests that while decentralization may be important for convergence, district level governance may not always prioritize SRH issues appropriately or promote effective integration across all levels of health-care as a consequence of decentralization (Murthy, 2005).

Directions of SRH and HIV Convergence

Following the International Conference on Population and Development (ICPD) a lot of interest has been generated in converging HIV prevention and treatment services with contraception, maternal and sexual health. Several studies around the world indicate that current patterns of convergence vary considerably (Bastos, 1992; Finger and Barnett, 1994; Lande, R., 1993) based on whether the focus is on convergence of HIV issues into ongoing SRH programs, or conversely SRH issues into HIV programs (e.g., see Figure 1).

DIRECTIONS OF SRH AND HIV CONVERGENCE

Figure 1



Directions of SRH and HIV Convergence

Convergence of HIV into Existing SRH Services

The potential benefits of converging HIV prevention and treatment with existing SRH issues, such as Family Planning (FP) are apparent (Network, 2004). Evidence from pilot projects conducted in India, Côte d'Ivoire, and Ethiopia suggest that integrating voluntary counseling and testing (VCT) into reproductive health services can reduce stigma associated with HIV, increase access to and use of VCT services, and reduce the cost of establishing VCT services (Myaya, 2004).

A comprehensive review by the World Health Organization (1999) found that integration of STI prevention components may enhance MCH/FP objectives by improving FP service quality, providers' attitudes, and communication skills. This was despite initial concerns that an integrated approach may overburden staff (O'Reilly et al., 1999; WHO, 1999). It was also shown that converged services improved user satisfaction, in part because such services provided a comprehensive response to their needs and an opportunity to discuss sexual and gender relations.

Among efforts to converge HIV with SRH services, in Kenya, a large collaborative initiative to develop and implement a national strategy to integrate services is well under way. Kenya is a promising setting for integration because it has adopted STI management in primary healthcare as part of its national policy (Shelton, 1999). While governmental support has been a major first step toward facilitating the convergence process in Kenya, continued progress requires overcoming a number of challenges (Network, 2004; see also Lush et al., 1999). For example, the ministry of health's (MoH) national AIDS and sexually transmitted diseases (STD) control program (NASCOP) and division of reproductive health conducted a country-wide study, which found that integration was generally acceptable to providers, but only some centers were ready to implement it for reasons related to a lack of technical knowledge (see Reynolds et al., 2003).

The ability of providers in low-resource settings to detect and treat STIs in women is severely limited by the lack of simple, affordable assessment techniques (Network, 2004). In these circumstances, syndromic management of STIs, which involves recognizing and treating STIs based on patient symptoms, is recommended. The findings regarding the utility of syndromic management of STIs have been less encouraging, however (Sloan et al., 2000). Syndromic management of STIs fails to identify a substantial proportion of women who are usually asymptomatic with infections such as Gonorrhea and Chlamydia. This is of particular concern because Gonorrhea and Chlamydia account for 45 per cent of curable cases of STIs per

year and can have severe consequences for pregnant women if untreated (WHO, 1984a). This is also significant as research on the relationship between HIV and other STIs reveals that the sexual transmission of the virus may be facilitated by the presence of other STIs (Piot et al., 1990). Nevertheless, as successfully modeled in the case of a Zimbabwe study (see Maggwa et al., 1999), FP and MCH providers have a significant role to play in screening clients syndromically, and then using laboratory tests for those suspected of infection.

Some successes with educating FP users about STIs have also been noted. For example, one project in Mexico informed FP users about contraceptive methods and also encouraged them to consider personal STI/HIV risk factors (Lazcano et al., 2000). The women who chose a contraceptive method themselves were more likely to choose condoms than those whose method choice was based on the physician's advice. The study concluded that giving women sufficient information to assess their own risk before choosing a contraceptive method may be (at least) as effective as providing risk assessment techniques for providers to use.

Anecdotal evidence suggests that in most instances, HIV services are integrated into existing SRH services rather than the other way around. This is because SRH services were developed within government health structures, whereas many HIV services were established as parallel structures and are often considered unsustainable (Gruskin and O'Malley, 2006). Nevertheless, there are several advantages to integrating SRH services into HIV as noted in the literature.

Convergence of SRH into HIV Services

Literature on convergence suggests that SRH services also have a great deal to contribute to HIV prevention and treatment (Berer, 2004). Closer links between SRH programs and HIV/AIDS related services, e.g., through two-way referral links rather than parallel efforts, represent a promising convergence opportunity. Ensuring safe pregnancy and delivery is a high priority for SRH services, and the urgency is reinforced by the possibility of adverse fetal and infant outcomes in the pres-

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Convergence of SRH into HIV Services

ence of STIs as well as risks of HIV transmission to infants during delivery. In an effort to integrate treatment and care for those with HIV and antenatal and delivery services, some programs have developed referral linkages with existing HIV/AIDS services run by national and international NGOs for long-term support. The Ndola Demonstration Project in Zambia and the “mother-to-child transmission (MTCT)-Plus” initiative established in 2001, coordinated by Columbia University to develop strategies for organizing sustainable referral links, are illustrations of efforts to create such linkages.

Research suggests that sexual and reproductive health needs of people living with HIV/AIDS have tended to relate almost exclusively to women’s needs for services to prevent MTCT of HIV (see Gruskin and O’Malley, 2006). However, with access to highly active antiretroviral treatment (HAART), it has become feasible for increasing numbers of positive people to lead healthy sex lives and have children. HIV positive women on HAART who want to use FP need to be informed about the increase or decrease in effectiveness of contraceptives with anti-retroviral (ARV) drugs as well as possible drug interactions (Public Health Service Task Force, 2003). Further, post-abortion care should be made available particularly where abortion services are illegal and unsafe abortion is widespread. For example, although abortion is illegal in Thailand, out of 49 positive women interviewed, who became pregnant, 28 chose to have an abortion (Institute for Population and Social Research, 1999-2001 study). Two of the main reasons cited for not wanting children included fear of having an infected child and fear of having an uninfected child and not knowing who would care for it. It is only in recent years that the sexual and reproductive health needs of positive people have begun to be recognized.

Sexual and reproductive health programs have traditionally tended to reach adult, married women. While HIV/AIDS oriented programs have typically adopted specialized approaches to reach those population groups whose practices put them at risk of HIV (and STIs). It is suggested that a greater effort “to develop [SRH and HIV]

services in tandem” (Askew and Berer, 2003, 65), could ensure that together these programs expand coverage of SRH and HIV prevention, care, and treatment services to population groups, like men, unmarried women, and youth.

Opportunities for involving men in antenatal and FP consultations are now being researched in South Africa, India, Zimbabwe, and Nigeria. Since gender inequalities tend to favor men and sexual and reproductive health decisions are made by them, there is growing realization that unless men are reached, program efforts will have limited impact. For example, research on sexual negotiation for HIV prevention has highlighted the inadequacy of strategies that target only women (Bujra and Baylies, 2001). Other examples highlight the need to redefine the role of young people in the process of translating HIV prevention programs and reproductive health rights into realities of their lives (Singh, 1999). The International Planned Parenthood Federation (IPPF) through its national affiliates has experimented with programs to promote involvement of men and young people (Nadkarni, 2002). The Family Planning Associations (FPAs) in Brazil, Honduras, and Jamaica have organized STI prevention campaigns for men in factories and community settings, as well as for adolescents in school and non-school settings (AIDS, 1996). Other feasibility and acceptability strategies to make clinic settings more “youth friendly” are also being explored (Dickson-Tetteh et al, 2001; Senderowitz, 1997), for example, for young people at elevated risk of HIV in Sub-Saharan Africa, Latin America, and Asia (Dehne and Riedner, 2001).

From the review of the literature it is evident that the direction of SRH-HIV convergence (i.e., convergence of HIV services into existing SRH services or vice versa) has important implications for the populations who will access services, the likelihood that healthcare providers will have the required knowledge and skills, and how the program services will be perceived within the community. Recent literature points to the promise of models of convergence that lie between these two extremes of directionality. It is suggested that the focus of convergence should expand beyond just integration and linkages of SRH and HIV, to methods used to ensure integration and linking of both SRH and HIV with primary health care (PHC) systems. The value of multiple health system entry points for different populations has long been recognized and is reflected in clinics that emphasize one set of services or another (see Gruskin and O’Malley, 2006).

Benefits and Challenges of Convergence

It is evident that some amount of progress has been made in this area of SRH-HIV convergence (Haberland and Measham, 2002). One success story that is frequently cited in the literature is the experience of Thailand. It is the only country to provide HIV/AIDS testing and treatment in all provisional hospitals. Hospitals in Thailand also provide abortion services and treatment of reproductive malignancy. Contraceptive and maternal health coverage is comparatively high, and a wide range of contraceptive choice is available through community clinics (Murthy, 2005). The Thai government's commitment and strong leadership have been factors critical to success.

Unlike with the Thai example, much of the credit for sustaining efforts initiated by the government to translate the ICPD Program of Action in India goes to advocacy efforts by many stakeholders, such as the NGOs, the private sector, and the community. NGOs in India have been particularly effective in pioneering innovative ways to provide quality services that are responsive to the needs of the community (Pachauri, 1994). *Panchayats*⁴ are also being seen as important community partners to involve in the process of convergence. Potentially, they repre-

sent a strong political force in decision-making at the grassroots. It is strongly argued that if constitutionally mandated structures of local governance could be strengthened, they could catalyze a process of empowerment for the disempowered, and thereby, create demand and accountability of efforts initiated to address sexual and reproductive health needs, including family planning and HIV/AIDS (Pachauri, 1999). The India experience underscores the need for collaboration by multiple stakeholders to sustain progress in the area of convergence (Pachauri, 2000).

While much still remains to be learnt about which SRH-HIV linkages will have the greatest impact, and how best to strengthen selected linkages in different program settings, there is growing consensus that additional commitment is needed to identify effective models and implement convergence. Careful priority setting and judicious program implementation promises to reap a number of important client, provider, and program consequences of convergence (see Table 1). Scarce resources need to be stretched to provide additional health benefits through convergence. At the international level strong leadership is needed to make

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Table 1

POTENTIAL BENEFITS OF SRH-HIV CONVERGENCE⁵

Client	Provider	Program
<ul style="list-style-type: none"> - Improved access to, and uptake of key SRH and HIV/AIDS services - Better access of people living with HIV/AIDS to SRH services tailored to their need - Reduced HIV/AIDS related stigma and discrimination - Greater support for dual protection against unintended pregnancy and STIs - Improved quality of care and greater satisfaction 	<ul style="list-style-type: none"> - Increased training and capacity of service providers - Improved provider knowledge and skills - Increased ability to meet client needs - Improved coverage of underserved and high risk populations, such as sex workers or men who have sex with men, with SRH services 	<ul style="list-style-type: none"> - Enhanced program effectiveness - Increased program efficiency - Cost and time savings through reduced duplication of service delivery functions - Expanded provision of health services across levels of health-care and different areas

Source: Berer, 2003; Moorman et. al, 2003; Murthy, 2005; Pachauri, 1994; Wasserheit and Holmes, 1992;

4. *Panchayat* refers to a council of elected members taking decisions on issues key to a village's social, cultural and economic life. Source: <<http://en.wikipedia.org/wiki/Panchayat>> [Accessed March 3, 2006].

5. Note: This is not intended to be an exhaustive list of benefits of convergence, but rather an illustration of some of the types of potential benefits to clients, providers, and programs from successful SRH-HIV integration.

The cost-effectiveness of convergence depends upon several factors, including clients' needs, HIV prevalence levels, and local resource settings.

Benefits and Challenges of Convergence

a difference. At the national levels, bureaucratic, top-down administrative systems and policies need to be replaced with planning which is people-centered (Pachauri, 2000).

A review of policies on convergence of health services in Asia (Murthy, 2005) found that a lack of administrative integration of SRH departments due to missing political will of policy makers was a critical barrier to convergence. The same study linked poor health infrastructure (e.g., in India, Nepal, Pakistan, Bangladesh, and the Philippines) and deteriorating health infrastructure (e.g., China, Cambodia, and Vietnam) to gaps in integration of SRH and HIV services. At the service delivery level the perception is that convergence often requires additional costs for training staff in STI management, HIV counseling, for delivery of MCH and FP services and for maintaining physical infrastructures, which challenge the implementation of convergence (Lush, 2002).

The cost-effectiveness of convergence depends upon several factors, including clients' needs, HIV prevalence levels, and local resource settings (USAID, 2003; Caldwell and Caldwell, 2002). Recent guidelines issued by the U.S. agency for international development (USAID) suggest that convergence may not be appropriate in countries where the HIV epidemic is concentrated, and HIV services specifically targeting individuals at highest risk of HIV infection are needed. Integrating services in such settings is unlikely to be cost-effective (USAID, 2003). The argument against convergence is also made in case of resource poor settings (e.g., Africa), where HIV has reached high prevalence levels and special attention is demanded by donor agencies (Caldwell and Caldwell, 2002). Program planners need to consider the feasibility of convergence based on estimations of whether the additional costs of converging SRH and HIV services are offset by the gains in efficiency and effectiveness of programs. It is also important to examine the parameters used in any cost-effectiveness analysis. For example, while addressing gender inequity may not be cost-effective either in terms of HIV prevention outcomes or SRH outcomes, it may nevertheless be cost-effective when additional benefits (for example, to hygiene, educational and economic development outcomes) are also taken into account.

A further strain on resources is also often imposed by donors who insist on separate systems of implementation and monitoring of expenditures

for projects they support. International donors form an active group in the convergence policy arena. And though many bilateral and multilateral donors are currently interested in convergence, they too have had separate departments for HIV and SRH, and have had separate funding programs and agendas for each (Berer, 2003b). Overstretched resources further impede integration by competition for limited funding from SRH and HIV 'camps' when attention is shifted to linking these issues (Berer, 2004). The responsibility for programs, budgets, and funding for SRH and HIV/AIDS continue to remain separated in most national health systems, and vertical programs have been maintained in spite of the support for integrated approaches.

Today, there is a growing recognition from both the SRH and HIV fields that "their issues overlap, [but] practical concerns limit the pace of strategy, policy, and program integration" (O'Malley, 2004, 63). While it is evident that "a single blueprint [for convergence] is unlikely to be appropriate" (Lush, 2002, 72), there is consensus that together governments, donors, NGOs, and civil society need to strengthen their commitment to take advantage of increased value opportunities offered by convergence models. Strategies for convergence need to be designed based on conceptualizations of SRH-HIV interventions, the populations they serve, the health systems that support them, and the demands of local contexts. These models of convergence would benefit the sustainability and effectiveness of both SRH and HIV programs, and allow each field to learn from the other.

REFERENCES

- AIDS (1996) *HIV Prevention and Family Planning: Integration Improves Client Services in Jamaica*. II (3).
- Askew, I. and Berer, M. (2003) *The Contribution of Sexual and Reproductive Health Services to the Fight Against HIV/AIDS: A Review*. Reproductive Health Matters. 11 (22): 51-73.
- Bastos dos Santos, R. (1992) *Reproductive Tract Infections in Mozambique: A Case Study of Integrated Services*. In Gemain, A. ed., Reproductive Tract Infections, New York: Plenum Press.
- Berer, M. (2003) *Integration of Sexual and Reproductive Health Service: A Health Sector Policy* [Editorial]. Reproductive Health Matters, 11(21),

6-15.

Berer, M. (2003b) *HIV/AIDS, Sexual and Reproductive Health: Intimately Related* [Editorial]. *Reproductive Health Matters*, 11, 6-11.

Berer, M. (2004) *HIV/AIDS, Sexual and Reproductive Health: Intersections and Implications for National Programs*. *Health Policy and Planning*, Volume 19 (Supplement 1), 62-70.

Bujra, J. and Baylies, C. (2001) *Targeting Men for a Change*. Research Highlights. Available at: www.id21.org/static/insights35art2.htm.

Caldwell, J. and Calwell, P. (2002) *Is Integration the Answer for Africa?* *International Family Planning Perspectives*, 28 (2).

Dehne, K.L. and Riedner, G. (2001) *Sexually Transmitted Infections among Adolescents: The Need for Adequate Health Services*. *Reproductive Health Matters*, 9 (17), 170-179.

Dickson-Tetteh, K., Pettifor, A., and Molek, W. (2001) *Working with Public Sector Clinics to Provide Adolescent-Friendly Services in South Africa*. *Reproductive Health Matters*, 9 (17), 160-169.

Finger, W.R. and Barnett B. (1994) *Regional Perspectives*. *Network*, 14 (4), 22-25.

Gruskin, S. and O'Malley, J. (2006) *Reproductive Choices for Women and Men Living with HIV*. Department of Reproductive Health and Research UNDP/UNFPA/WHO/World Bank Special Program of Research Development and Research Training in Human Reproduction.

Haberland, N. and Measham, D. (2002) (editors) *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning*. Population Council: New York.

Institute for Population and Social Research, *HIV Positive Women in Thailand: Their Voices and Choices*. The International Community of Women Living With HIV/AIDS (ICW), Institute for Population and Social Research, Faculty of Nursing (Khon Kaen University), The Power of Life Support Group. In S. Gruskin and J. O'Malley, *Reproductive Choices for Women and Men Living with HIV*. Department of Reproductive Health and Research UNDP/UNFPA/WHO/World Bank Special Program of Research Development and Research Training in Human Reproduction (2006). Available at http://www.icw.org/files/Voices_and_Choices_Thailand.pdf [Accessed March 1, 2006].

Kauffman, J. and Messersmith, L. (2005) *Integrating the Fields of Sexual and Reproductive Health and HIV/AIDS*. Working Paper. Harvard University, Cambridge, MA.

Lande, R. (1993) *Sexual and Reproductive Health: What are the Possibilities?* *Planned Parenthood Challenges*, 2, 19021.

Lazcano Ponce, E.C., Sloan, N.L., Winikoff, B., Langer, A., Coggins, C., Heimbürger, A., Conde-Glez, C.J., Salmeron, J. (2000) *The Power of Information and Contraceptive Choice in Family Planning in Mexico*. *Sexually Transmitted Infections*, 76 (4), 277-281.

Lush, L. (2002) *Service Integration: An Overview of Policy Developments*. *International Family Planning Perspectives*, Volume 28 (2), 71-76.

Lush, L., Cleland, J., Walt, G. and Mayhew, S. (1999) *Integrating Reproductive Health: Myth and Ideology*. *Bulletin of the World Health Organization*, 77 (9).

Maggwa, B.N., Askew, I.D. Marangwanda, C. et. al (1999) *Demand for and Cost-Effectiveness of Integrating RTI/HIV Services with Clinic-Based Family Planning Services in Zimbabwe*. Nairobi: Population Council, 1999.

Moorman, J., Murthy, R.K., and Weller, S. (2003) *Integration of Sexual and Reproductive Health Services, Africa, Asia, and Latin America*. Paper prepared for the Initiative for Sexual and Reproductive Rights in Health Sector Reforms, Women's Health Project, South Africa.

Murthy, R.K. (2005) *The Implications of Integration for Sexual and Reproductive Health Services in Asia*. Available at: www.wits.ac.za/whp/rightsandreforms/docs/integrationasia.pdf [Accessed on March 6, 2006]

Myaya, M. (2004) *Integrating Voluntary Counseling and Testing Services into Reproductive Health Settings: Stepwise Guidelines for Program Planners, Managers, and Service Providers*. London, England: International Planned Parenthood Federation South Asia Regional Office and United Nations Population Fund.

Nadkarni, V. (2002) *Integration of STI/HIV/AIDS in Family Planning Services: The FPA Experience*. *The Journal of Family Welfare*, Volume 48, Special Issue, 6-21.

Network (2004) *Integrating Services*. Volume 23, Number 3, The Family Planning/HIV Collabora-

tive Series, Family Health International.

O'Malley, J. (2004) *Can this Marriage Work? Linking the Response to AIDS with Sexual and Reproductive Health and Rights*. Online Newsletter: Countdown 2015: ICPD at 10, Fall, 59-63.

O'Reilly, K., Dehne, K., Snow, R. (1999) *Should Management of Sexually Transmitted Infections be Integrated into Family Planning Services: Evidence and Challenges*. *Reproductive Health Matters*, 7 (14), 49-59.

Pachauri, S. (1994) *Relationship between AIDS and Family Planning Programs: A Rationale for Developing Integrated Reproductive Health Services*. *Health Transition Review*, Supplement to Volume 4, 321-347.

Pachauri, S. (1994a) *Reaching India's Poor: Non-Governmental Approaches to Community Health*. New Delhi: Sage Publications.

Pachauri, S. (1999) *Moving toward Reproductive Health: Issues and Evidence. Implementing a Reproductive Health Agenda in India: The Beginning*. Pages 340. Population Council, New Delhi, India.

Pachauri, S. (2000) *Round Table on HIV/AIDS, Malaria, Tuberculosis, and Poverty Reduction*. Paper prepared for Round Table on HIV/AIDS, Malaria, Tuberculosis, and Poverty Reduction. September, Belgium, Brussels.

Piot, P., Laga, M., Ryder, R., Perriens, J., Temmerman, M., Heyward, W., and Curran, J.W. (1990) *The Global Epidemiology of HIV Infection: Continuity, Heterogeneity, and Change*. *AIDS* 3, 403-412.

Public Health Service Task Force (2003) *Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Intervention to Reduce Perinatal HIV-1 Transmission in the United States*. Rockville, MS; U.S. Department of Health and Human Services; Sperling R.S., Shapiro, D.E., and McSherry, G.D. et al. Safety of the Maternal-infant Zidovudine Regimen Utilized in the Pediatric AIDS Clinic Trial Group 076 Study. *AIDS*, 1998; 12 (14): 1805-1813.

Reynolds, H.W., Liku, J., Maggwa, N.B., et. al (2003) *Assessment of Voluntary Counseling and Testing Centers in Kenya: Potential Demand, Acceptability, Readiness, and Feasibility of Integrating Family Planning Services into VCT*. Research Triangle Park, North Carolina: Family Health International.

Sayeed, H. (1999) *Country Study of Pakistan*. In ARROW (ed.) *Taking up the Cairo Challenge: Country Studies in Asia and Pacific*, ARROW, Malaysia.

Senderowitz, J. (1997) *Reproductive Health Programs for Young Adults: School-based Programs*. Washington, D.C.: Pathfinder International.

Shelton, J.D. (1999) *Prevention First: A Three-Pronged Strategy to Integrate Family Planning Program Efforts Against HIV and Sexually Transmitted Infections*. *Family Planning Perspectives*, 25 (3).

Singh, S. (1999) *Youth: A Resource for Today and Tomorrow*. In S. Pachauri and S. Subramanian (eds.) *Implementing A Reproductive Health Agenda in India: The Beginning*. Population Council, New Delhi, India.

Sloan, N. Winikoff, B., Haberland, N., Coggins, C., and Elias, C. (2000) *Screening and Syndromic Approaches to Identify Gonorrhea and Chlamydial Infection Among Women*. *Studies in Family Planning*, 31 (1), 55-68.

U.S. Agency for International Development (USAID) *Family Planning/HIV Integration: Technical Guidance for USAID-Supporting Field Programs*. Washington, D.C.: USAID, 2003.

Wasserheit, J.N. and Holmes, K.K. (1992) *Reproductive Tract Infections: Challenges for International Health Policy, Programs, and Research*. Pages 7-34 in *Reproductive Tract Infections: Global Impact and Priorities for Women's Reproductive Health*, ed. A. Germain, K.K. Holmes, P. Piot, and J.N. Wasserheit, New York: Plenum Press.

World Health Organization (1996) *Integration of Health Care Delivery*. WHO Technical Report Series, 861. Geneva: Switzerland.

World Health Organization (1984a) *Simplified Approaches for Sexually-Transmitted Diseases (STD): Control at the Primary Health Care (PHC) Level*. Working Group Report. World Health Organization, 1984: Geneva.

World Health Organization (1999). Dehne, K.L. and Snow, R. *Integrating STI Management Services into Family Planning Services: What are the Benefits?* World Health Organization, 1999: Geneva.

World Health Organization (2004) *The Glion Call for Action on Family Planning and Prevention of Mother-to-Child Transmission*. Glion, Switzerland, May 3-5.

WHO/UNFPA/UNAIDS/IPPF (2005) *Sexual and Reproductive Health and HIV/AIDS: A Framework for Priority Linkages*. Available at: <<http://www.who.int/reproductive-health/stis/linking.html>> [Accessed on February 25, 2006].



Report on State-Level Meetings on SRH-HIV Convergence

Four State-level meetings on SRH, HIV service convergence were held – in Bihar (Patna) on March 10, 2006, in Andhra Pradesh (Hyderabad) on March 13, 2006, in Maharashtra (Mumbai) on March 18, 2006, and in Uttar Pradesh (Lucknow) on April 18, 2006. The objectives of the meetings were to bring together NGO and government stakeholders to begin to develop a common understanding of what is meant by convergence, to explore state policy on convergence, to share examples of SRH/HIV service convergence and to orient participants to the PATH Convergence Project..

March 10, 2006: Bihar (Patna) State-level Meeting:

The Bihar meeting was attended by 51 participants the majority of whom were from local NGOs working with women, children and adolescents. Representatives from Pathfinder International, who are working in three districts of Bihar on family planning and SRH issues through a number of local NGOs, were also present at the meeting.

Mr. Surinder Prasad Singh, the new Project Director Bihar State AIDS Control Society (BSACS), attended the meeting and agreed that convergence of SRH and HIV services was needed particularly in Bihar. Dr. Geetanjali Kumari (Additional Director BSACS) and Ms Sarita Singh (NGO Coordinator Bihar State Health Society) also made presentations about the Bihar Government's ideas for convergence. Sharing the latest reports from a state-wide mobile awareness-cum-testing (MAT) campaign (the first of its kind conducted in Bihar), Dr. Geetanjali Kumari stated that in many districts of Bihar, the HIV sero-prevalence was found to be more than 1% for the general population – with Sitamarhi district having the highest sero-prevalence of 3.7%.

Participants from NGOs also spoke about the need for convergence and presented some of the benefits of convergence and some barriers to achieving convergence for the State. In particular the presentation from Gramin Evam Nagar Vikas Parishad made a strong case for converging and integrating SRH and HIV services.

It was noted that in Bihar, however, it may be difficult to access people with HIV as the Bihar Network of Positive People is in its infancy and stigma and discrimination against people with HIV is high. Similarly, very few NGOs work with sex workers on HIV/AIDS issues. These may be important challenges for the Convergence Project in Bihar.

March 13, 2006: Andhra Pradesh (Hyderabad) State-level Meeting

The Andhra Pradesh meeting was attended by 59 participants – the majority of whom were from the NGO sector, including NGOs from Srikakulam district of A.P. Government representation at the meeting was very strong – Dr. CBS Venkata Ramana, Joint Commissioner Health and Family Welfare (Government of A.P.), Dr. P Somasekhar Reddy, Director Health Services (Government of A.P.), Ms. K Damayanthi, Project Director Andhra Pradesh State AIDS Control Society (APSACS) and Ms Anita Rego, Project Support Unit APSACS attended the meeting and made important presentations. A sizeable number of NGOs who work with sex workers and people with HIV attended the meeting. In addition to local NGOs, representatives from the International HIV/AIDS Alliance, HLFPT, and Oxfam also attended the meeting.

Convergence of SRH and HIV services is already being discussed within the government departments and at the level of health policy-makers in A.P. From discussions, it was apparent that the Principal Secretary Health and the Minister of Health A.P. Government were also on board.

The Commissioner of Health and Family Welfare Department, Dr. Ramana pointed out that resource allocation and stigma and social issues may hamper or preclude successful convergence of SRH and HIV services in the state. He also pointed out that the Reproductive Child Health Programme did not have the same client base addressed by the State AIDS Control program.

In her presentation, Ms. Damayanthi the Project Director APSACS made an impassioned plea to at least initiate piloting of convergence in 10 high HIV prevalence districts of A.P. She said that it was vital to make an attempt to converge services and promised that she would try and procure additional funds to supplement and support the state government's efforts.

NGO participants also agreed during the group discussion that followed, that while there were significant barriers to convergence vis-à-vis conceptual clarity, overcoming stigma, appropriate resource allocation and sustainability of initial effort, converging of SRH and HIV services would lead to better service reach, improved outcomes, be cost-effective in the long run and reduce stigma and discrimination around

HIV/AIDS.

March 18, 2006: Maharashtra (Mumbai) State-level Meeting

The Maharashtra meeting was attended by 29 participants – all from the NGO sector. Among NGOs present, there were groups who worked with sex workers, with people with HIV and also with migrant workers.

Representatives from the government sector could not attend the meeting as the Maharashtra Assembly was in session that weekend. Because of this the PATH Convergence Team had met earlier with senior officials of the Bureau of Family Welfare, Dept. of Health, Maharashtra State AIDS Control Society (MSACS) and Mumbai District AIDS Control Society (MDACS). They had welcomed PATH's initiative on convergence issues and had wished the meeting success.

At the meeting, Dr. Kalpana Apte, representative from Family Planning Association of India (FPAI) made a presentation on convergence in action, showing the model FPAI is implementing. She pointed out their successes and the barriers and constraints they have encountered.

Dr. Goud, of the SOS Foundation Nashik presented their thoughts on the barriers and challenges as well as the benefits of convergence and pointed out the possible next steps for NGOs.

Ms Nutan Zarakar, Project Management Specialist for USAID (Mumbai Office) who attended the meeting, expressed interest in the PATH Convergence research and in the probable models of convergence that will emerge. She agreed to facilitate a meeting of all relevant government departmental secretaries as an immediate next step.

During the group discussion, NGO participants agreed that convergence would lead to cost-optimization, reduce stigma and discrimination and increase the reach of service delivery. They also highlighted the challenges, which included defining roles and responsibilities, building capacities and altering attitudes of field staff, sustainability of effort, etc.

April 18, 2006: Uttar Pradesh (Lucknow) State-level Meeting:

The Uttar Pradesh meeting was attended by 50 participants representing NGOs and civil society organisations. A majority of the participants worked with women, a few with adolescents and about 3 or 4 organisations said they worked with sex workers.

In addition to health sector organisations, participants included representatives from the UP Mahila Samakhya and the UP Total Literacy Mission. Two representatives from the UP Network of Positive People attended the meeting and participated actively in the group discussion and during the Q&A session. Representatives from SIFPSA and Naz Foundation International also attended the meeting.

The UP Government health sector was represented by Dr. Nayyara Shakeel (Jt. Director RCH, Directorate of Family Welfare, GoUP), Dr. Mridula Sharma and Dr. Rajeev Choudhry (Assistant Directors, UPSACS) and Professor M.Z. Idris (Head of the Dept. of Community Medicine, King George Medical University).

Ms Jashodhara Dasgupta of Sahayog (a civil society organisation) presented an overview of the possible areas of convergence in UP that included integrating services at PHC level and bringing in gender and rights-based perspectives into SRH and HIV services. She said barriers to convergence included vertical programming, crumbling PHC infrastructure and services, stigma and target-based monitoring.

Mr. Khushwant Singh of Ankur Yuva Chetna Shivir said barriers to convergence in UP included (a) a rigid government system with breakdown in the supply cycle, (b) taboos around SRH/HIV issues and (c) undefined and undiagnosed areas of high-risk activity for HIV. He added that convergence of SRH/HIV services would be more cost-effective, increase access to services, help reduce gender and power imbalances, increase community ownership and lead to sustainable impact.

Representatives of FPAI (UP) shared some of their findings from an exploratory study on HIV/AIDS in 5 districts of UP. They shared that their study revealed that in UP, awareness of HIV was varied among different sub-groups of population.

Dr. Rajeev Chowdhry (Asst. Director) UPSACS provided a brief overview of the work of UPSACS saying that number of targeted interventions was proposed to be increased from 21 to 60 within the year, and that plans were to have VCT services at all 273 CHC in the state.

Dr. Nayyara Shakeel (Jt. Director, RCH) Dept. of H&FW, GoUP shared that under RCH-II Programme, RTI/STI clinics would be increased in a phased manner throughout the state and that programmes for adolescent girls (school-going and non-school going) were also planned – these programmes showed that the Govt. of UP were con-

Report on State-Level Meetings

sidering options of convergence.

During the Q&A session between presenters and participants, Ms Sehba Hussain of BETI (a development NGO) welcomed the PATH Convergence initiative commenting that the moment was opportune to launch convergence as this is the final year of the 10th Plan, with NACP III due to begin shortly, and with the NRHM having just completed one year.

Participants agreed during the group discussion that convergence would improve access to services, reduce inhibitions to access, be more cost-effective and time-saving, improve evaluation and lead to realisation of sexual and reproductive rights by the community.

They felt that challenges and barriers to converging SRH/HIV services in UP included bureaucratic indifference and political interference, poor public health infrastructure and service delivery, taboos around SRH, pregnancy and childbirth, gender discrimination and inadequate male participation, different vertical programmes, poor provider attitudes, lack of transparency and corruption.

The next round of state-level meetings on Convergence will be held in August/September 2006.



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PATH is an international, nonprofit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public- and private-sector partners, we help provide appropriate health technologies and vital strategies that change the way people think and act.

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