



Forging Linkages Between HIV/AIDS and Sexual Reproductive Health

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Why Link SRH and HIV?

- Critical to achieving the MDGs, specifically to:
 - Promote gender equality and empower women
 - Reduce child and infant mortality
 - Improve maternal health
 - Halt and reduce the spread of HIV/AIDS and other diseases
- Each address vulnerable groups and those at most risk, socioeconomic inequalities and stigma reduction
- Each face health system challenges: weak infrastructure, outreach capabilities, ineffective M&E and surveillance, inadequate fiduciary systems, inefficient supply chains and human resource shortages
- Opportunity to maximize cost effectiveness and improve effective use of financial and human resources

2

What is the rationale for linkages with HIV?

- Offers opportunity for clients to address multiple needs
- Reaches similar target groups with common interventions (sexually active men and women); and engages groups at most risk
- Reduces MTC transmission
- Increases dual protection from pregnancy, HIV and other STIs
- Reduces stigma
- Increases efficiencies in skills, facilities and supply chain management

3

What are the barriers for linkages?

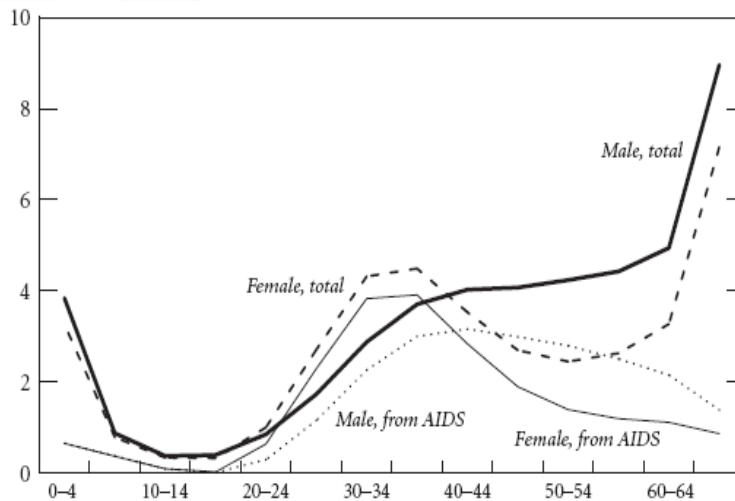
Country constraints:

- Weak institutions and coordination, lack of joint policies
- Vertical planning processes, budgets, logistics and M&E
- Inaction on existing knowledge and work within existing institutional structures
- Pre and in service training do not address integration needs
- Limited community involvement in some countries

Donor constraints:

- Vertical financing influenced by political values
- Financing mis-aligned with country priorities
- Donor competition and poor harmonization, including separate grant mechanisms (e.g. procurement and reporting)
- Challenges to implement the 2005 Paris Declaration

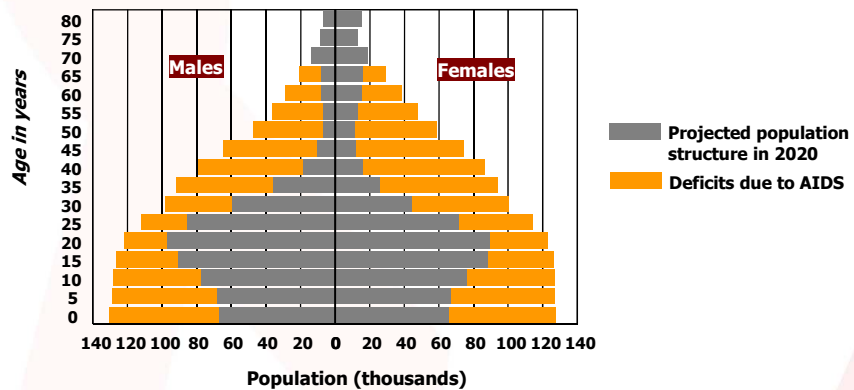
Mortality Rates by Age and Sex in Zambia, 2004 (%)



Source: Markus Haacker, 2004



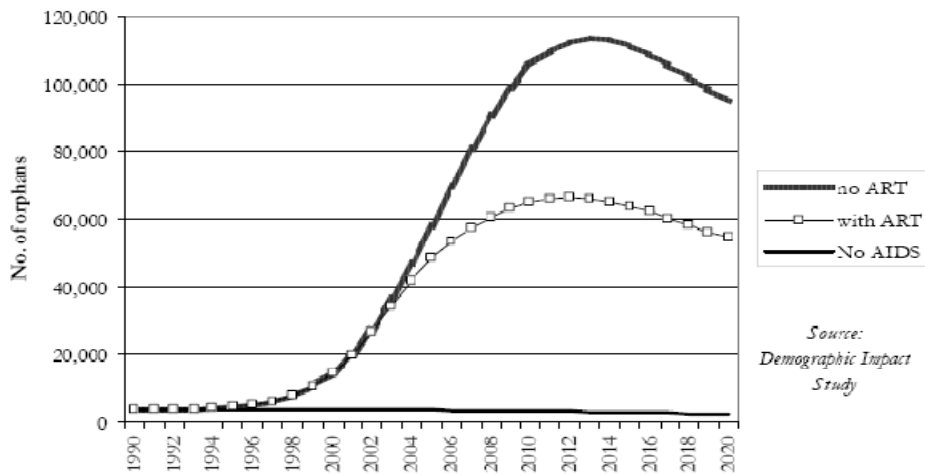
Projected Population Structure With and Without the AIDS Epidemic, Botswana, 2020



Source: US Census Bureau, World Population Profile, 2000



Numbers of orphans in Botswana (children who have lost both parents)



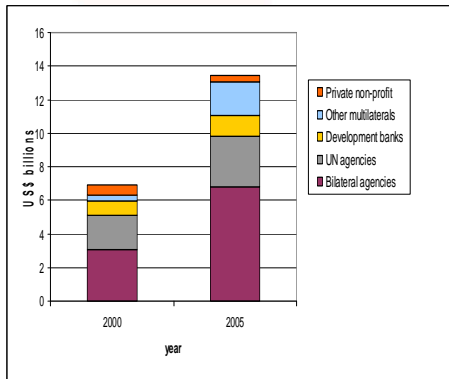
Source:
Demographic Impact
Study

Source: Econsult, 2006

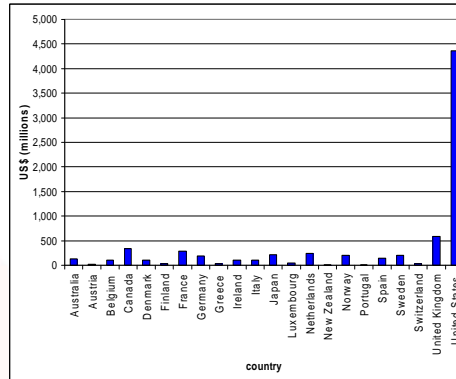
Macroeconomic Impact

- **Public finances**
 - Increased health expenditures, reducing public investment in other sectors
 - Reduces fiscal revenues/tax base
 - Reduces GDP growth
- **Decline in domestic savings and investments**
 - Private and government saving is reduced due to increased health spending and related social support
 - Negative effect on domestic and Foreign Direct Investment
- **Labour Market**
 - Change in labour force and labour participation
 - Change in age structure of labour force
 - Reduce productivity due to absenteeism, high turnover, etc

Development assistance for health, by source, 2000 and 2005, US\$ billion



Development assistance for health from bilaterals in 2005

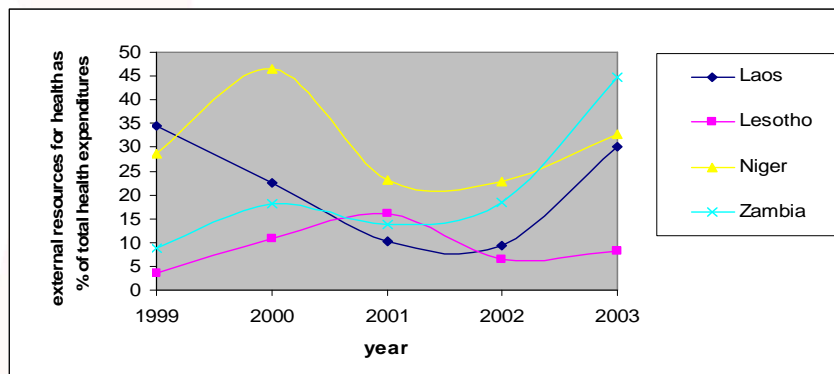


Source: **ACI Africa** 2007
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Source: OECD/DAC, 2007

The World Bank

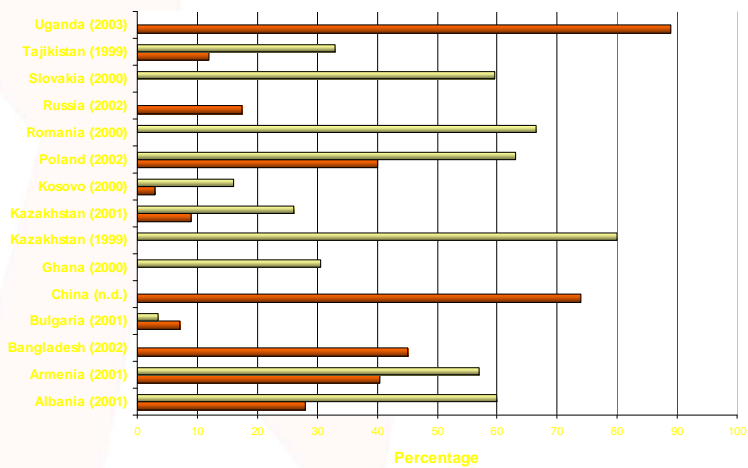
Financial sustainability in key, as countries face extreme volatility in external resources for health



Source: World Development Indicators, 2006.
ACI Africa
AIDS Campaign Team for Africa

The World Bank

Proportion of patients making informal payments by type of service, selected countries, 1998-2002



Source: Lewis, 2006.

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Outpatient Hospital

The World Bank

HIV and CPR Relationship

Adult HIV/AIDS Prevalence

Higher (>8%) HIV

Lower (<8%) HIV

Higher HIV and Higher CPR
115 million people - AFT1

Lower HIV and Higher CPR

No SSA countries fall in this category

Higher HIV and Lower CPR
108 million people - AFT3

Lower HIV and Lower CPR
466 million people - AFT2

CPR (modern methods)

Higher (>20%) CPR

Lower (<20%) CPR

Botswana* South Africa
Kenya Swaziland*
Lesotho* Zambia
Malawi Zimbabwe
Namibia

Burundi* Mozambique
CAR* Rwanda
Cameroon Cote d'Ivoire Tanzania

Angola Ethiopia Mali
Benin Gabon* Mauritania*
Burkina Faso Gambia* Niger*
Chad* Ghana Nigeria
Comoros* Guinea Senegal
Congo Guinea Bissau* Sierra Leone*
DR Congo Liberia Somalia*
Eritrea Madagascar Sudan*

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The Way Forward

- Develop better tools for prioritized and costed joint policies, plans and reporting
- Consider reorganization of MOH to improve integration
- Invest more to address health systems constraints, e.g. human resource capacity, improved joint M&E, surveillance and diagnostics , supply chain management
- Conduct operations research to identify ways to strengthen service delivery coordination (e.g. harmonized procurement processes and supply chains)
- Strengthen public private sector partnerships
- Support country assessments to identify obstacles and opportunities for collaboration
- Improve coordination among civil society efforts

13

What is needed from donors?

- Support country plans and priorities
- Harmonized procedures (procurement, financial management, monitoring and reporting) - the Three Ones
- Predictable, non ideological, long-term financing
- Technical assistance offered and shared through country processes
- Consistent evidence-based policy advice
- Support operations research and evaluation of outcomes (in terms of health, cost-effectiveness, stigma, and access to services)
- Invest in impact evaluation

14

A snapshot of service integration

- 3 models:
 - FP added to counseling and testing
 - FP added to care and treatment
 - Counseling and testing added to FP
- 5 countries:
 - Ethiopia, Kenya, Rwanda, **Uganda**, South Africa

What did we learn?

Facilities are unprepared

- Care and treatment centers
 - Few had FP job aids, posters or pamphlets, most had some stock out of contraceptives in prior 3 months
- Counseling and testing centers
 - Most lacked FP job aids, posters, or pamphlets, many had stock outs of contraceptives including CONDOMS in prior 3 months
- Family planning centers
 - Many lacked CT job aids or protocols, CT posters and pamphlets, some had stock outs of HIV test kits

Providers are not empowered

- Care and treatment providers
 - Most had not been trained in FP; half lacked FP job aids
- Counseling and testing providers
 - Most lacked training in FP; most trained during service
- Family planning providers
 - Many had some training in HIV; also trained in-service

Providers are not convinced

- While many believe that integration will improve services, large minorities in the 3 services are not yet convinced
- Most providers had biases about methods that are appropriate for HIV+ women that are not consistent with WHO guidelines
- Many providers believe that HIV+ women should only use condoms, yet are confused about concept of dual protection

Integration requires whole-site preparation

- Services must be targeted to client profiles
- Clinics need to strengthen commodity systems, provide IEC to generate demand
- Providers need training, medical eligibility updates, job aids, less bias re: appropriate methods
- Supervisors need to do more than deliver supplies and identify training opportunities