

INTEGRATING HIV & SEXUAL AND REPRODUCTIVE HEALTH

A PACIFIC SPECIFIC MAPPING



Acknowledgments

This report was carried out by Family Planning International. However, it could not have been completed without the assistance, time and effort provided by a range of individuals and organisations. Family Planning International would therefore like to thank: Population Action International for their support of the project; all those individuals who agreed to participate in interviews or who provided information, and; Bright Communications for overseeing the design and printing of the report.

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Acronyms

ADRA	Adventist Development Relief Agency	NDOH	National Department of Health
AHD	Adolescent Health and Development	NGO	Non-governmental Organisation
AIDS	Acquired Immune-deficiency Syndrome	NSP	National Strategic Plan
ANC	Antenatal Care	NZAP	New Zealand Aid Programme ¹
ART	Antiretroviral Treatment	PC&SS	Pacific Counselling and Social Services
AusAID	Australian Agency for International Development	PICTs	Pacific Island Countries and Territories
BCC	Behaviour Change and Communication	PIRMCCM	Pacific Island Regional Multi-Country Coordinating Mechanism
CCM	Country Coordinating Mechanism	PLHIV	People Living with HIV
EU	European Union	PNG	Papua New Guinea
FSM	Fiji School of Medicine	PPTCT	Prevention of Parent to Child Transmission
HAMP Act	HIV/AIDS Management and Prevention Act	PRSIP II	Pacific Regional Strategy Implementation Plan II
HIV	Human Immunodeficiency Virus	SPC	Secretariat of the Pacific Community
ICAAP	International Congress on AIDS in the Asia Pacific	SRH	Sexual and Reproductive Health
ICPD PoA	International Conference on Population and Development Programme of Action	STI	Sexually Transmitted Infection
IEC	Information Education and Communication	UN	United Nations
IPPF	International Planned Parenthood Federation	UNAIDS	The Joint United Nations Programme on HIV/AIDS
MCH	Maternal Child Health	UNFPA	United Nations Population Fund
MOH	Ministry of Health	UNICEF	United Nations Children's Fund
MSI	Marie Stopes International	VCCT	Voluntary Confidential Counselling and Testing
NAC	National AIDS Council	WHO	World Health Organization

¹ In July 2010 New Zealand's Agency for International Development (NZAID) was re-named the New Zealand Aid Programme (NZAP). This followed the removal of NZAID's semi-autonomous status and its reintegration with the New Zealand Ministry of Foreign Affairs and Trade in April of 2009.

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All efforts were made to ensure that the information presented in *Integrating HIV & Sexual and Reproductive Health - A Pacific Specific Mapping* was accurate at the time of publication. Family Planning International accepts no liability for errors.

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Executive summary

Over the past decade, Pacific Island countries have seen a rapid increase in HIV related activities that have largely been disconnected from broader sexual and reproductive health (SRH) activities. International research indicates that the synergies between HIV and SRH can be better used to improve health outcomes. However, despite a number of high level calls for greater linkages and integration, as well as the creation of avenues for this to occur, very little linkage and integration has yet been achieved at either the policy or service levels in the Pacific region. Where it has, it remains limited and ad-hoc, often available only in urban areas and most often, dependent on donor funding and NGO implementation. Further, little information is available on exactly what is being linked and integrated and how effective it is.

'Integrating HIV & Sexual and Reproductive Health: A Pacific Specific Mapping', builds on efforts by Family Planning International and Population Action International, to identify linkage and integration activity around HIV and sexual and reproductive health in the Pacific region. Using a review of existing literature and interviews from Papua New Guinea, the Solomon Islands, Fiji and Kiribati the report outlines barriers to, and entry points for, advancing HIV and sexual and reproductive health (SRH) linkages and integration in the Pacific region.

Barriers identified as obstructing the advancement of linkages and integration include:

- the conceptual division between HIV and SRH
- weak national policy
- limited and inequitable funding
- underutilised funding opportunities
- inadequate institutional capacity
- weak civil society advocacy
- poor political support
- inadequate health systems capacity
- persistent stigma and discrimination
- inadequate attention to legal implications
- resistance to integration

Interviews suggests a range of key entry points for advancing linkages and integration. These include:

- growing regional awareness and support for integration
- the regional refocus on primary health care
- the existence of avenues for strengthening national policy
- the existence of a base for growing further civil society and political support
- preliminary Pacific research findings that show positive outcomes of integration
- the continued availability of funding opportunities
- ongoing efforts to improve institutional and systems capacity
- an existing base of linked and integrated service providers.

Based on these findings, the report recommends a range of actions specific to advancing linkages and integration within the Pacific. These include:

- undertaking more Pacific specific research
- scaling up efforts to build political support
- scaling up efforts to strengthen and engage civil society
- promoting the regional focus on health systems strengthening and primary health care
- challenging the conceptual division between HIV and SRH
- scaling up advocacy for more equitable funding
- promoting the use and continuation of existing funding mechanisms
- scaling up HIV and SRH training of health workforces.

It is hoped that the report will help facilitate greater discussion among policy makers, programmers and regional stakeholders about Pacific specific HIV and SRH linkages and integration, and that the information it provides can be used to plan for and advance country appropriate planning, financing and implementation of such initiatives.



1 Introduction

The core purpose of this report is to map aspects of country context that present barriers to, or key entry points for, the advancement of linkages and integration between human immunodeficiency virus (HIV)² and sexual and reproductive health (SRH) activities in four Pacific Island countries. Aspects of country context include; legislation, policies, systems, socio-cultural perspectives, services, funding, infrastructure and capacity. The report also outlines: linkages and integration definitions, rationales, approaches and risks; the Pacific SRH context, and; existing regional linkage and integration approaches and services. It is intended that this information can be used by a wide range of HIV and SRH stakeholders including policy makers and civil society, to appropriately advance integration activities in the region.

...no known effort has yet been made to identify key entry points for, or barriers to, the advancement of linkages and integration in the region.

The report is not intended as a critique of past or current work on HIV or SRH in the Pacific. Neither is it intended to promote a single approach to, or model of, linkages and/or integration. However, it is motivated by a range of key factors.

First and foremost, reproductive health, including sexual health, is a human right, defined as: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."³ To this end, and in the context of primary health care, the International

Conference on Population and Development Programme of Action (ICPD PoA), calls on governments to progressively ensure "universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health." It also explicitly notes that this includes access to HIV services.⁴ However, the Pacific has not yet achieved the ICPD PoA agenda, and therefore has not achieved universal access to SRH for all Pacific peoples.⁵

Second, international research shows that linkages and integration between HIV and SRH activities can help promote universal access to services, resulting in improved health, improved primary health care systems,⁶ and therefore, the realisation of rights.

Third, there is increased interest and activity around linkages and integration in the Pacific, including from two of the region's largest HIV funding mechanisms – the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the HIV/STI Response Fund.⁷ Nonetheless, no known effort has yet been made to identify key entry points for, or barriers to, the advancement of linkages and integration in the region.⁸ The report seeks to address this gap.

1.1 Scope

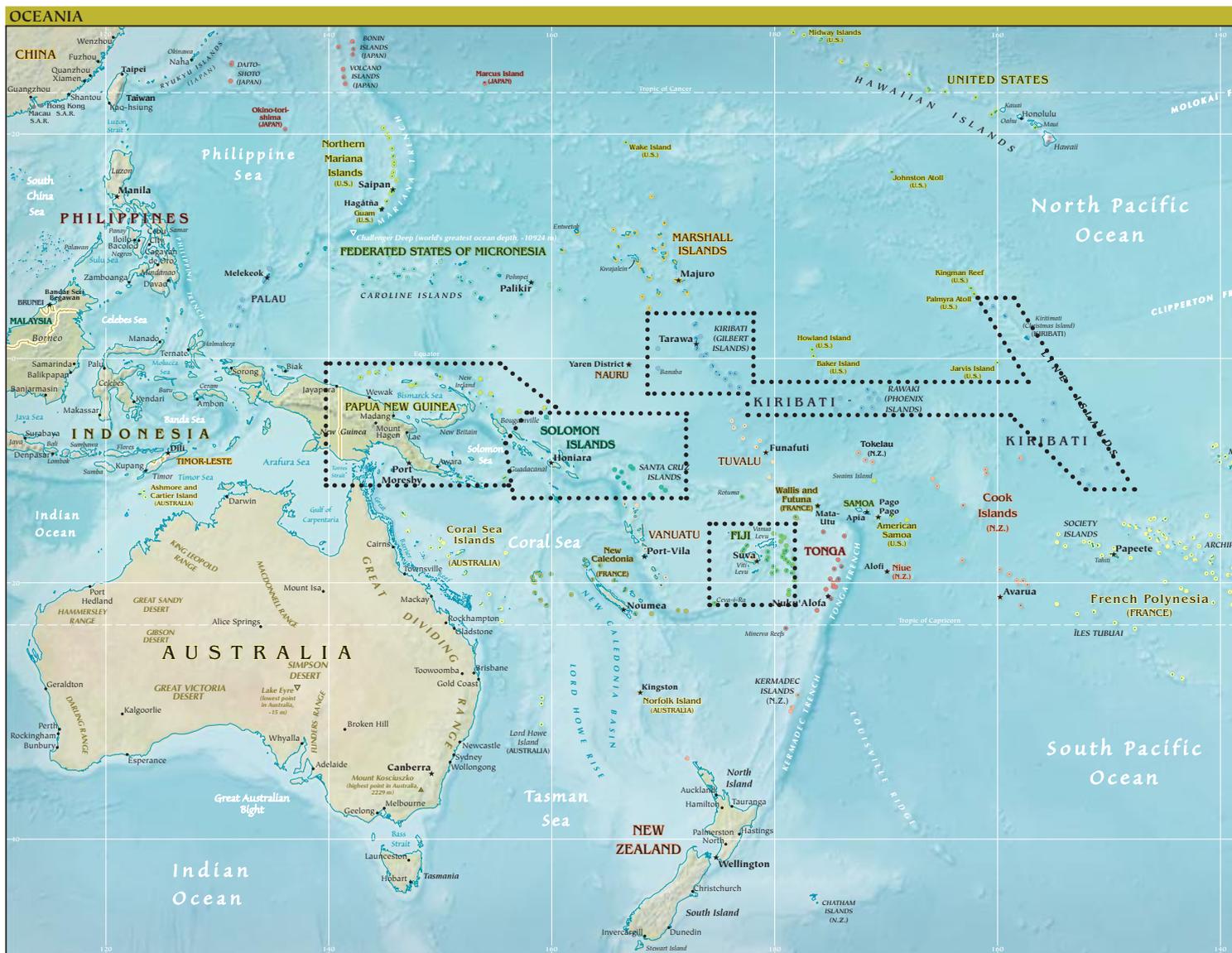
There are 22 Pacific Island Countries and Territories (PICTs). The scope of the mapping was limited to four of these countries – Papua New Guinea, the Solomon Islands, Fiji and Kiribati. These were selected for two key reasons. First, HIV has been reported in all four and each of these represents either a high, middle or low point on the spectrum of Pacific HIV epidemics.⁹ Second, research suggests these countries

	Population	% of population under 24 years	Contraceptive prevalence rate	Adolescent fertility rate	Maternal mortality ratio	Chlamydia prevalence rate	Cumulative reported HIV/AIDS cases
PNG	6,609,745	58%	24%	65	733	-	28,294
Kiribati	98,989	57%	18%	39	158	13%	52
Solomon Islands	535,007	60%	27%	67	175	11%	13 ¹⁰
Fiji	843,888	47%	44%	37	35	29%	333

*All data comes from: (SPC, 2010a) and (FPI, 2009b)

2 AIDS requires specialised treatment and is not a focus of this report.
 3 (UNFPA, 2004, p. 45)
 4 (Ibid., p.10 & 47)
 5 (UNFPA & ESCAP, 2009, p. 1)
 6 (WHO et al, 2008, p. 1)

7 (PAI, 2007) and (FPI, 2009a)
 8 (FPI, 2009a)
 9 (UNAIDS, 2009, p. 2)
 10 WHO estimates for the Solomon Islands indicate total cases could be as high as 350.



Source: The World Factbook 2009. Washington DC: Central Intelligence Agency, 2009

can significantly improve a range of SRH indicators and in particular, that they have high levels of risky sexual behaviour.¹¹ This, combined with large youth populations and the fact that sexual intercourse remains the Pacific's predominant mode of HIV transmission, makes these countries vulnerable to the further spread of HIV.¹² It also increases the potential value of HIV and SRH linkages and integration.

1.2 Methodology

A literature review of existing international and Pacific data and information relating to linkages and integration was conducted. This was used to outline: linkages and integration definitions, rationales, approaches and risks; the Pacific SRH context, and; existing regional linkage and integration approaches and services. It was also used to identify any documented information highlighting regional or country specific entry points or barriers to advancing linkages and integration.

To complement the literature review, all four countries were visited and semi-structured interviews¹³ were

11 (FPI, 2009b)

12 (WHO, 2006) and (UNAIDS, 2009)

13 The questionnaire was influenced by: (IPPF et al, 2009)

conducted with approximately forty different HIV and SRH stakeholders. Interviewees represented non-governmental organisations (NGOs), governments, multilateral and bilateral donor agencies and the private sector. They were identified using a snowball approach and interviews targeted opinions and views on key entry points and barriers to advancing linkages and integration. In cases where face to face interviews could not be arranged, emails and phones were used to complete interviews. The identity of interviewees has been kept confidential, but a list of organisations contacted can be found in Appendix 1.

Interview responses were collated and compared in order to identify common sub-themes presenting either key entry points or barriers to advancing linkages and integration. Where possible, identified sub-themes were crosschecked with information identified in the literature review. Final findings for all four countries are presented under a chapter on barriers and a chapter on key entry points and organised according to sub-theme.

1.3 Limitations

The complexity of the HIV and SRH environment in the Pacific meant that the report encountered some limitations. For example, the large number of organisations involved in local and regional HIV and/or SRH initiatives meant that not all could be identified. Similarly, some key individuals and organisations could not be contacted or did not reply to inquiries. Further, while most interviewees could easily identify other organisations for potential interview, few had in-depth knowledge of the linkage and integration activities of these organisations. This meant it was difficult to crosscheck information about linkages and integration activities.

In particular, the Solomon Island's Ministry of Health and Medical Services requested that a human ethics application be made before interviews were conducted with its officials. An application was made but no response was ever provided. This prevented interviews with Solomon Islands health officials.

Other limitations included, the high cost of travel and accommodation which limited the time that could be spent in each country for data collection as well as the number of visits that could be made. Some potential interviewees were not in-country or were not available during the time the interviewer was in-country. Accessing national health policies and strategy documents such as National Strategic Plans on HIV/STIs (NSPs) and particularly reproductive health policies also proved more challenging than initially anticipated.

While the concept of linked and integrated primary health care services is not new, HIV and SRH linkage and integration is a recent concept in the Pacific. As a result, only some interviewees were directly involved with linkage and integration efforts. This meant many interviewees had little to no practical experience with funding, designing and implementing linked and integrated activities.

Finally, interviews and documents from all four countries repeatedly revealed similarities between barriers to, and key entry points to, advancing linkages and integration. This masks other contextual differences between the four countries such as; population size, HIV prevalence rates, geography, and health system structures. These differences must be acknowledged and factored into the design of country-appropriate linked and integrated policies and services.



2 Understanding linkages and integration

2.1 Definitions of linkages and integration

The concept of HIV and SRH linkages and integration has emerged relatively recently. As such, different definitions can be found internationally and these are sometimes understood and articulated differently by different organisations and people.

This report defines integration as:

“Various types of sexual and reproductive health/family planning and HIV/AIDS services or operational programmes that can be joined together to enhance outcomes.”¹⁴

This report defines linkages, a closely related but different concept, as:

“The policy, programmatic, services and advocacy synergies between sexual and reproductive health/family planning and HIV/AIDS.”¹⁵

Simple examples of these two concepts include: an integrated clinic where a client can access a comprehensive range of services from one place, sometimes referred to as a one-stop-shop, and; different service providers linked by a referral system. However, because of the variety of ways linkages and/or integration can be achieved, it is useful to think of them as two opposing ends of the same spectrum. It is also important to note that integration and linkages can occur at the preventative level (information, education and behaviour change), the treatment level (clinical diagnosis and treatment), and at the strategy/policy level.

2.2 Rationale for linkages and integration

Evidence suggests there are a number of rationales for seeking greater linkages and integration between HIV and SRH services. These include:

- improved access to, and uptake of, key HIV and SRH services;
- improved access to SRH services by People Living with HIV (PLHIV);

- reduced HIV related stigma and discrimination;
- improved health coverage of underserved populations;
- enhanced programme effectiveness and efficiency;
- improved quality of care;
- increased uptake of dual protection against unintended pregnancies and STIs including HIV;
- better utilisation of scarce resources.¹⁶

It is worth noting that efforts to link and integrate HIV and SRH complement the international development community's move away from vertical funding of disease focused projects and programmes, as well as its renewed focus on health systems strengthening – a move supported by the Pacific Ministers of Health.¹⁷

Over the last decade, evidence has also increasingly emerged to show that a narrow focus on vertical HIV programmes can have negative impacts on broader health systems and objectives. These can include:

- the shifting of resources and attention to HIV and away from other key health areas;
- the movement of skilled health workers and managers from other health areas to HIV programmes in search of better pay;
- the prioritisation of HIV related commodities and drugs over others;
- the provision of HIV information to external donors but not to national health information systems.¹⁸

As an alternative to the vertical approach, linkages and integration offer a process for spreading HIV resources across health systems more equitably. This is achieved by focusing on the synergies and common objectives that exist between HIV and SRH programmes.¹⁹ In doing so, the overall health system is strengthened and more able to respond appropriately to people's needs. This better enables people to realise their SRH and helps reestablish the conceptual idea that SRH includes HIV and that both should be an interconnected part of primary health care as set out by the ICPD PoA.²⁰

¹⁴ (Hardee et al, 2009, p. 6)

¹⁵ (Ibid.)

¹⁶ (WHO et al, 2008, p. 1)

¹⁷ (WHO & SPC, 2009a)

¹⁸ (Levine & Oomman, 2009)

¹⁹ (Ibid.)

²⁰ (UNFPA, 2004, pp. 45 & 46)

2.3 Approaches to linkages and integration

Based on successfully integrated services in Africa, Asia and the Caribbean, research shows that there is no “one size fits all” approach to implementing linkages and integration. Approaches to implementing linked and integrated services should be based on individual country context including:

- HIV epidemiology;
- sexual and reproductive health indicators;
- sexual behaviours;
- the general environment affecting health systems.²¹

This is particularly true in the Pacific region where country context can vary significantly. Still, some common HIV and SRH services and approaches to linkages and integration are identified below.

Common HIV services include:

- HIV prevention and education;
- voluntary confidential counselling and testing (VCCT);
- prevention of parent-to-child transmission (PPTCT);
- clinical care for PLHIV, including antiretroviral treatment (ART);
- psychosocial and other services for PLHIV (family care and support).

Common SRH services include:

- family planning;
- maternal and antenatal care (ANC);
- gender based violence prevention and management;
- sexually transmitted infection (STI) prevention and management;
- other SRH services (sexuality education).²²

In the Pacific region it is important to remember that linkages and/or integration are not always present even within HIV services, and that this also applies to SRH services. For example, antenatal care clinics do not necessarily provide family planning services, while VCCT services may not necessarily supply ART.

There are a range of potential approaches for how different services can be linked and/or integrated. Importantly, these can be bi-directional, i.e., HIV to SRH or vice-versa.²³ Approaches include:

1. **Between a specific SRH service and a specific HIV service; e.g., family planning linked or integrated with HIV prevention and education.**
2. **Between a specific SRH service and a range of HIV services or vice-versa; e.g., family planning services integrated or linked with a clinic that provides all, or a range of, HIV services.**
3. **Between a range of SRH services and a range of HIV services; e.g., the one-stop-shop clinic that provides comprehensive and integrated HIV and SRH services.**

2.4 Risks of linkages and integration

Creating linkages between HIV and SRH services does carry potential risks. For example, service linkages largely rely on referral systems. This means individuals must be able to travel between different health providers and there can be many barriers to this (particularly for women). These include:

- a lack of access to money;
- a lack of public transport or its high cost;
- the distance between health providers;
- having time available to make health visits;
- having someone to provide child-care and manage other community or household responsibilities;
- finding health centres;
- fear of discrimination.

These challenges add value to fully integrated services where clients are more likely to be able to access all their needs in one visit. However, there are also potential risks associated with integration. Three key examples include:

1. *“Integration is not advisable if decentralization leads to competition with other priorities.”²⁴*

²¹ (Hardee et al, 2009, pp.18-31)

²² (IPPF et al, 2008, p. 1)

²³ (Ibid.)

²⁴ (Hardee et al, 2009, p. 17)

Health systems have a range of priorities all competing for the same finite resources. Decisions to expand integrated services must therefore be justifiably based on a complex range of contextual health factors and carefully balanced to ensure consequences for other health priorities are limited and acceptable.

2. *“Integration of reproductive health with other services that are fundamentally weak [or vice-versa] may weaken all services.”²⁵*

If resources (equipment, infrastructure, human skill and staff numbers), are not regularly maintained and upgraded/up-skilled, then service quality will likely suffer as a result. Introducing extra service requirements into this environment will likely result in the quality of the new service falling to the level of existing services or worse.

3. *“The integration of HIV services into a reproductive health program may not be appropriate at a national level if an epidemic is concentrated or low-level. In this scenario, the majority of reproductive health clients may not be at risk of HIV or in need of HIV-related services and therefore, targeted HIV programming would have more impact.”²⁶*

This may be particularly relevant in the Pacific where, excluding PNG, HIV prevalence is considered low, most at risk populations and risky sexual behaviours are generally well identified and other SRH indicators show an equal if not greater need for attention. However, there is no reason why targeted services could not be integrated. It is also worth noting that HIV surveillance is poor in the Pacific and that expanded VCCT would go some way to improving this. Further still, the presence of HIV in all but three PICTs, its continued predominant transmission through heterosexual sex, and high levels of risky sexual behaviour (particularly amongst youth), present a strong ethical argument for the provision of

integrated HIV and SRH information and education to the general public.²⁷

Importantly, there are a number of other unanswered questions relating to linkages and integration in the Pacific context. For example:

- the costs;
- the best approaches to achieving linkages and integration;
- the optimal level or scale of linkage or integration;
- the most viable options for linkages where complete integration is not possible.²⁸

Further, international research has identified a range of contextual factors that can inhibit effective linkages and integration between HIV and SRH services. These could lead to or compound the above scenarios. They include:

- lack of commitment from stakeholders;
- non-sustainable funding;
- clinics that are understaffed, have low morale, high turnover and inadequate training;
- inadequate infrastructure, equipment, and commodities;
- lack of male participation;
- women not sufficiently empowered to make SRH decisions;
- cultural and literacy issues;
- adverse social events/domestic violence incidence;
- poor programme management and supervision;
- stigma preventing clients from utilising services.²⁹

Ultimately, many of these challenges could be seen to affect many aspects of a health system, not simply those relating to linkages and integration. Therefore they are issues that must be managed and/or prevented wherever possible. They are not reason enough to forgo the progressive achievement of linked and integrated HIV and SRH services at the primary health care level.

25 (Ibid.)

26 (Ibid.)

27 (FPI, 2009b)

28 (WHO & UNICEF, 2009, p. 10)

29 (WHO et al, 2008, p. 3)



3 The Pacific SRH context

In the Pacific, as around the world, processes for addressing SRH including HIV, are guided by a range of international health frameworks. Key among these is the ICPD PoA. In affirmation of people's right to sexual and reproductive health, the ICPD PoA calls on all states to provide primary health care that progressively ensures all people have "universal access to health-care services, including those related to reproductive health care." It also explicitly notes that this includes those services for the prevention, detection and treatment of HIV and AIDS.³⁰

However, since the ICPD PoA, a range of decisions made predominantly by high level donor agencies, combined with the severity of the global HIV epidemic, led to an increase in HIV focus and funding but also to its financial, programmatic and managerial separation from SRH.³¹ The Pacific region has not escaped this global trend and has seen a particularly noticeable and rapid increase in HIV funding and institution building – efforts that have significantly improved the region's ability to address HIV but caused some marginalisation of broader SRH issues.³²

... there are only 9.6 million people living in all 22 PICTs – this equates to approximately US\$ 8 million in HIV money per person.

For example, in order to guide the Pacific response to HIV, there have been two key regional strategies: the Pacific Regional Strategy on HIV and AIDS (2004-2008), and its replacement, the Pacific Regional Strategy on HIV and Other STIs (2009-2013) – which includes a substantive implementation plan.³³ Conversely, there have also been two regional SRH strategies: the Pacific Plan of Action for Reproductive Health Commodity Security 2003-2008, followed by its successor the Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008-2015.³⁴ However, both have existed in relative isolation from the region's HIV and STI strategies and have not seen an equivalent level

of attention or implementation. Further, unlike the HIV and STI strategies, the implementation of the two SRH strategies has not been as well linked to large funding bodies such as the Global Fund or the HIV/STI Response Fund.

Similarly, the implementation of the region's HIV response has been facilitated by a significant increase in HIV funding from bilateral and multilateral donors. In particular, these include the Global Fund and the HIV/STI Response Fund – the latter replacing a previous regional HIV fund known as the Pacific Regional HIV/AIDS Project.³⁵ Combined estimates suggest that "Between 2001 and 2009 funding for HIV activities in the region increased more than fivefold and [that] more than US\$ 77 million was available for HIV activities in 2008."³⁶ To give this further perspective, there are only 9.6 million people living in all 22 PICTs – this equates to approximately US\$ 8 million in HIV money per person.³⁷ Conversely, while other SRH work has continued, it has not seen an equivalent level of funding and in some areas, such as family planning, it has actually seen a decrease.³⁸

The increase in HIV funds and focus has also facilitated the growth of a number of HIV specific institutions. For example, in line with the UNAIDS Three Ones principles,³⁹ most PICTs now have a National AIDS Council (NAC) or equivalent.⁴⁰ Separate from ministries of health, NACs act as the national coordinating authority for all HIV activities.⁴¹ Similarly, with the arrival of the Global Fund, most PICTs now have separate institutions known as Country Coordinating Mechanisms (CCMs) and 12 have joined these under the Pacific Island Regional Multi-Country Coordinating Mechanism (PIRMCCM).⁴² Conversely, while reproductive health committees (they have various names) exist in most PICTs, they often lack the status afforded to NACs, have little "support from senior ministry or department of health officials," tend to be underfunded/under-resourced (comparatively), are faced with a reluctance by other programmes to share funding, and often lack policy or strategic guidance.⁴³

30 (UNFPA, 2004, pp. 10 & 54-55)

31 (Germain et al, 2009)

32 (Robertson, 2007, p. 37)

33 (SPC, 2009b)

34 (SPC, 2005) and (SPC, 2009b)

35 (SPC, 2008, p. 1)

36 (UNAIDS, 2009)

37 (SPC, 2010a)

38 (APA, 2008, p.38) and (Robertson, 2007, p. 37)

39 The Three Ones Principles are: one coordinating national HIV/AIDS strategy, one national HIV/AIDS coordinating authority and, one national HIV/AIDS mechanism for monitoring and evaluation.

40 (PRHP, 2006)

41 (PIRMCCM, 2007, p. 36)

42 CCMs, and the PIRMCCM can also be used for tuberculosis and malaria proposals. Original members include: Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Niue, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu. New members include: Marshall Islands, Nauru.

43 (WHO, 2009, p. 10)

To illustrate this further, 14 PICTs currently have draft or final NSPs on HIV/STIs, while best estimates suggest only 6 specific reproductive health policies.⁴⁴

Finally, with the exception of PNG, all PICTs have low HIV prevalence rates – rates that are overwhelmingly due to transmission through sexual relations and mother to child transmission. Simultaneously, all PICTs including PNG, continue to face a wide range of other pressing SRH issues. For example: limited access to SRH information and education; low contraceptive use; high maternal mortality; high adolescent and total fertility rates; high STI rates, and; high rates of gender based violence – all of which contribute to morbidity and mortality.⁴⁵

As has occurred globally over the past decade,⁴⁶ these facts have led to a growing recognition of a Pacific HIV and SRH imbalance. They have also increased acceptance of the view that mutually beneficial outcomes can be achieved by building on and balancing the synergies that exist between HIV and broader SRH issues. In turn, this has been manifested through an increased number of regional level calls for greater linkage and integration of HIV and SRH activities, but also through the inclusion of avenues for implementing linkages and integration within regional strategies, frameworks and policies.⁴⁷ The following chapter outlines these.

... with the exception of PNG, all PICTs have low HIV prevalence rates – rates that are overwhelmingly due to transmission through sexual relations and mother to child transmission.

⁴⁴ (UNAIDS, 2009, p.104) and (WHO, 2009, p. 4) No information is available on French and US territories.

⁴⁵ (UNAIDS, 2009, p. 20 & 25) and (FPI, 2009b)

⁴⁶ (Levine & Oomman, 2009)

⁴⁷ (WHO & UNICEF, 2009)



4 The regional approach to linkages and integration

Pacific regional efforts to better enable linkages and integration between HIV and SRH activities have largely manifested themselves in two ways. These are through regional level calls for such change, but also through regional strategies and frameworks that create some avenues for the implementation of greater linkages and integration at the country level. The existing key regional efforts are set out below.

4.1 Guilin Framework

Between 2006 and 2007, a number of Asia-Pacific governments, along with UNFPA, UNICEF, UNAIDS, and WHO, met to discuss and ultimately to develop the Asia-Pacific Operational Framework for Linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services – also known as the Guilin Framework. The purpose of the Guilin Framework is to provide Asia-Pacific governments with guidance on how to strengthen linkages between reproductive health, adolescent reproductive health, and the prevention and management of HIV and other STIs. Importantly, the Guilin Framework promotes the terminology of linkages over integration⁴⁸ and a subsequent 2009 follow-up workshop defined it as:

“The combination of services that creates opportunities for systematic referrals within and between programmes, with the overall goal of providing outcomes that are greater than the sum of individual services.”⁴⁹

To date, no PICT has fully operationalised the Guilin Framework.⁵⁰ However, it remains the only regional level framework specifically dedicated to providing governments with a guide towards greater linkages between HIV and SRH.

4.2 The Eighth Meeting of Ministers of Health

Since 1995, there have been eight ministerial conferences at which Pacific Ministers of Health have gathered to advance their vision of Healthy Islands. These meetings set regional health objectives and provide the highest level commitment to achieving

health outcomes. The most recent ministerial conference was held in 2009, in Madang PNG. It covered a wide range of issues including; child and maternal health, HIV and STIs, and health system strengthening. The eighth recommendation of the Ministers under the topic of: “Prevention and control of HIV/AIDS and other sexually transmitted infections”, was:

“Strengthen integration and links between HIV/STI services and other health services such as reproductive, maternal and child health and tuberculosis.”⁵¹

4.3 The Report of the Commission on AIDS

In 2007, the Independent Commission on AIDS in the Pacific was tasked with reporting on the HIV and AIDS situation in the Pacific. This was concluded in December 2009 with the release of ‘Turning the Tide: An open strategy for a response to AIDS in the Pacific’ – also known as the Report of the Commission on AIDS in the Pacific. The purpose of the report was to provide an “objective and independent analysis of the status and impacts of the [HIV] epidemics in the region, in order to assess and provide policy options to countries and territories and their development partners.”⁵² The report indicated that integration efforts needed to go further and specifically recommended three policy options involving linkages or integration:

“Treatment for HIV, opportunistic infections and STIs and prevention of mother-to-child transmission programmes must be integrated within a strengthened health system.”

[“To review] the experience from other regions in implementing innovative prevention programmes that integrate HIV with other behaviour-change programmes (such as drug and alcohol use, sexual and reproductive health and gender based violence).”

48 (WHO & UNICEF, 2009)

49 (Ibid., p. 7)

50 (Ibid.)

51 (WHO & SPC, 2009b, pp. 31-32)

52 (UNAIDS, 2009, p. V)

“Establish and expand youth-friendly facilities, to improve access to HIV prevention services and commodities and appropriate sexual and reproductive health services.”⁵³

4.4 The Policy Framework

In November of 2008, Ministers of Health and Government officials from 14 Pacific PICTs – including all four countries covered by this report – signed on to the Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008 – 2015 (The Policy Framework). The Policy Framework follows on from the 2003, Pacific Plan of Action for Reproductive Health Commodity Security. The core objective of The Policy Framework is to: “Ensure that by 2015 every person in the region will have access to reproductive health services and commodities of their choice.”⁵⁴ With regard to linkages and integration, the The Policy Framework recommends:

“Where appropriate, integrated approaches that are human rights and gender-based are adopted within broader national plans to address reproductive health, including family planning, maternal health, STIs and HIV.”

“Ministries of Health should strengthen integrated services and linkages between reproductive health and HIV to enable the delivery of integrated services, as appropriate, and increased opportunities for prevention and care.”⁵⁵

4.5 The Regional Strategy

In 2004, the Pacific Island Leaders Forum endorsed the Pacific Regional Strategy on HIV and AIDS (2004-2008). In 2007, it was agreed that this would be expanded to become the Pacific Regional Strategy on HIV and Other STIs 2009-2013 (The Regional Strategy). This decision was made based on the understanding that while progress in addressing HIV had been made, it needed to be maintained and improved. It also expanded its focus to include other STIs, taking into account new data on the high prevalence of STIs in the region, a concern in and of itself, but one also recognised as further facilitating the transmission of HIV. The Regional Strategy has one overall goal “To reduce the spread and impact of HIV and other STIs while embracing people living with and affected by HIV in Pacific communities.”⁵⁶

The Regional Strategy sets out a wide range of actions for achieving its overall goal and categorises these under six themes. Theme three, “Continuum of treatment, care and support systems and services,” explicitly identifies linkages and integration of services as a key action:

“Strengthen linkages and/or integration of HIV and STI services with broader sexual and reproductive health services.”⁵⁷

4.6 Pacific Regional Strategy Implementation Plan II

The Regional Strategy is supported by an implementation plan known as the Pacific Regional Strategy Implementation Plan on HIV and STIs (PRSIP II). Under each of The Regional Strategy’s themes, PRSIP II sets out in detail, outcomes, outputs and activities for how the overall accomplishment of The Regional Strategy will be achieved. Under themes one, two and three, PRSIP II specifically identifies multiple avenues for advancing linkages and integration. These include:

- training and planning in integration;
- piloting integration projects/programmes;

⁵³ (*Ibid.*, pp. 7-8)

⁵⁴ (UNFPA, 2008, p. 1.1)

⁵⁵ (*Ibid.* pp. 3.1.3 (C) & 3.4.4)

⁵⁶ (SPC, 2009b, p. 5)

⁵⁷ (*Ibid.*, p. 16)

- the need for integration to occur broadly between all HIV, AIDS and other SRH services;
- for integration to occur between specific HIV and AIDS services such as PPTCT and VCCT and other SRH services;
- for PLHIV to have access to SRH services such as family planning;
- for civil society organisations to provide HIV, STI and other SRH services;
- to undertake behaviour change projects/ programmes that educate people in SRH including HIV and STIs.⁵⁸

Importantly, PRSIP II identifies where these outputs are interconnected and identifies lead and collaborating agencies already involved in implementation or planning implementation. Also, applicants to the HIV/STI Response Fund must address issues identified in PRSIP II.⁵⁹

4.7 The Strategic Action Plan

The Regional Strategic Action Plan for the Prevention and Control of Sexually Transmitted Infections 2008-2012 (The Strategic Action Plan), is based on a WHO Global Strategy for the Prevention and Control of Sexually Transmitted Infections that was launched in 2006. Unlike the above strategies and frameworks, The Strategic Action Plan covers 15 Asian countries as well as all PICTs. Its core goal is to: "Reduce STI related morbidity and mortality in the region."⁶⁰

The Strategic Action Plan has five key objectives, including the expansion of access to STI care. Under this objective it explicitly identifies as a key intervention:

*"Operational linkages with other programmes/services [including] ...as part of services that already exist, such as well-person clinics, maternal and child health centres and reproductive health facilities... prevention of mother to child transmission (PMTCT) and antiretroviral therapy (ART) services... [and] HIV testing and counselling."*⁶¹

⁵⁸ (SPC, 2009c)

⁵⁹ (SPC, 2009a, p. 1)

⁶⁰ (WHO, 2008, p. 24)

⁶¹ (*Ibid.*, pp. 27 & 35)



5 Existing linked and integrated services

There are a number of existing linked and integrated HIV and SRH service in the Pacific. This is in part the result of the above regional efforts, but is also a reflection of the work of governments and particularly the work of a range of NGOs, donor agencies and a small number of private sector organisations.

However, in all four countries covered by this report, well linked HIV and SRH services remain uncommon and are faced with varying levels of absentee referrals. Similarly, integrated HIV and SRH services are not yet widely available and where they are, they are commonly described as ad-hoc and limited. In most instances, this is because they do not yet offer a comprehensive range of HIV and SRH services and because they are most commonly available only in urban areas. Some other commonalities can be identified between the linked and integrated services that currently exist in the four countries covered by this report.

First, they are often implemented by NGOs (often faith-based organisations in PNG) with international expertise and networks, and/or large multilateral or intergovernmental organisations such as UN bodies or the Secretariat of the Pacific Community (SPC). Similarly, many of these services are reliant on funding from the latter group or donor agencies. Government led linkage and/or integration projects are increasing but generally continue to have limited reach.

Second, HIV prevention is increasingly being linked or integrated with broader SRH issues such as STIs, gender based violence and sexual violence, through information education communication (IEC) and behaviour change communication (BCC) programmes. In large part, this is because HIV and SRH linkages and integration are often easier and less costly to implement through prevention programmes than they are through clinical services. There has also been a particular emphasis on and therefore funding for, preventative HIV and STI work in the Pacific.⁶² To illustrate this, a variety of linked and/or integrated projects that provide IEC or BCC services can be found in all four countries.

Third, clinical HIV treatment services are predominantly being developed as stand-alone facilities or are linked or integrated with existing SRH services – not the reverse. The latter is driven by two factors. First, NSPs exist in all four countries and these have a focus on the expansion of HIV services, particularly VCCT and PPTCT.⁶³ Second, HIV services are relatively new and already existing urban and rural health centres provide ideal locations and in some cases offer health workers that can deliver HIV and SRH services. However, there is limited monitoring and evaluation of this expansion⁶⁴ and as a result, there is currently very little accessible information on how often new clinical HIV treatment services are being linked and integrated with existing SRH services and/or how effective this is.

5.1 A government and NGO approach

Until recently, Fiji had predominantly relied on three government “STI Hub Centres” to manage STI and HIV testing and treatment. These three Hubs are located in Lautoka, Suva and Lambasa. While they are increasingly intended to provide comprehensive SRH services, each Hub differs slightly depending on the local area needs. For example, because a reproductive health clinic is in walking distance of the Suva Hub, most SRH needs are simply referred (linked) to this clinic.⁶⁵

More recently, through the help of an NGO called Pacific Counselling and Social Services (PC&SS), Fiji has been better able to expand and link VCCT services with government ANC services. In particular, PC&SS’s assistance has enabled VCCT services to be provided to antenatal women in five Fijian hospitals ensuring that 80% of antenatal women (annually), now have access to VCCT before giving birth.⁶⁶

5.2 Utilising the private sector

The HIV/AIDS Prevention and Control in Rural Development Enclaves Project, is a cooperative effort between the PNG government, six private sector organisations and the Asian Development Bank. The project works to make a substantial contribution to the delivery of quality primary health care services in

62 (UNAIDS, 2009, p.109)

63 (NAC, 2006), (NAC, 2005), (HIV Aids Task Force, 2005) and (NACA, 2007)

64 (UNAIDS, 2009, p. 104)

65 (Personal Communication, OSSHHM, 2010)

66 (Cohen, 2010, p. 7)



rural areas of PNG where the government alone has difficulty providing services. To date, its activities have included the refurbishment of over 60 health centres, assistance in the training of staff, the supply of drugs, vehicles and medical equipment, access to VCCT, and the provision of SRH (including HIV and STI) education to local communities.⁶⁷

5.3 Integrated behaviour change

Stepping Stones is a programme that works within Pacific communities to provide comprehensive SRH information and education in order to promote positive SRH behaviour change. Over an 8 – 16 week period, community members involved in Stepping Stones learn about topics including; STIs and HIV, gender, violence, drugs and alcohol abuse, sexuality and relationships. Stepping Stones has been implemented in Fiji, the Solomon Islands, Kiribati, Vanuatu and the Federated States of Micronesia. It has been supported by the HIV STI Response Fund and is overseen by the Foundation of the Peoples of the South Pacific International.⁶⁸

5.4 Treatment, care and support

Treatment, care and support services for PLHIV are not yet widely available in the Pacific. They are also not commonly linked or integrated with SRH services. However, Family Health International in PNG has been implementing a Continuum of Prevention to Care and Treatment model in PNG's National Capital District and Madang. This model is supposed to be scaled-up by the NDOH and already links PLHIV to some other SRH services. Similarly, in Fiji, the Fiji Network for HIV + People and PC&SS provide continuum of care services to PLHIV and this is also linked to broader SRH services. The Kiribati Family Health Association has also recently received funding from the HIV/STI Response Fund to begin similar continuum of care services and this will be linked with some SRH services that it already provides.

5.5 A faith-based approach

In 2003, in the Solomon Islands, the Adventist Development Relief Agency (ADRA) helped to set up a Sexual and Reproductive Health Church Committee. This is a committee of eight Christian denomination churches in the Solomon Islands. The purpose of the committee is to coordinate and engage the different churches in assisting in the prevention of HIV by providing comprehensive SRH IEC to their communities. With the assistance of ADRA, AusAID, and Global Youth and Leadership Nexus Solomon Islands, a Reproductive Health and HIV manual was developed for the committee in 2008. The manual is designed to provide a tool for delivering up-to-date and accurate HIV and SRH information and links this to biblical references so that the information is more user friendly within church communities. The manual provides a unique way of uniting and directly engaging churches in ensuring their communities have access to quality SRH information and education.⁶⁹

5.6 One-stop-shops

While well integrated services are limited and not wide spread, there are approaches being implemented in each of the four countries that are, or are close to providing a one-stop-shop. For example, an integrated range of HIV and SRH services can be found at the following service providers:

PNG

- Marie Stopes International (MSI) PNG clinics, Port Moresby, Lae and Mt Hagen
- Lawes Road Clinic, Port Moresby
- Nine Mile Clinic, Port Moresby

Fiji

- Our Place (supported by the SPC's Adolescent Health and Development programme (AHD)), Suva
- Marie Stopes International Pacific (MSI) clinic, Suva

Solomon Islands

- Solomon Islands Planned Parenthood Association clinic (supported by AHD and MSI), Honiara

Kiribati

- The AHD and UNFPA youth centre, Betio
- Kiribati Family Health Association, Bairiki

All these sites are located in urban centres and MSI services require a small fee.

67 (PINA, 2010)

68 (Miller, 2010, p. 13)

69 (ADRA et al, 2008)



6 Key barriers to advancing linkages and integration

6.1 Persistent conceptual divisions exist

As has been noted, the Pacific followed the global trend and has seen a separation of HIV from SRH programmes, funding and policy. Guiding this are three different regional strategies/frameworks. While each creates some avenues for, or calls for, linkages and integration of HIV and SRH services, each has a core goal/objective specific to either HIV, STIs or SRH and none explicitly engage each other. They all therefore perpetuate policy divisions between HIV, STIs and SRH rather than comprehensive SRH policy cohesion. This creates a complicated and poorly connected network of strategies that is not conducive to the effective provision of linked and integrated services on the ground.

6.2 National policy remains weak

It is unclear as to whether national reproductive health policies and NSPs on HIV/STIs have harmonised approaches to linkages and integration. In part, this is because draft reproductive health policies for Kiribati, Fiji and the Solomon Islands could not be obtained. However, the PNG draft reproductive health policy does not include a substantive plan for HIV and SRH linkage and integration.⁷⁰

Similarly, NSPs give only limited attention to HIV and SRH linkages and integration. Where called for, details go little farther than: "Develop operational linkages with other SRH services," or; "Provide adequate HIV rapid test kits for all antenatal and family planning clinics in the country."⁷¹ NSPs remain silent on: the financial costs; where the staffing, training and equipment will come from; why expansion will occur in certain sites and not others; which services are actually being linked or integrated; how risks will be managed, and; how expansion will be maintained etc. In effect, NSPs imply an expectation that some linkages and integration will occur, but do not address how or why in a consistent or comprehensive fashion.⁷² Further, NSPs have been poorly implemented as a whole.⁷³

6.3 Funding is inadequate and inequitable

Across all four countries, the need for greater funding for HIV and particularly SRH was clearly identified as a barrier to the implementation of effective linkages and integration. This is because in all four countries, significant improvements can be made to frontline HIV and SRH primary health care services. This includes improvement and expansion of infrastructure, the workforce and equipment. As was noted: "without resources you cannot add more and build in the capacity at the primary health care setting." Further, while the increased regional focus on HIV has also increased the funding available for HIV activities, there has been no equivalent funding increase for SRH activities. Funding for HIV and funding for SRH must therefore be more equitable.

"Without resources you cannot add more and build in the capacity at the primary health care setting."

6.4 Global Fund opportunities have been underutilised

The Global Fund presents a significant source of funding that can be used to advance linkages and integration between HIV and SRH activities. However, the Fiji CCM has not made a successful HIV proposal to Global Fund since withdrawing from PIRMCCM in 2007. Similarly, the Solomon Islands CCM which partially withdrew from the PIRMCCM in 2007, has failed to obtain Global Fund funding for HIV in both round 7 and round 9,⁷⁴ and the PNG CCM has failed to access Global Fund funds for HIV since its successful round 4 application in 2005.⁷⁵

Global Fund Technical Review Panel reports for PNG's and Fiji's round 9 applications clearly indicate that a range of country specific challenges have contributed to failed proposals. However, interviews and the Review Panels indicate that contributing factors include the highly demanding nature of Global Fund processes, and the often limited capacity of CCM members, particularly civil society organisations.⁷⁶ This is despite

70 (NDOH, 2009)

71 (NAC, 2006, p. 18) and (NACA, 2007)

72 (NAC, 2006), (NAC, 2005), (HIV Aids Task Force, 2005) and (NACA, 2007)

73 (UNAIDS, 2009, pp. 3 & 104)

74 (Republic of Fiji, 2010) and (SINAC, 2010)

75 (Global Fund, 2010b)

76 (Global Fund, 2009a) and (Global Fund, 2009b)

assistance to CCM members from external consultants – assistance that some members in each of the three countries felt was inadequate or too little too late, and which was a concern raised by the last independent evaluation of UNAIDS in the Pacific.⁷⁷

Finally, with the exception of the intention to increase linkages and integration between HIV, ANC and Maternal and Child Health through PNG's round 9 proposal, and the two linkage pilots in the PIRMCCM round 7 proposal, HIV and SRH linkages and integration have largely been neglected in recent proposals to the Global Fund.⁷⁸

6.5 Response Fund opportunities have been underutilised

The HIV/STI Response Fund was set up with the intention of promoting the implementation of The Regional Strategy and its implementation plan PRSIP II – both of which create avenues for the implementation of HIV and SRH linkages and integration. However, while the Response Fund was widely noted as being more accessible and user-friendly than the Global Fund, communications with SPC indicate that a minority of the proposals made to the fund's six streams have been focused on the implementation of linkages and integration.⁷⁹

Further, all Response Fund money has now been allocated from funds received from donors until 2013. This means there will be no further calls for funding proposals unless donors decide to put in additional funding. The only exception to this is the Community Action Grant (stream III of the fund), which is available only to community based organisations and for a total amount of up to \$10,000 AUD per applicant. Currently there is no indication that replenishment of the fund is being discussed by donors.⁸⁰

...there will be no further calls for funding proposals unless donors decide to put in additional funding.

6.6 Institutional harmonisation is needed

In the Solomon Islands, PNG and Fiji, coordination of national level HIV activities is dominated by the NACs, the Ministries/Department of Health (MOH/ NDOH), and the Global Fund CCMs. However, the responsibilities of, the capacity of, and the relationships between these organisations is extremely complex and has frequently contributed to a range of issues including: role confusion, tensions between the bodies and, the ineffective management of funds and ineffective implementation of HIV services. In particular, NACs – which under the Three Ones principles are supposed to operate as the main HIV coordinating authority – have often underperformed due to a range of issues including lack of capacity and poor management.⁸¹ For example, the PNG NAC was established in 1997 and reestablished in 2008 after a period of "poor performance and poor leadership."⁸² Despite this reestablishment, the most recent report of the Independent Review Group on HIV/AIDS noted that there were still "significant" challenges relating predominantly to the relationship between the NAC and its secretariat.⁸³

The complexity of, and the often dysfunctional nature of the relationships between these institutions presents a significant barrier to effective implementation of HIV and SRH linkages and integration. Further, NACs and CCMs have to date shown little interest in widening their focus to include broader SRH issues.

6.7 Civil society advocacy is weak

Many large NGOs provide linked and integrated HIV and SRH services. However, their advocacy efforts around linkages and integration have at best been limited, and have not been cooperative or coordinated. This is true both within and across individual countries. Only one organisation in PNG was identified as having recently advocated directly to government for greater linkages and integration. As a result, there is no unified regional or national civil society voice advocating for greater integration.

77 (Doupe, 2009, p. 5)

78 (PNG CCM, 2009, pp. 22 & 52), (PIRMCCM, 2007, p. 152) and (Solomon Islands CCM, 2009)

79 (Personal Communication, SPC, 2010a)

80 (Ibid.)

81 (PRHP, 2006, pp. 7 & 10) and (UNAIDS, 2009, p. 59)

82 (UNAIDS, 2009, p. 60)

83 (Aggleton et al, 2009, p.18)

Further, in all four countries there are other civil society actors such as churches and even private sector organisations that have, or are increasingly playing an important role in the provision of HIV and/or SRH services. However, there has been no sustained engagement of these groups for the purpose of linkages and integration advocacy.

6.8 Health system capacity is inadequate

In all four countries, health system capacity presents a serious barrier to effectively advancing linked and integrated HIV and SRH services. This is because the health systems in all four countries (to different degrees), already struggle to provide the range of services they are currently tasked with, particularly in rural areas and particularly in PNG.

Challenges include: ineffective administration of the workforce (including pay); workforce shortages; limited infrastructure; lack of technical skills; lack of equipment and commodities; complex health systems; poor coordination between health stakeholders; challenging geography and in some cases, an inability to effectively absorb and utilise health funding. The impact of these challenges include: varying levels of HIV and SRH service quality; staff burnout; competition between services; the limiting of services to specific times (days of the week or hours during the day) and a lack of confidentiality. In PNG and the Solomon Islands, poor management and accountability means that some health facilities may not be regularly staffed and this may contribute to “ghost workers” – individuals on the payroll that are not actually working.

Further, in PNG, one interviewee noted that the push to expand VCCT services was in part resulting in the crowding out of, or at the least, a shift in focus away from, other basic STI services which were not receiving similar assistance. This is supported by findings of the Report of the Commission on AIDS in the Pacific.⁸⁴ Alternatively, one interviewee in the Solomon Islands noted that VCCT services provided from general primary health clinics were at risk of being crowded out by

the greater demand for other health care services like treatment for malaria.

6.9 Political support is weak

There is a lack of broad based political focus and commitment on HIV and particularly SRH. As a result, there is a paucity of political interest in linkages and integration of HIV and SRH. Further, where political support for HIV and SRH has been expanded, it has been difficult to sustain, and is at risk of frequent undermining by the actions of other high profile individuals. Political support in PNG was identified as being so poor, that one interviewee stated “We are in a bad, bad, dark, dark place.”

“We are in a bad, bad, dark, dark place.”

6.10 Persistent discrimination, stigma and ideology

Discrimination and stigma continue to deter people from using HIV and SRH services and is therefore a barrier to linkages and integration. For example, it remains not uncommon for men and women who access STI, HIV and family planning services to be put at increased risk of being stigmatised or discriminated against by communities, family members, partners and even health workers. This is particularly the case for marginalised groups such as youth (especially young girls), women and sex workers. In Kiribati, one interviewee noted with regard to the stigma around sex workers: “The first time they go into a clinic will be the last time they are seen.”

The lack of privacy and confidentiality in small island communities where gossip spreads quickly increases the risk of stigma and discrimination. Similarly, it was noted in both PNG and Fiji that often the most accessible HIV services are located in STI clinics that are highly visible and well known or labeled as STI clinics.

“The first time they go into a clinic will be the last time they are seen.”

⁸⁴ (UNAIDS, 2009, p. 60)

This perpetuates the perception that anyone using these facilities has a sexually transmitted infection.

The ideologies or doctrines disseminated by certain churches in all four countries are also perpetuate discrimination and stigma, particularly around the use of condoms. Further, in PNG and Fiji, there are reports of some church leaders telling community members that prayer is the only effective management of HIV and AIDS resulting in some individuals ending ART use.

6.11 Legal environment requires attention

Pacific HIV and SRH stakeholders have yet to fully consider the implications of current legislation on linkages and integration. Very few interviewees had any knowledge of how current legal structures may create barriers or opportunities for advancing linkages and integration. Further, recent reviews of HIV legislation such as, 'Enabling effective responses, HIV in the Pacific island countries: options for human-rights based legislative reform', have largely left linkages and integration unexplored.⁸⁵

However, in Fiji it was noted that laws limiting the ability of front line nurses to take blood may need to be amended if more wide spread integrated VCCT services were to be sought. Similarly, there was some concern around the 'Fiji Crimes Decree', which has the potential to drive particular most at risk populations, such as sex workers, underground making it more difficult to provide them with services (integrated or other).

In Fiji it was noted that laws limiting the ability of front line nurses to take blood may need to be amended if more wide spread integrated VCCT services were to be sought.

In PNG, the Organic Law on Provincial Governments and Local Level Governments was identified as legislation that complicates health system management and function and which will likely do the same for linked or integrated HIV and SRH policy and services.

Similarly, where useful legislation has been passed, for example the PNG HIV/AIDS Management and Prevention Act (HAMP Act), enforcement has often been poor.

6.12 Resistance to integration

There are two indications of resistance to integration in the Pacific. The first is based on the view that integration is an "African model," inappropriate for Pacific Islands with low HIV prevalence rates (all excluding PNG). The rationale for this is based on:

- Where HIV prevalence is low (unlike many Southern African states), the majority of a PICT's population is not at high risk of HIV and most people are therefore not likely to need or use wide spread HIV services.
- In the Pacific, most at risk populations (where much of the epidemic is concentrated) are relatively well identified and many are less likely to utilise public HIV and SRH services.⁸⁶ It may therefore be more effective to create specific services for most at risk populations.
- Taking a targeted approach could be significantly more cost-effective than large scale (i.e. national) roll out of integrated services.

A lack of research on integrated services in low prevalence Pacific Islands means there is little evidence based data to refute these arguments.

The second is based on the view that to date, efforts to advance integration have largely been led by regional level stakeholders. The lack of involvement in linkages and integration by PICT political leaders, governments and civil society, promotes a perception that linkages and integration are another top-down foreign health system intervention that will inevitably add to the workload of the health workforce. Given existing pressures on PICT health workforces, this could present a significant barrier to achieving health workforce buy-in.

⁸⁵ (UNDP & UNAIDS, 2009)

⁸⁶ (McMillan & Worth, 2010, p.10)



7 Key entry points to advancing linkages and integration

7.1 There is growing regional support

As has occurred internationally, there is growing regional level support for greater linkages and integration of HIV and SRH activities. This is apparent from the increase in high level calls for greater linkages and integration, as well as from the fact that all regional STI, HIV and SRH strategies promote or create avenues for service linkages and integration. Further, interviews indicate that there is a good level of understanding behind the rationale for linkages and integration and that this is contributing to acceptance. As one interviewee noted: "I think the interest and the understanding of it [integration] is growing and the benefits of it are being seen and accepted..." This support provides a strong base from which to build advocacy for greater linkages and integration – both at the regional level but also at the national level.

7.2 Linkages and integration remain emerging issues

Discussions about what constitutes linkages and integration and how best to achieve them are continuing at the regional level and have only just begun at the national level. For example, at the time of writing, the WHO office in Fiji was cooperating with a range of regional organisations to develop further regional HIV, STI and SRH integration policy. Further, there is no single definition of either linkages or integration common to all HIV and SRH stakeholders operating in the Pacific, nor any set rules prescribing approaches. As such, there is a window of opportunity for advocates of linkages and integration to better engage in discussions about the meanings of these concepts and approaches to implementing them.

7.3 Region is refocussed on primary health care

The region's return to an increased focus on strengthening health systems and primary healthcare offers a key entry point for advancing linkages and integration. This is because international research shows linkages and integration can strengthen health systems and improve people's health. In turn, this enables

linkages and integration to be advocated for under the broader umbrella of health systems strengthening and primary health care improvement. Further, this has the added potential benefit of reducing health workforce resistance to linkages and integration, because strengthening primary health care is broadly supported by the health workforce and political leaders.

7.4 Opportunities exist to strengthen national policy

Although both reproductive health policies and NSPs do not currently provide strong mechanisms for advancing HIV and SRH linkages and integration, they remain key entry points for this purpose. In particular, there are two opportunities for ensuring integration is better included within national policies. First, at the time of writing, all four reproductive health policies were in draft form. Though potentially short, a window of opportunity exists to better address linkages and integration before these policies are finalised.

Second, all NSPs covered by this report were either in their last year, had already lapsed or in the case of PNG, were currently being re-drafted. Further, while all funds under the HIV/STI Response Fund have been allocated, disbursement of funds allocated under funding stream one, National Strategic Plan Support Grants, is just beginning. This means that some NSPs are likely to see re-drafting over the next 6-12 months. This provides another window of opportunity to advocate for NSPs to better address linkages and integration aspirations.

7.5 Civil society could play a stronger advocacy role

There are a number of large NGOs that support and already provide linked and integrated services. These could build a strong coalition for the promotion of linkages and integration between HIV and SRH. The combined resources and geographic spread of such a group would enable it to operate more effectively both within and across countries, as well as better enable more unified advocacy directly to governments, donors, regional stakeholders and broader civil society such as smaller NGOs and faith-based organisations.

Further, such a group could provide an effective mechanism for engaging the growing number of private sector organisations now operating in the Pacific – an increasing number of which are also making commitments to addressing HIV and SRH challenges (particularly in PNG).

7.6 Preliminary Pacific research shows positive outcomes

With funding from round 7 of Global Fund, UNFPA implemented linkages and integration pilots in the Federated States of Micronesia and Vanuatu. While a report outlining the pilot's feasibility is not yet available, preliminary anecdotal comments about the pilot in the Federated States of Micronesia suggest positive results:

"...so the women go in to see a counselor first for their pre test counselling then they go to the nurse to have their ANC check up, then they see the doctor. It's like a chain through the clinic. They're getting through in less time by employing those counselors and adding those few extra rooms – it's sped up the whole process...It's shown it can be done I think."

Similarly, the WHO in cooperation with the NDOH, Family Health International and Hope World Wide has also initiated a linkages pilot programme in PNG.⁸⁷ This pilot scheme has successfully helped up to nine health clinics link and integrate a range of services – for example; ANC, Family Planning, VCCT, STI diagnostics and treatment, with HIV management and care, including ART. No formal evaluation is yet available, however, preliminary reporting from the first two pilots notes:

"Small units of linkages in small clusters of rural PNG is possible as shown in the two pilot sites...[and] can promote integration and rational use of resources."⁸⁸

These preliminary anecdotal results provide impetus for calling for further, more detailed studies of linked and integrated services in the Pacific context. In particular, information from such studies could significantly contribute to determining what types of linked and integrated services are most appropriate within the context of individual PICTs.

7.7 Funding opportunities still exist

Despite a range of challenges in accessing funding, opportunities remain available to those seeking funding for linkage and integration activities. For example, Global Fund still provides an important potential source of funds for integration as it continues to indicate that it will fund proposals that appropriately support linkages and integration:

"The [Global Fund] Board encourages countries and partners, as a matter of urgency, to work together in the context of opportunities presented through grant reprogramming, Round 10, and changes to the Global Fund grant architecture to urgently scale up investments in MCH [Maternal and Child Health] in the context of Global Fund's core mandate."⁸⁹

According to interviews, both Fiji and the Solomon Islands are also exploring how to access specific Global Fund secretariat funds which can be used to assist the CCMs to improve their performance.

Funding also remains accessible under the HIV/STI Response Fund's stream III (Community Action Grants) and there is the possibility that the fund will be replenished at the next mid term review. Further, because much of the fund's money has not yet been dispersed, there is the possibility that linkage and integration activities will result from projects implemented in the future, including those supported by the NSP support grants.

Finally, AusAID was identified as a bilateral donor that has been increasingly more supportive of linkages

⁸⁷ (WHO & UNICEF, 2009, p. 12)

⁸⁸ (WHO, unpublished)

⁸⁹ (PAI, 2010)

and integration. While this is particularly relevant to PNG,⁹⁰ AusAID is active throughout the Pacific and has significant influence with other regional donors.

7.8 Existing political support can be improved

The few political leaders actively advocating for HIV and SRH in the Pacific are committed and have earned a significant measure of respect across the region. Their efforts provide a key entry point for expanding advocacy on linkages and integration of HIV and SRH within political circles. There are also other mechanisms that can be better utilised to advocate and inform Pacific political leaders on the value of linkages and integration. For example, cross party parliamentarian groups on population and development now exist in Papua New Guinea, New Zealand and Australia while 17 Pacific Island countries are jointly represented at the Pacific Legislators for Population and Governance. Advocacy for greater integration channeled through these groups could go some way towards directly influencing Pacific political leaders to give greater support to HIV and SRH linkages and integration.

7.9 Improvement of institutional coordination is ongoing

The tensions that often exist between MOH/NDOH, NACs and CCMs are not a new phenomenon. Significant effort is being made by these institutions to clarify roles and to improve relationships. Where necessary, NACs have even been reestablished. Further, as was alluded to by the Report of the Commission on AIDS in the Pacific, there are no rules prescribing the need for three separate HIV coordinating institutions. Where appropriate, some of these institutions could be merged.⁹¹ The approach to national HIV coordination in Kiribati provides one alternative option that has shown some success in reducing institutional challenges. Further still, there are no rules preventing these institutions from cooperating and coordinating their activities more effectively with those institutions involved in SRH.

7.10 Efforts to address health system capacity are ongoing

There are a number of important initiatives underway to help up-skill and train more health-workforce staff in all four countries. A number of these fall under the umbrella of the Pacific Human Resources for Health Alliance.⁹² While these alone cannot solve the capacity problems of health systems, they are assisting in mitigating these and provide key entry points for advancing linkages and integration through the training of health workers in both HIV and SRH skills.

Current organisations involved in the training of health workers include the WHO, UNFPA, the EU, AusAID, the New Zealand Aid Programme, PC&SS, the Fiji School of Medicine (FSM) and the Fiji School of Nursing. Together and individually, a range of these organisations are supporting projects/courses that ensure health workers have the ability to address clients' SRH and HIV related needs. Examples of these include: the UNFPA and FSM Reproductive Health Training Programme; the FSM and Albion Street Centre Pacific Health Care Workforce Development Project – Sexual Health and HIV; the PC&SS HIV Test Practitioners Training, and; the WHO led midwifery curriculum review in PNG and Nursing Diploma in Kiribati.

7.11 Linked and integrated services already exist

In all four countries, there are some existing linked and integrated HIV and SRH service providers. While the expansion of these services is hindered by a range of challenges, their number continues to grow. They also show that linked and integrated services can be achieved in the Pacific and they offer important existing case studies for research purposes. However, they also provide ideal hubs for expansion because they reduce initial setup costs, have staff who are already skilled in linked and integrated service provision, and have unique institutional knowledge. As such they are perhaps the single most important key entry point for the advancement of linkages and integration within the Pacific.

⁹⁰ (AusAid, 2009)

⁹¹ (UNAIDS, 2009, p. 4)

⁹² (WHO & SPC, 2009c)



8 Actions for advancing Pacific linkages and integration

International research suggests that by developing appropriate linkages and integration between Pacific HIV and SRH policies and services, health systems will be strengthened, primary health care will more effectively meet client needs, and HIV and SRH objectives will be better achieved. Put differently, significant steps will be made towards the realisation of SRH for all Pacific Island peoples.

However, in order to achieve the above, a number of questions need to be answered, and a range of barriers grounded in particular country context will need to be overcome and/or managed. This process will require a sustained effort that recognises the diversity of PICTs and progressively works to find appropriate country specific approaches to achieving linked and integrated HIV and SRH activities. In particular, this process must also recognise that at its essence, HIV and SRH linkages and integration are as much about strengthening health systems so that they effectively meet the needs of all their clients, as they are about enabling people to realise their right to health.⁹³

To this end five of the WHO's "six essential building blocks" for a functional health system,⁹⁴ have been adapted to provide a useful guide to advancing HIV and SRH linkages and integration in the Pacific.

This process will require a sustained effort that recognises the diversity of PICTs and progressively works to find appropriate country specific approaches ...

1. Health information systems

- Undertake more Pacific specific research on linkages and integration. To advance linked and integrated services effectively – in a way that limits risks and maximises benefit – further PICT specific research is needed on the costs, approaches and, scale of linkages and integration. All policy that seeks to advance linkages and integration should be evidence based.

2. Leadership, governance, stewardship

- Scale-up efforts to build political support for HIV and SRH linkage and integration. Political commitment is critical to driving policy change that can advance HIV and SRH linkages and integration and to creating an environment free from stigma and discrimination.
- Scale-up efforts to strengthen, inform and unify civil society. This will better enable civil society to engage in regional discussions and decisions that affect linkages and integration. This will also contribute to an environment free from stigma and discrimination.
- Continue to promote the regional focus on health systems strengthening, particularly the focus on building quality primary health care services.
- Challenge the conceptual division between HIV and SRH, and the perpetuation of this division within regional SRH, HIV and STI strategies as well as within health institutions such as NACs, MOH/NDOH, and CCMs. Harmonising regional SRH, HIV and STI strategies and related health institutions – through their amalgamation (where appropriate) – will significantly assist in the breaking down of these divisions and contribute to advancing HIV and SRH linkages and integration.

⁹³ (Hunt & Backman, 2008, pp. 40-41)

⁹⁴ (Ibid., pp. 50-53)

3. Health financing

- Scale-up advocacy for health funding that can be used for the mutual benefit of interconnected health issues such as HIV and SRH.
- Promote more effective utilisation of those funding mechanisms that currently enable the implementation of HIV and SRH linkages and integration.
- Advocate for greater and more equitable funding between HIV and SRH.

4. Health workforce

- Continue to scale-up efforts to train new and up-skill existing health workforce members so that they can provide both HIV and SRH services.
- Continue efforts to share knowledge and experience in managing effective health workforces.

5. Health services

- Support and build on those existing linked and integrated HIV and SRH services so that they are available to a greater number of people and so that their institutional knowledge can be shared and learnt from.
- Scale-up efforts to improve the underlying health infrastructure in PICTs, this will contribute to the improvement of overall service quality as well as the working environment for the health workforce.

When these actions are undertaken and sustained, they will significantly contribute to the advancement of HIV and SRH linkages and integration within the Pacific. They will also further the ICPD PoA agenda by strengthening health systems, improving peoples health, and enabling the realisation of human rights.



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Appendix 1

Interviewees represented a wide range of organisations. These are set out below.

Papua New Guinea:

National Department of Health (NDOH), National AIDS Council (NAC), United Nations Population Fund (UNFPA), United Nations Child Fund (UNICEF), Asian Development Bank (ADB), Anglicare, Family Health International (FHI), Marie Stopes International Papua New Guinea (MSI PNG), Population Services International (PSI), the New Zealand Aid Programme (NZAP), and the World Health Organization (WHO).

Fiji:

Fiji Ministry of Health (MOH), United Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF), Fiji Women's Rights Movement (FWRM), Women's Action for Change (WAC), Fiji Women's Crisis Centre (FWCC), Fiji School of Medicine (FSM), Pacific Counselling and Social Services (PC&SS), Secretariat of the Pacific Community (SPC), Foundation of the Peoples of the South Pacific International (FSPI), Oceania Society for Sexual Health and HIV Medicine (OSSHHM), Marie Stopes International Pacific (MSI), AIDS Taskforce, Fiji Red

Cross, the Fiji Council of Social Services (FCOSS), and the World Health Organization (WHO).

Kiribati:

Kiribati Ministry of Health (MOH), World Health Organization (WHO), European Union (EU), New Zealand Aid Programme (NZAP), Australian Agency for International Development (AusAID), United Nations Child Fund (UNICEF), Kiribati Family Health Association (KFHA), Kiribati Association of Non-Governmental Organisations (KANGO), Marine Training Centre (MTC), and the South Pacific Marine Services (SPMS), Kiribati Red Cross.

Solomon Islands:

Solomon Islands Planned Parenthood Association (SIPPA), Marie Stopes International Pacific (MSI), Solomon Islands Development Trust (SIDT), Oxfam, World Vision, Adventist Development Relief Agency (ADRA), United Nations Child Fund (UNICEF), Australian Agency for International Development (AusAID), and Adolescent Health and Development Secretariat of the Pacific Community (AHD).