Integrating Sexual and Reproductive Health and Rights (SRHR) and HIV: Lessons from the Field
Kaiser Family Foundation
July 20, 2010

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

MARIA ANTIONETTA ALCAIDE: Good morning, everyone. My name is Maria Antionetta Alcaide. I work with International Planned Parenthood Federation, Western Hemisphere Region, and it's really my pleasure to be here in this panel. I think that we're going to have a very exciting panel.

We have here the experts on integration, the people who are – have been really in the field experiencing what integration means, so I think that this is the time, like, to ask all the questions about it. Everything that you want to know about integration and you didn't dare to ask, this is the time. And I don't want to put you on the spotlight [laughter], but just like to raise a little bit of excitement about the panel.

So, the format of the panel will be – we have, like, we're going to try to have, like, a very lively conversation here. The idea is, like, not to have presentation, but really a conversation for about 40 minutes and then the idea will be to open for questions and comments to the audience, so we're going to have another around 40 minutes for comments and questions. So I want to start, like, introducing the panelists.

We have Marieta de Vos other there. Marieta lives in Capetown in South Africa and is the Executive Director of the

Masai Training Services and Healing Center for Women. She has been with the organization for nine years.

She studies demography and started her career in the government in 1983 where she gained experience in the Department of Education Health and Social Development. She was particularly involved with policy development training and development records, gender issues and funding.

So she joined the organization in 1997 and since there, she's been working, like, a lot on issues related with HIV, UNGASS, monitoring integration.

We have here Drasko Kostovski. Drasko has been working for more than 10 years, so that's since he was, like, a baby [laughter] in the field of HIV and sexual reproductive health and rights.

As a civil society activist, he started as a volunteer in Youth for Participation programs and social marketing. At present, he is the Program Director for the Health Education and Research Association here in Macedonia. His work there is focused on advocacy for sexual rights and people living with HIV/AIDS.

And I think – well, a lot of people know here in Macedonia and he has been working on the promotion of enhancement of sexual reproductive health and rights and comprehensive sexuality education.

Here we have Elizabeth Castillo from Colombia. Elizabeth Castillo is the coordinator of the Sexual Health and Gender program in Profamilia, Colombia. She's also a lawyer and she is – she is a very well-known activist – lesbian activist and activist for gay rights from Colombia.

And finally, Dudu Simelane. Dudu is Executive Director of Family Life Association of Swaziland. Family Life Association is a an IPPF member specializing in the provision of sexual and reproductive health services, family planning and the provision of HIV programs, recognizing the natural synergies between these two areas. So as I said, like, I mean, like, really, we're going to hear a lot of experience on how these are linked in the service provision.

She has served on several national committees and boards in Swaziland in areas of HIV and AIDS, sexual reproductive health, gender issues and human rights; and she also has a lot of experience on advocacy on international levels, so I think – as I said in the beginning, we have a very interesting panel and a very – with a lot of experience.

So I would like to start, like, the panel with, like, more general discussions. And we know, like – as we said, we've been talking about integration there. There are, like, commitments of our integration. We see the UNGASS integration, there are very strong commitments about to put together sexual

and reproductive health and rights and HIV, but also how to transform it into integrated services, integrated policies and also how to integrate in funding.

So we have, like, these large commitments, but then, when it comes to the grass roots levels, like, the idea to talk about what does it mean? So I would like to start from the beginning asking you how would – how everything started. How you came up with the idea, okay, let's put this together and how was that process like? I mean, of you starting thinking about integrating services and integrating the work that you're doing, so who wants to start? Marieta?

MARIETA DE VOS: Yes, well, for us it started at two levels, the one was more at a policy level where Masai, together with 40 other organizations, wanted to give input to the country's UNGASS reporting 2008. And so, we formed this UNGASS forum and it was all organizations who worked on the sexual reproductive health field, but also violence against women organizations.

And so we started looking at all the factors around sexual reproductive health and HIV, you know, what are the linkages there? And then we started a whole study, but I can talk about that later. For my own organization, that's really working at the local level.

We try to provide services for victims of domestic and sexual abuse and we realized that there are not integrated services at all because for an abused woman, there is very high risk of contracting HIV, but there's also a lot of sexual reproductive health needs for that woman.

And, ideally, there should be one place where there, you know, where there are services for that woman. And so, we started that in our organization delivering all the services integrated and, you know, just trying to do it and then measuring it and evaluating it and it worked wonderfully.

MARIA ANTIONETTA ALCAIDE: So I think that, like, it's very interesting the perspective of how you can do work on integration at the policy level, but also, coming from the needs of the actual – like, in this case, women, like – and using gender-based violence in the midst of the survivors, and victims of gender-based violence is an entry point for integration.

MARIETA DE VOS: Yes.

MARIA ANTIONETTA ALCAIDE: And I don't know what it's like, I mean, the experience, for example, for Profamilia, Colombia, like on – you have, I mean, this massive infrastructure in Colombia where, I mean, like, really you are the main provider for sexual and reproductive health services.

How did you enter HIV like the work that you're doing now in integration of HIV and sexual reproductive health?

ELIZABETH CASTILLO: Well, actually, first was the work and then the speech. I mean, we began to work in the same field on gender-based violence topics and we are health providers.

That's what we do every day. So we began to began to put some topics on the services, on the provide – on our current activities, or traditional activities on sexual health, and HIV began – just become as a new topic including other services, step by step. First not thinking from the beginning as a broad idea which will grow with the time, no. It was something that begun with the work on the field of every day.

MARIA ANTIONETTA ALCAIDE: So first, like, I mean, you felt the need and then you realized, Oh, we're, like, I mean, we're putting together these services and, actually, it was, I mean, like you were really there in the forefront, like doing it.

ELIZABETH CASTILLO: Yes.

MARIA ANTIONETTA ALCAIDE: What about like the work that you were doing with the Family Life Association in Swaziland?

DUDU SIMELANE: We started as a family planning organization as most member associations of IPPF, and then

began to comprehensively integrate other reproductive health services and, more recently, HIV where we started with minimal services, such as, the peer education that we would all – would normally do, but also move onto HIV counseling and testing and comprehensively then integrated ART including PMTCT so we do see the four prongs of PMTCT in our work and play. Yes.

MARIA ANTIONETTA ALCAIDE: So we have different entry points: the political entry point and gender-based violence, more like the health provision and including HIV; more specific family planning. And I know that in here, you are working more with young people and also with people living with HIV so can you tell us a little bit more about how you started working on integration?

DRASKO KOSTOVSKI: Well, it was a natural process, an integral natural process. This doesn't mean that, practically, it was an easy process. So it was like putting the puzzle together but not having all the – all the parts of the puzzle. So we started from the HIV issue. Practically we were young peer educators and volunteers, then we continued for advocating for [inaudible] throughout the country and making it free of charge and accessible.

And we started then to work with people living with HIV and providing care, support and treatment, but within the development of the organization and the governing processes

inside, we saw – and certainly being – becoming part of the IBPF family certainly helped us – we saw that our impact on HIV will be greater if we broaden our approach because HIV is part of sexual reproductive health and, especially, rights.

So this was the turning point of the organization, but I think that the main thing that was affecting this change going on sexual reproductive health including HIV – or linking with HIV – was practically from the demands of our clients. So we were trying to satisfy their needs and their demands.

MARIA ANTIONETTA ALCAIDE: I think Drasko is starting talking about, like, maybe, what were the challenges, or what type of changes you have to implement in your own organization, or what type of challenges you faced when you started? So I would like maybe to move into that direction a little bit.

When you started thinking – or maybe not even thinking about it, but it was – but implementing this integration, what are the main challenges that you faced internally in your own organization, but also externally? What did you have to overcome in order to make it happen?

ELIZABETH CASTILLO: Well, in our case it was – tried to convince everybody that we – that HIV was, in fact, another topic to Profamilia, another topic to work from the field of sexual health. And we find a way working on health as a broad concept, as a main core concept, that within the work, health -

HIV was a part – it's another part of the job. It was another part of our current work.

When we [inaudible] the link, just we put another element, that was the idea, we put another element on the services. And the Board believed us.

MARIA ANTIONETTA ALCAIDE: So having the Board on board was really important. And this is a challenge for service providers too, like, it's not something that comes necessarily naturally, so what's the experience in, like, for example, in your case, Marieta, what has – what are those challenges?

MARIETA DE VOS: For us, the biggest challenge was to get all our staff trained because we had, you know, about 25 field workers very skilled in counseling women that are abused, but they weren't skilled in VCT.

So we had to skill them firstly in being able to counsel, and then in our sexual reproductive health clinic, we had to make sure that our counselor there could work with both males and females, because we were originally a women's organization really focusing on the needs of women.

But if you want to really integrate, I think one of the factors you have to look at is how can you assist men, you know, in terms of contraception, and couple counseling around HIV and facility planning and things like that, so there's a

lot of new information that our workers had to, you know, had to know.

MARIA ANTIONETTA ALCAIDE: And how did you convince them, like, okay, you were expressing this and then you have to express in this match, like, was that easier or did you have some resistance?

MARIETA DE VOS: That was relatively easy because our workers actually came to us with that – with the need because the clients come to them with a need. So it almost happened naturally as Drasko said. That need came from the ground.

MARIA ANTIONETTA ALCAIDE: Okay. And follow-up what you were saying, like, about building on the needs of people.

DRASKO KOSTOVSKI: Well, yes, that was the entry point of – for making this approach and this idea, but mainly, we have actually problems with the broader – how to say - with the communication of the state quarters.

Because, in general, when you talk about HIV in Macedonia, you are on a safe ground because there are some built capacities for HIV, but talking for sexual and reproductive health, and especially, sexual rights, you're confronting some kind of strong opposition and not understanding of this issue because mainly – main of the state – main part of the state quarters are thinking that this is beyond health problems when you talk about sexuality and

talking about rights. It's something that is not connected with providing services – health services.

So we are still confronting having problems in advocating for linkages and policy and program interventions, so we can say that what we are doing now is getting evidence and working only on integration of services so we can present the – maybe not the cost benefit, but the successful outcomes of that approach.

MARIA ANTIONETTA ALCAIDE: So you found, like, challenges internally, but one of the big challenges – and I would like to talk a little bit about that, because I'm sure the audience would be interested also to know the challenges outside of the organization and the different – how, maybe as Drasko was saying, maybe HIV was perceived like a health-specific issue and then maybe you want to bring it to rights; for example, maybe there is some resistance to the outside. So what is your experience in Swaziland with that internal and external resistance?

DUDU SIMELANE: Okay, I think – let me just add to my earlier intervention that male circumcision was – is part of the service package that we provide. And then, in terms of going to highlight what is or what have been the challenges, I think we have seen that integration, generally, has placed a burden on our health systems.

And I think that's one of the messages that I would like to highlight here, to say that as we integrate, I think we need to be aware that there will be a demand on health systems; however, we have been able to overcome that because we've been able to strengthen our pharmacy and laboratory services, but also our transportation system in terms of taking samples to laboratory where we cannot have them tested internally within the organization.

But also, systems in terms of data management, because as we will all appreciate, there is a burden on the health providers on recording the different kind of services that they provide, so that increased burden of recording is somewhat of a challenge.

And needing to train staff in the various services that need to be provided is a challenge, and we have been fortunate through IPPF to be able to train our staff comprehensively, but also through the partnership with the Minister of Health to train those staff to be competent. So those challenges would also include developing strong staff competencies in integrated service provision.

I think those would be the challenges, but also in terms of service delivery itself, you know, people have a preference of whether they want a medical clinic or an

integrated clinic, especially as it relates to client waiting time, which is a challenge in some sense.

Because, for instance, if a client comes requiring family planning – perhaps it's just a refill and if they are in a cue waiting for somebody who is in HIV counseling and testing, that takes a while, so that client waiting time is a challenge.

And I think we need to be aware that those are some of the challenges that we have grappled with. And I think in [inaudible] of service probation as well, traditionally, our service providers may have known that, oh, I'll be doing the city and I'll be doing ANCs and I'll be seeing the mothers.

But now this integration comes with a wide range of services and requiring that each service provider be able to provide the several range of services, so that is a challenge, but, like I say, we've been able to overcome that through training and skills building on the part of the – of our service providers.

MARIA ANTIONETTA ALCAIDE: I think it's very interesting when – what Dudu was saying, like, I mean, it's not just a matter of putting everything together. Like you say, okay, you're already doing family planning, you are already doing some HIV, so you just put it together. This creates more demands, so I think it's very interesting to see how, like,

your own organization having changing, like, for example, including men.

I think that's a very good example of how integration also impacts the way that the organization works. But also, you need to wait – to change the way that you're working like waiting times, training, laboratory services, so it has to mean – but in almost every aspect of your organization. And I would like to know, I mean, thinking also about external challenges.

I would like to know if these have had some impact in the political work that you're doing, or in the discourse that you have had as an organization, and in the conversation with other stakeholders, if this integration at the clinical services has also had an impact on them at the political level and on the external – and the external work that you're doing.

MARIETA DE VOS: I could share that in terms of the external environment, and its being the substitute, or not being the substitute to integration, I think we have not seen any challenges. We were a bit skeptical ourselves because we have a stronger comparative advantage in family planning and reproductive health.

And when we got into this new area, we were not too sure ourselves, but we really felt that we needed to provide a service because we really felt that we were losing our clients, perhaps to lack of follow-up – our family planning clients, for

instance, when they were pregnant, when they tested HIV positive what do you do? So we really felt that in order to provide a continuum of care, let's integrate comprehensive treatment or HIV services.

And that was very well received by our partners, the government and all – and all of our funding partners and we were accredited by the Minister of Health and that is – that is one positive aspect to this because then we are one of the designated ART and HIV sites in our country, so there has been quite a wider acceptance on that part.

But we do recognize that other organizations may have a bigger comparative advantage, so our partnerships come in handy to help, you know, bad situations where we may not be stronger in other areas, but I think, generally, we were well received by the external environment including the government.

ELIZABETH CASTILLO: I think that this conversation shows a lot of things, but one of the most important is we have different points of beginning. We have different kinds of epidemics, or different ways of epidemics and it's really important to know where – how is the situation in our country to improve the services, to make this integration.

And I just wanted to add about the training. In our case, we have a focus – we have populations on the epidemic and we have regular one percent and, et cetera, but in our case,

the beginning was with rights. When we began to do this training with our staff was with rights, and the other part was not only for care providers.

It's absolutely necessary that everybody be involved in the same. We have, as Antoinetta said, a huge organization with a huge staff, so work not only with care providers, but also with the watchman on the door and the women who bring the coffee to everybody. That is really important if you want to do real integration and involve the new populations as LDVD or trans, or whatever.

DRASKO KOSTOVSKI: As long as you're providing services for the marginalized groups, for the key population; men having sex with men, women having sex with women and drug users and sex workers, you don't have a problem because you're providing quality services.

And it's an NGO job and with international money, so nobody has a problem with it. [Laughter]. But in the moment when you start to talk about rights, talk about putting homosexuality in the role of wanton discrimination, or in some other legislative, then you are starting to have problems and to be recognized as an organization that is promoting something that is not good.

MARIA ANTIONETTA ALCAIDE: So it's when you translate those services to political action, or when you are questioning

the government response to that is when it comes – you may have some backlash.

DRASKO KOSTOVSKI: Yes. You are practically handling with the baggage of the public health – the whole public health. So if you're keeping it on the side and in silence, everybody is okay with that, but if you put up – show it up, then you have problems.

MARIA ANTIONETTA ALCAIDE: Is that your experience, Marieta?

MARIETA DE VOS: Yes, well we found the – for the 2010 UNGASS report, that the report that our organizations and the UNGASS forum put together, the executive summary of that is – three-page summary – was actually annexed to the country report which said to us it is an acknowledgment of the whole – it's council and government that the integration of sexual reproductive health and HIV services is a huge topic and that it needs attention and that it was acknowledged.

So for us, that was a huge success. Also, we recently heard that our national health department's Sexual Reproductive Health unit are starting to develop a whole new overarching sexual reproductive health policy which is going to link all the policies that there are at the moment together – together with the HIV policies.

So that for me is wonderful because this is the first thing that we said needs to happen in the country. And then, it also – I think it links with an international link that we have, the UNGASS forum that is led by Gestos in Brazil where the same project was done in 12 countries and we learned from one another and we can make recommendations to government. So I think, yes, we were relatively successful with what we want to do.

Our point was, in our report, was there are some many linkages between sexual reproductive health and HIV, but we don't look at all of them. These changes needed at the policy level and at systems and at the ground level. Often at the ground level, it's already working, but the systems between the different departments and NGOs is not working, and often the policies, of course, are there, but the different policies aren't linked. And that needs to happen.

MARIA ANTIONETTA ALCAIDE: And I think that you're touching in a very – something that has been very sensitive in the point of integration is, like, how do you integrate, for example, at the government level - the different projects or problems are working on different issues, so that you can also have like a comprehensive policy and a comprehensive approach to different issues. And I think that that has been something that has been sensitive.

And I want to refer to one thing that Elizabeth was saying. I mean, we have been talking up to now in very general terms about integration, but we know that the epidemic is different and, just as an example, the countries that we have here, like, in Colombia and Macedonia, we have concentrated epidemics.

Some – like the approach may be different, while in South Africa, in Swaziland, we have more generalized epidemics. So I would like to maybe, like, move the conversation into that direction before we open to questions. From your experience, do you think it's the friendlier approach by having generalized epidemics or concentrate epidemics? And what may be the main differences, I mean, by knowing your epidemic? So, I don't know –

DRASKO KOSTOVSKI: Well, I can start from having in mind the strategic consideration for strengthening linkages between family planning and HIV/AIDS. It's a document of the World Health Organization and U.S. Aid and other organizations.

So, practically, in this document listed the challenges when you are integrating family planning services with HIV or sexual reproductive health services with HIV. And one of the challenges is that it might not reach most of the risk populations, and the second one is to be – unlikely to be cost

effective in a real low HIV prevalence and concentrated epidemics.

So in regard to the first one, well, we have another experience. We are functioning with most of the risk population because – especially with men having sex with men – because, to be concrete, we made our integration within our youth centers so, actually, at the beginning they were sexual reproductive health services providing sexual productive health services starting from gynecologists, peer education.

We continue with social worker covering gender based and domestic violence. We proceed with general practitioner. Now we have a dermatologist. Dermatologists in Macedonia are the male doctor in the first line. They are not covering only skin problems. They are working on sexual and productive health as well.

Actually at the end we included the vicity [misspelling?] as well as providing contraception, dual protection, condoms etc. At the beginning, we had a partnership and a good network of NGOs that are providing services and a good network of gatekeepers.

Our partner organization was sending their people to our center. Today we can say that we are very proud that these people are coming on their own. They do not need any guidance. They do not need referrals. They do not the gatekeeper to

bring them to our center. That has been because they are saying that we can get a couple of services in one place and we can say what we are. This is the only place. We do not need a referral note from GP we have it all here.

Where is the challenge? Where is the problem? The problem is in that part or service that we could not provide because we are not able to provide all of the services. There are some other services that we are making a referral, but there are many of them that we are just sending the people back to the regular health system. This is the problem. The problem is to continue with this very hard to sustain system that is very costly. It needs a lot of funds to cover all of the service providers.

We must keep up and continue. If we stop then we will make a larger problem then before we started. People would be acquainted with this kind of service and will be close to this kind of service. Then we will again be marginalized and left aside.

Another point that I want to make is that you must start working to the service providing on empowering this population. How to take part in advocacy for this access, for access to these services and advocacy for their rights.

MARIA ANTONIETA ALCALDE: I think that view, especially on concentrated epidemics, that has been one of the questions. It is really integration and answer in concentrated epidemics.

Especially with MSM and other populations that may not find an answer in sexual and reproductive health services. I think your experience with HERA is like if you partner with the right organization, if you target that population, it is possible and it is a successful story. I would like to hear about maybe a generalized epidemic. It is really successful? How is it different from what Drasko was telling us?

DUDU SIMELANE: In generalized epidemic like in the case of Swaziland, we are providing services to the general population. Of course, different organizations are targeting whether it is young people and prioritizing that. I think this is still a generalized epidemic. We do see that populations such as MSM and sex workers would then fall in the cracks in terms of our reach to them with the kind of services that we provide.

I think that is still a concern and that is what we need to work on. I might add that we are working with an international organization in Swaziland to address or to provide health services for sex workers. What we do in that arrangement, sex workers will present themselves to our clinics with a voucher from the organization that I am talking about.

They will get access to services. They are prioritized. We do not insist they stand in the queue because we do not want them to be stigmatized. I think that is one way to address special populations such as sex workers.

I think we also need to step up to the plate ourselves in terms of strengthening our skills, even cancelling skills or instance. We cannot assume counseling for STIs for instance in a person, men having sex with men would be the same as somebody else in a heterosexual relationship.

I think we also need to get those skills, gain those skills and how we address in a more friendly, in the same way we talk about youth friendly services let's also talk about services that are friendly to special populations such as MSM, sex workers and so on. That is still a challenge and that is still a gap.

MARIA ANTONIETA ALCALDE: You are talking about generalized epidemic, the challenges to address everyone but how to make it also friendly for a specific population. It is still a challenge. Is that the experience that you have faced in South Africa?

MARIETA DE VOS: Although it is a generalized epidemic, we are focusing on women of reproductive age. It would be your whole range of women from 12 up to 50, not only pregnant women.

For us that is very important. Looking at the whole area of women and looking at sexual health and reproductive health.

I think there are so many points where we can look at integration. One of our partners at the University of Cape Town, the Women's Health Research Unit, they have now developed an integrated counseling model for newly diagnosed HIV positive women.

That is one place. Mosaic has thought that, where is the place where you find women that are most likely, most likely HIV positive or most likely on their way of becoming HIV positive is at abortion clinics. This is a point of prevention that nobody thinks about. We know work is being done. We are focusing on that.

Another process that we are busy with is a group of organizations looking at treatment guidelines for women of reproductive age. We will also say that the specific point lesbian health, we look at that. We want to put guidelines together to say, okay if you want to have an integrated service in these fields; these are the things that the service provider must look at.

MARIA ANTONIETA ALCALDE: To close this round, what are you experiencing? Especially in Columbia, having concentrated epidemic, but also low prevalence.

ELIZABETH CASTILLO: We have to make the most with our traditional clients. Traditional clients are women. Maybe they model a huge provider of services to cancer to women around the country. I see how different our situation in example to us. The involvement of HIV is not exactly focused on MSN.

We have to talk and to think and involve women in the process. We have feminization of the epidemic. An example with my MSM friends, their organizations of AIDS work around the country, they do not like to listen of feminization. This is the reality.

In 15 years, we change the relation between ten men and one woman. Now we have in the last year two women for each one man. We have a situation in which we think is a challenge. It is an opportunity to think in our usual clients and institutions. More involvement of new people and they are invited to come. We are working a lot on the stigma MSM reduction.

It is too broad the concept. Not only to MSM but from the field of HIV to also understand that women are involved in HIV and we have an opportunity to work in a field that we see mostly hiding or mostly on the consideration of the work of HIV.

MARIA ANTONIETA ALCALDE: Again, we are talking about integration in general. We know when it comes to the actual reality how that may take different forms. How by knowing and understanding better your epidemic, you can also shift. Knowing your own organization and coming from what your organization can do.

One of the things that I think is a common element is partnerships. How can you partner with other organizations or you can be more effective and you can understand that you may not be able to solve everything, but you are able to really make the most of what you have.

Before we open to comments from the audience, I would like just to give you an opportunity. I do not want to think about the magic bullet or something. What is the one key element, something that you would like to highlight to the audience?

If you want to strengthen integration, what is your key element, key message to the audience? What would be that thing that we should not forget? Who wants to start and then we are going to open for questions and comments to the audience. Dudu.

DUDU SIMELANE: My key message is partnerships. I think I have mentioned that we have partnered with an organization to provide services for sex workers. Also over

and beyond that I think when we talk of integration or images, we have organizations that are traditionally reproductive health organizations and HIV organizations. All of those are bringing in a comparative advantage that enhances interventions.

I think for me that is very important if we are to make integration or linkages more meaningful. Also not just that but also it helps to maximize your human resources and funding opportunities. We do know that there is perhaps no fund for reproductive health.

We have the Global Fund on AIDS, TB, and Malaria. We could already see an opportunity. If we are to propose interventions in the Global Fund to be supported as long as even if it is family planning, as long as it results in positive outcomes for HIV I do not see why not.

I think those partnerships would enhance. I think that is my message.

MARIA ANTONIETA ALCALDE: The key element, work together, partnership. What other could be or may be strengthening the same message?

DRASKO KOSTOVSKI: I would say keep up with the needs of key population. Try to provide everything your clients are demanding. Try to satisfy their needs.

The second thing is to understand integration as a need of some massive structure of health system and clinics. Try to integrate whatever you have. Let us say we are providing outreach throughout the country and we decided to include STA testing besides the visit. Try to integrate whatever you have.

Continue with interventions on this level of providing services. Track your progress and collect information so you can go further on the second level of linkages and advocating for policy and program change within the state health system.

MARIETA DE VOS: I would say that coordination at local level is absolutely essential. We are a long way from clinics and nurses providing every conceivable SR agent and HIV service in one facility. They should be very good coordination, systems, and processes and start small at local level because that works.

MARIA ANTONIETA ALCALDE: Great. Coordination, partnership and integrate what you have and do not be overwhelmed that thinking it is a massive thing.

ELIZABETH CASTILLO: I want to say the first message is integration is possible and it is not necessary to have huge resources to begin to provide this service. You can just improve what you are doing and you could do it.

The second point is to use the definition of health of whom. Use it. It is not only about biological topics, it is

also about mental, psychological, and social topics. In our case it was really useful to work and to broaden our population as an example to LGBT people and not only to provide them health services but also to provide a lot of possibilities in the LGBT community center. We are a traditional family planning association and we work to an LGBT community center. We could work from the field of the definition of health in the broad concept.

MARIA ANTONIETA ALCAIDE: Broaden your definition of health. We can talk for hours about these. I would like to continue the conversation, but now including the audience. We are going to take questions, comments, complaints, jokes or about the conversations that we have had. We have two microphones.

We have four but we would prefer you to come to the front. We are going to take 3-4 questions, identify yourself, who are you, your country, and your organization and try to be brief.

MARVIN BUNTAL: I will try to be brief. Marvin Buntal ULSVA. First I would like to congratulate the panelists in very interesting presentation. Just wanted to also point out that it was very useful because in the Caribbean PAHO and UNICEF have been working together on elimination of mother to child transmission and congenital encephalitis which is an

opportunity for integration. Additional integration is an important pillar in that intervention.

Also, UNFB has been working with promoting with governments and systems and the importance of integration. This is very relevant. I would like to ask, I am not sure if I missed it, if I did you can just ignore me but what are the arguments one of the points that was just made was about studying your progress with the integration and tracking. What is the concrete evidence that you have to show that integration does improve health outcomes? That is one.

I would like to also get the opinion of someone on the panel on the argument that integration would take away the focus on HIV, particularly as it relates to reducing stigma and discrimination resulting in reverse of the gains we have made so far. Thank you.

MARIA ANTONIETA ALCALDE: Thank you very much.

DELORES DOCKERY: My name is Delores Dockery. I am from the U.S., a person living with HIV. What I want to know is for you to talk a little bit more about what specific steps that you are taking to train staff to address their biases against marginalized population including people living with HIV.

There are many complaints of HIV positive people who have experienced stigma in family planning settings and I want

to know if there are any mechanisms in place to get the advice of clients who you serve in developing your structure and implementing your programs. The clients being negative were positive.

MARIA ANTONIETA ALCALDE: Thank you very much. We are going to take two more questions. Please.

CASSANDRA MICKISH: My name is Cassandra Mickish. I manage the resources for HIV/AIDS and sexual and reproductive health integration website. One of the issues that I hear a lot is an issue that several of you have touched on today is about the increasing burden on staff for integration of services.

You are increasing the amount of training that staff need, you are increasing the amount of time that staff needs to spend with patients, the number of services that you need to provide and probably even making your services more available to more people so you are getting more patients or clients. I was wondering if you could talk a little bit more in detail about how you have actually managed that increased burden.

MARIA ANTONIETA ALCALDE: Thank you. One more question.

SARLO HILEM: Okay. My name is Sarlo Hilem [misspelled?] from the Parker Foundation in Ethiopia. I was recently in an east African country and one of the biggest IPPA

affiliate. I used to work with them 25 years ago and they used to provide 99-percent of its activities were family planning.

When I went there a few weeks ago, 70-percent of its activities were HIV/AIDS. What changed between then and now is the funding stream. Most of the funding now comes from HIV/AIDS, so we have moved our emphasis from reproductive health and planning to the HIV/AIDS. You mentioned this briefly.

For the last 20 years, we that are advocates of family planning have been sort of the orphans of reproductive health because more and more family planning just disappeared from the scene. Now things have changed. Global health is now accepting proposals for integration for family planning HIV/AIDS program.

The Global has initiated of President Obama encourages integration. The question that I have is are we ready for that? When I say are we ready, I do not mean just providing contraceptives and counseling, but comprehensive integration of services.

If a rural Swazi women comes to FLAS for service with her four-month-old child, she has an integrated service in her mind. That is the most natural thing to expect. When she comes to FLAS she gets vertical services. She sees our VCT, which she has to for family planning among other things.

Now we have a golden age for integration. Funding sources are integrating. Are we ready for that? That is a question for any one of you.

MARIA ANTONIETA ALCAIDE: Thank you. I will take one more question on this side because this queue is longer. We are going to have a round of answers and then we are going to come back. So, please.

CHRISTINE MUNDURU: Thank you. My name is Christine Munduru. I work with the Open Society newsletter for East Africa. I come from Uganda. I would like to have a clearer understanding of what human rights services you have integrated into the sexual and health reproductive services that we are talking about.

You also mentioned that if you prevent services to MSM or women having sex with men you have no problem. When you start putting it out, then you have a problem. That to me shows that there is no integration between human rights services and the rest of the services we are talking about.

I wanted a clearer understanding of what human rights service you people are integrating in your activities.

Second, if you wanted to advocate for integrated services by governments, what would be your recommendation? Thank you.

MARIA ANTONIETA ALCALDE: Now we are going to have the round of answers. I will ask each of you to answer the questions that you feel were targeted or were directed to you. Who wants to start? Any question that you feel that were directed to you.

ELIZABETH CASTILLO: Two or three people asked about the training and how to train the staff and maybe the last one question could be involved with an answer that I want to give you.

The safest land is beginning with training right. Begin the training with the topics of human rights and involve the people in those topics. Doing a strong connection with health and how to provide health services on the frame of human rights.

It helps also if you have restricted conditions in your countries. Some kind of reduction. I am talking about my experience. Maybe I am so varying to try to talk about experiences in countries where you have restricted conditions in example to work with LGBT topics.

If you in the field of health, it helps a lot to think about something that provides a service to key populations who are with some conditions specific or not. Promoting homosexuality or nothing. You are just providing services of health.

Back to the answer of training. The training must have a strong connection between human rights and health. Once again, I repeat again and again with a broad concept. A concept of health not only health as biological topics. It is necessary to involve other possibilities on training. Try to broaden the concept of health and connective with human rights.

MARIA ANTONIETA ALCALDE: that is answering two questions. We have questions about do we have evidence that this is successful. The whole argument that this is referring to integration. I think we have a question about this is referring to HIV but also how family planning services have been affected and where the balance is. The increased burden of staff. How this is putting a lot of pressure on staff and how can we integrate human rights. How are we doing it and recommendations for advocacy? Do any of you have answers to those questions?

MARIETA DE VOS: I also want to start with the human rights one. I think our organizations work is absolutely based on human rights. Even if we do counseling or if we do outreach in communities we try to link everything we do to rights.

For us central of the rights to choose in terms of abortion or not. It is for us a very important right and we advocate it all of the time. The right to have children for HIV positive couples. For us that is very important. The

right to safety for abused women. We also bring them in. We are really pushing also for the decriminalization of sex work. It is a very important thing in terms of SRH and HIV integration.

Whether we are ready for integration, I do not think so. I think there is so much to do in terms of systems work. If that woman comes to the clinic from a rural place and she needs a pap smear, she needs her ARVs, and she needs some mental health counseling maybe we cannot provide all of that in one day.

That for me is why the coordination and the planning at local level is so important so that we can see through very strong referrals and better appointment systems and things like that, that we can provide a more comprehensive service.

The more positive health outcomes, that question is interesting. We do not have research to show that the integration is necessarily leading to better health outcomes. What we have is our client satisfaction comments.

We talk to our clients afterwards and there we get a lot of positive comments of women saying that they were very surprised when they got to the service and they got all of these additional services that they did nt even expect. A sense of gratefulness, which is ridiculous because they should have it.

Also the fact that the stigma has gone away. In an integrated center, women often say that the stigma is not there at the service. I think is the ideal that we should look at.

DRASKO KOSTOVSKI: We are actually at the moment making some kind of cost efficiency study on our work. We do not have concrete results of our cost efficiency or cost efficiency about the work of our centers or any of our results where we are making an improvement of any health indicators.

What we have is the same. We have a large increase of the number of clients, especially clients from most at risk populations. So, that's a very satisfying result for us. In regards of the question of people living with HIV, I can give you a small example of integration, and also again, partnership.

That is that we are providing counseling services. There is a counseling center that is mainly a care and treatment center. The one in Macedonia that is in partnership, that we are organizing a partnership with the state clinic for HIV. But these people, people living with HIV, that are using the services, care, treatment and support actually are not getting any other services.

So, the services that are connected to their sexual and reproductive health and positive prevention are practically

provided in our youth family services. So there is a referral list.

In regards of human rights services, well, as Marieta already said, having service provider that is not stigmatizing and you are living with HIV and having access to services is the first thing.

But also we are providing something else, again in partnership with other NGOs, and actually our social worker is making a database of human rights violations. We are also providing legal aide. So if the client wants to go and have legal support and go in court, we are ready to support him.

What to do with the government and to make some kind of changes? Yes, we are close. We are working on service level. We are also very loud and active in our advocacy for sexual rights. We can say that actually the new strategy for sexual and reproductive health has some kind of elements of linkages and is also involving sexual rights. Yes, there is some progress. But the main problem is the implementation of all these national strategic documents.

We can make the change. We can make any kind of change of the political world, but there is no change in the implementation of these strategic documents.

MARIA ANTONIETA ALCALDE: Dudu, do you want to add something before we pass to the second row?

DUDU SIMELANE: Yes. Okay, I just wanted to also add something to the evidence. There was a question on concrete evidence. I think IPPF and UNFPA, WHO and UN AIDS have produced this document called *Linkages: Evidence Review and Recommendations* and I think it's important that you look at this.

You can pick it up at the IPPF booth and I think UNFPA booth, as well. But there is also other evidence and here it's highlighted that there are some concrete studies that have been done. But also, currently in three member associations of IPPF in Africa, Swaziland, Malawi and Kenya, there are several studies that have been undertaken right now on the costs and benefits of integrating reproductive health and HIV. Already some of the evidence is coming out and is being presented at this conference.

On Thursday evening, there will be a session, a presentation, from the London School and you just look out for Integra, the project is called Integra. There are several posters that have been exhibited in the poster exhibition around that.

So I think there is evidence and very, very strong evidence, I believe. Also, the issues of stigma will also be unearthed in those studies. But already in Swaziland, we are doing, under the London school leadership, in the partnership,

we are doing studies and there is a collaborative study that has been done.

Already, some of the preliminary findings are telling us that there is a general preference for integrated service sites because people really feel no one will know why I'm here, we're all the same clients, we're all carrying the same registration book and so on. So I think there is evidence that is already speaking to stigma reduction in integration.

In terms of staff training, I think there was a question in terms of how we try to eliminate stigma or bias. We, in our organization, Family Life Association of Swaziland, have done several various clarification workshops for our staff.

In terms of trying not to cloud our professional responsibility with values and what you believe in and religion and so on. But that is not enough done in one organization or let's just say several. We need more. We need the government to also embrace that concept of values clarification so that all those benefits trickle across the entire health system.

In terms of how we address increasing not enough time on staff, that is a challenge, but we do work around it in terms of giving staff time off when time off is due. But really, it does place considerable strain on staff integration of additional services into the service package.

I think the way out of it is to have additional staff. But normally, in a limited resource settings we don't have the luxury to do that. So we find ways around it such as additional staff time off, but also bringing in relief staff when other people have taken leave to sort of alleviate that burden and frustration.

There was a question on IPPF now moving to HIV as opposed to family planning or reproductive health. I think that, yes, maybe that observation is valid. But I think we're all trying to say is it's integration. As much as possible, we don't want to demarcate or verticalize [misspelled?].

Yes, perhaps we are now being visible as a federation as IPPF in HIV. But I think it's the nature of the work that we do. I think this message in this session was about integration.

I personally think integration is the way to go because we're targeting the same target group with both SRH and HIV services. But, also the same service providers should and are the ones providing the services, which are bidirectional in nature.

So I think, while that may be an observation, which is not out of the way, but I think let's try and not say we are 70-percent, we're 95-percent. I think let's try and work towards a convergence to say it is an integrated service that you are providing.

I think in terms of what we would recommend, I would recommend to government, again I will point you to this document. Also, in IPPF and I think the partners include ICW, UN AIDS, UNFP, WHO, Young Positives, and GNP+, there is a rapid assessment tool for sexual reproductive health and HIV linkages.

It's a rapid assessment tool, which we are using in several countries including Swaziland, where we want to come out with findings that will help us determine what interventions must we put in place at different levels, whether it's a service, delivery level, program level and policy level.

For me, I think what I would say to the government is to say we advocate around putting in place or bringing synergies around HIV/AIDS strategic plans and reproductive health strategic plans so that we have one strategy that addresses everything, which is HIV and reproductive health. So I think those would be my responses.

MARIA ANTONIETA ALCALDE: So I will take four more questions. We'll take four more questions and then, okay – I will ask everyone to be brief. So, please go ahead.

MONICA: My name is Monica from Argentina. I think that if we're going to provide more integrated services that we need to talk about how we integrate the different expertises and backgrounds and disciplines in the health team. I know this is difficult, but I would

like people to talk about their experiences on multidisciplinary or what – I don't exactly in English. Thank you.

MARIA ANTONIETA ALCALDE: Thank you.

CORNELIA HANOS-DION: Yes, my name is Cornelia Hanos-Dion [misspelled?], Church of Sweden. I have a question for Dudu Simelane. First of all, I would like to recognize the importance of flaws in Swaziland. What are the challenges, Dudu, that you face as flaws working on sexual and reproductive rights in Swaziland? Can you work on rights? Can you promote the right part of this in Swaziland? And if, how do you do it?

MARIA ANTONIETA ALCALDE: Thank you very much. Please.

JENNIFER BUSHEE: Okay. My name is Jennifer Bushee, and I'm from Stop AIDS Now, an organization based in the Netherlands. I have a really concrete question. I'll try to keep it short as well. I haven't heard a lot of examples of conscious decisions not to integrate and I'm just curious. I'm generally convinced about integration ideologically and also quite practically, but are there cases where it was possible, you could've done it, but you chose not to do it for a specific reason based on the circumstances?

MARIA ANTONIETA ALCALDE: Thank you.

NICKY: Good afternoon. My name is Nicky [misspelled?]. I'm from the African Sexual Alliance in South Africa. My question is directed to you, Sister Dudu. I'm afraid I won't be able to be brief,

brief, brief because she's touched base on a subject that I'm very passionate about.

For starters, I'm quite interested, how do you identify or how do you reach sex workers? Is it that they come to you and disclose or you go out on outreach and do outreaches and then get them mobilized to come and use the services? In the way that you have done this, has this enabled sex workers to utilize the services that you provide for them?

I also heard you mention partnerships. When you mean partnerships, do you mean on service provision or do you also mean advocating for the rights of sex workers, and perhaps also providing legal assistance to sex workers? I'm also interested in knowing what's the legal position of sex workers in Swaziland? As we know, in most African countries, it's impossible to come out as sex workers and client because of the discrimination and consequences one faces after that. Thank you.

MARIA ANTONIETA ALCALDE: Thank you very much.

REGINA BYOCKI: Thank you for the enriching discussion. My name is Regina Byocki[misspelled?] working with the Gender Health Kenyan Office. I'll try to be short. I'm also convinced about integration, and it is true, integration is the way to go.

But, just a few concerns. We are trained to integrate RH to HIV. RH has its own standards, quality assurance. HIV has its own standards of quality assurance. We are talking about cost effective

integrations, strategies and interventions. We're also talking about maximizing on the available resources and leveraging and all that.

But I'm concerned. As we talk of cost effective strategies, cost effective integration strategies, how do we ensure that we don't compromise on the quality of services we give in this integrated service delivery point? Thank you.

MARIA ANTONIETA ALCALDE: Thank you. Thank you very much. We have two more questions. Because of time, we're going to take it now because we want to have time to do another round.

SHIADD: Thank you. My name is Shiadd [misspelled?]. I work in Marie Stopes Bangladesh. We are providing services across 62 districts out of 64. Mostly we provide the total comprehensive reproductive health services. So we have documented many things during the discussions. One is about stigmatize or discriminations. I'm heading the advocacy rights and the [iaudible] unit. From our experience, what we can see is that we've got to have a very strong accountability framework. This is number one.

Number two, you've got to let your clients know what is their entitlement. So mostly we do things very frequently, but what we don't do, we don't create any room for raising voice after client. So what we do, we also gave some information if your rights are not realized, so this is the tools through which you can raise your voice and then we give back to the clients. These are the three steps.

Number two, we have talked about the integrations. Yes, integration is very good because most of the clients wants subservices, they're not worried. But the only problem is the localized mobilizations because different donor has different interest. Most donor wants very sporadic projects. I want local HIV projects, I want mental health projects, I want [inaudible], I want right and rights projects. But when you integrate, then you see that the donor really don't want to spend money in the pocket.

Number three is when we give services, we only focus on the technical aspect of the providers. We provide infection prevention training, we provide syndromic case management training, but we don't provide the rights. We mostly don't spend money on that. But you don't need to have a very big investment. When you give a new training, that's a right to traditions.

For example, what is rights-based services and what is not? There's one difference, your mindset. You are delivering the same services with one attitude. Once you've gone through training, then you are delivering the same services within the same infrastructures but with a different attitude.

That's why we try to build the capacity of all our service providers. Yes, initially our provider have very much benefit to contact the HIV positive delivery. So we are doing that. What did we do them? We did infection prevention. This is the wrong understanding about your HIV sort of things.

Third, if you'd like to integrate, one thing is very much important for you. Don't care about the funding at NC. Build your capacity first, institutional capacity. What only we can deliver without the minimal external support from your donors.

So, initially we are very CYB focus program. We started since 1988. Now we have huge ranges of program. We provide HIV services program, we provide clinical training, we provide rights-based training, we provide mental health services, family planning services, a huge range of services. Why are we successful? Because we build our capacity first. Thank you very much.

MARIA ANTONIETA ALCALDE: Thank you. And the last question.

RONNIE LOWE: Hi, Ronnie Lowe [misspelled?] from Save the Children, and I have a brief question. Given the growth of HIV funding in recent years, but the disproportionate funding for family planning, there are examples of integrating some content into reproductive health services.

But given the large scale programs now, thanks to the Global Fund and PEPFAR and some of the other donors that are really driving some very large programs and program infrastructure, do we have any examples of country programs where the donors have gotten together and coordinated to ensure that contraceptive commodities and some capacity building is matched to these large scale programs? Because it does seem like there are some efficiencies we ought to be working toward.

MARIA ANTONIETA ALCALDE: Thank you very much. We have very diverse questions, several questions. How to work with multidisciplinary teams. Two questions specific for Dudu. What are the challenges working with rights and how are you working and integrating sexual rights and reproductive rights in specific? Specifically with sex workers, what is the work that you're doing if you outreach for sex workers to work around the rights of sex workers?

Well examples of maybe cases where you have the choice to integrate and you decided not to do it, if you have had that experience. How to do it, like putting together the services without compromising the quality. I think that the examples of the work indicates other organizations are doing, I think it's also good to know. There are several organizations and we can comment on that.

Two questions specifically about donors. How to integrate when you have different donors and different priorities, and if there are other examples of donors actually integrating their efforts for us to integrate.

So if we can be brief because we are coming to an end. So if you can be very brief, these are going to be your last remarks, too. So, who wants to start?

ELIZABETH CASTILLO: I just want to say something about the first question. It was how integrating creates the possibility to work on different experiences. I think with partnerships. We don't

have to know, it's not our obligation to know to do everything, but it's really important to know who do what we don't do, who knows about, we don't have idea, and work with the partnerships can be a really effective way to find support. If we don't have support of rights or try to do partnerships with another organization who all are from the field of rights.

About the donors, well, we don't have the problem, actually. Our main donor is IPPF and the work that we've been doing by IPPF — I say, again, just we don't have to do a huge change that's on their services.

We are not doing huge change. We don't need more people on the staff or whatever, just we are doing what — we work every day that the focus and because we don't have huge costs, of course the donor put the agenda, and I don't know how to suggest, maybe just to try to convince the donors about the importance of, try to work from more broad concepts.

Not only HIV because we work only with HIV and only with key populations. In five years, we will be working, ah, I thought we forgot women, let's go to work with women. So it's important to try to — Of course, I know it's not easy because we have the colleague from the projects and we send what we have, but maybe donors must be sitting here.

Not you? It could be more effective to try to teach them it's important to work from more wide concepts, not only from each key population because it's very limited.

MARIA ANTONIETA ALCALDE: Great. Dudu, you have two specific questions and I will ask you to be brief, please.

DUDU SIMELANE: Okay. I think on the first question on reproductive rights, I think my response would be when we talk of SRH and R, the last R tends to be a smaller R because unfortunately, it's just unfortunate. But it is difficult to advocate for sexual rights, I must say. In Swaziland, we are a traditionally strong society, and we really need to be as an organization. We really need to be conscious of the culture and the environment that we are in.

So it is challenging, like I say, but I think there are efforts to work to us. For instance, in a clinical setting, we do respect the rights of young people, the right to confidentiality, the right to choice and all, but that's perhaps not enough. So I think more still needs to be done and we need to find ways around that.

In terms of sex work, I think there are several questions around sex work. How we partner, is our partnership only for services? Yes, our partnership is only for services at this point in time.

Several years ago, we worked through FHI and got support with PSI to work on the sex work project. When that project came to a close, we still had sex workers as part of the group that we were

targeting and providing services. We've maintained that cohort and those are the ones that we have continued to provide services for. There are not many interventions around sex work, sex workers, but we do acknowledge that they are there, and there are efforts to address them in the new strategic framework on HIV.

In terms of the legal position, yes, sex work is criminalized in Swaziland. It is illegal. But, again, there's providers of services and people working in HIV, they are there, sex work is there. I think we shouldn't ignore that because we're all about trying to prevent HIV. So, if we provide services, we're doing just that, whether it's illegal or whatever the case. But I think in terms of service provision, we have the responsibility to provide services.

I think those were the questions. Thank you.

MARIA ANTONIETA ALCALDE: Thank you very much, Dudu. Just final remarks.

DRASKO KOSTOVSKI: I would say something about the move to disciplinary approach. Well, our team was practically trained in a course of two years. It was a team of state health providers, and also young people, and also maybe some younger health providers.

During that period of trainings for different kind of sensibilization, trainings on human rights, training on working with different key population. Actually, they've got a good

capacity to work in the center, and they are working as a good move to disciplinary team.

But also, we had a good system in place for monitoring of their work, and also a good database for collecting the data and satisfaction of the clients. So somehow we are following the work of that move to disciplinary.

The second question was about the deconstruction of integration, examples of non-integration. Well, I was thinking, and I think that you should not integrate if you're not assessing the needs of the key populations and your clients.You can't integrate when you know that it is good but you don't have money.

MARIA ANTONIETA ALCALDE: Thank you very much. Marieta?

MARIETA DE VOS: Just very briefly, I think the question around the harnessing of efficiencies around commodities is very important. It's slowly starting with the Global Fund now, but I think we should look much more closely at the procurement systems of government. In our country, I think with female condoms, it's a very big issue, and we look at that.

In terms of the quality standards question from Kenya, I think before integration happens, there should be a planning unit that looks at the different quality standards because they do overlap. I think new protocols needs to be written so that the staff

that deliver the services aren't overburdened also, in terms of things they need to complete on which they are being assessed.

Then, just lastly, also about not integration, I haven't heard of many, but we've heard of some public clinics where there was fear of integration. It mostly had to do with staff capacity.

MARIA ANTONIETA ALCALDE: That's very good, like anything that in a way, we cover all the elements. Again, we can talk about these for hours. But just like me, I've been taking some notes of key messages. So I think we have different people that need to hear stronger about integration, we want governments.

I think one of the elements that we broached is that we need to create an enabling environment for integration. So that means that policies that are integrated. That means remove legal areas that are preventing key populations to access services.

So really, the work that government can do, it's really important. I know for integrate, the way that government is working at the different levels. I think another message for donors, we also heard that donors need to coordinate they're efforts. It's really hard to integrate if you have to respond to different needs and different emphases.

Also, I think one element that wasn't brought directly, but indirectly is about funding conditionality's and the importance to remove funding conditionality's, so we can actually work with key populations and move forward on this work.

I think strong messages to NGOs about to not be overwhelmed about the idea of you have to integrate everything and you have to do it right now. About partnerships, we need to know each other and start working with each other so we can actually – the only way to integrate

And I think that's a very strong message, is if we coordinate and work together and create partnerships, the importance to collect information in order to show our success, to integrate also our advocacy efforts, so it's not only about services. It's about rights, and it's about really coordinating for a better political environment. The importance to work with key populations including women and girls. So we really need to integrate to respond to the needs of our clients.

Finally, I think that this is both for donors, government and NGOs. For NGOs, it's like this is a long-term investment. It's not something that you do in one year, it's not just one funding. If we're going to move forward for integration, it has to be long-term because we are creating the demand and we are responding to a need, so we have to be responsible for that.

I think a message for everyone is we need to continue this conversation and to ensure that next time that we meet, we actually have new challenges, but also new answers to all the questions that you have. So I want to thank you for joining us. I hope that you

have enjoyed as much as I did, like, this session. So thank you very much. [Applause]

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.