

Linking Sexual and Reproductive Health and HIV/AIDS

Gateways to integration

a case study from Serbia

Investing in Youth:

Reaching those most vulnerable to HIV



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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
IPPF	International Planned Parenthood Federation
ISH	Institute for Students' Health
SOAAIDS	STI AIDS Netherlands (an expertise centre for HIV/AIDS and other STIs)
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Linking Sexual and Reproductive Health and HIV/AIDS

The majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding, all of which are fundamental elements of sexual and reproductive health care. In addition, sexual and reproductive health problems share many of the same root causes as HIV/AIDS, such as poverty, gender inequality, stigma and discrimination, and marginalization of vulnerable groups. Despite this, services for sexual and reproductive health and for HIV/AIDS still largely exist as separate, vertical programmes.

Global commitments to strengthen linkages

Building blocks

To raise awareness of the pressing need for more widespread linkages between sexual and reproductive health and HIV/AIDS, UNFPA and UNAIDS, in collaboration with Family Care International, held a high-level consultative meeting in June 2004 with government ministers and parliamentarians from around the world, ambassadors, leaders of United Nations and other multilateral agencies, non-governmental and donor organizations, as well as young people and people living with HIV. The meeting resulted in *The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health*,ⁱ which challenges the sexual and reproductive health and HIV/AIDS communities to examine how they might improve collaboration.

An earlier meeting, held in Glion, Switzerland (May, 2004), and initiated by WHO and UNFPA, took a close look at the role of family planning in reducing HIV infection among women and children. This conference resulted in *The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children*.ⁱⁱ

In December 2005, a global partners' meeting was convened to discuss progress in implementing a comprehensive approach to prevention of mother-to-child transmission. This consultation also stressed the importance of linking

sexual and reproductive health and HIV/AIDS services, and led to a *Call to Action: Towards an HIV-free and AIDS-free Generation*,ⁱⁱⁱ as did the most recent PMTCT consultation in Johannesburg November 2007, resulting in a Consensus Statement: *Achieving Universal Access to Comprehensive Prevention of Mother-to-Child Transmission Services*.^{iv}

Linking HIV/AIDS and sexual and reproductive health was included as one of the Essential Policy Actions for HIV Prevention in the UNAIDS policy position paper on *Intensifying HIV Prevention*, which was issued in 2005.^v

Framework for universal access

The above commitments culminated in the Political Declaration on HIV/AIDS arising from the 2006 Review of the United Nations Special Session on HIV/AIDS (UNGASS), which also stressed how vital it is to link HIV/AIDS with sexual and reproductive health.^{vi} Following the commitment by G8 members¹ and, subsequently, heads of states and governments at the 2005 United Nations World Summit, the UNAIDS Secretariat and its partners have been defining a concept and a framework for Universal Access to HIV/AIDS Prevention, Treatment and Care by 2010.^{vii} Efforts towards universal access underline the importance of strengthened linkages between sexual and reproductive health and HIV/AIDS.

¹ G8 summits: Since 1975, the heads of state or government of the major industrial democracies have been meeting annually to deal with the major economic and political issues facing their domestic societies and the international community as a whole. G8 countries are France, United States, United Kingdom, Germany, Japan, Italy, Canada and the Russian Federation.

The potential benefits of linking sexual and reproductive health and HIV/AIDS include:

- improved access to sexual and reproductive health and HIV services
- increased uptake of services
- better sexual and reproductive health services, tailored to meet the needs of women and men living with HIV
- reduced HIV/AIDS-related stigma and discrimination
- improved coverage of under-served and marginalized populations, including sex workers, people who use drugs and men who have sex with men
- greater support for dual protection against unintended pregnancies and sexually transmitted infections, including HIV
- improved quality of care
- enhanced programme effectiveness and efficiency^{viii}

Another aim of linking sexual and reproductive health and HIV/AIDS is to accelerate progress towards achieving the goals agreed at the International Conference on Population and Development^{ix} and the Millennium Development Goals,^x especially those that aim to reduce poverty, promote gender equality and empower women, improve maternal health, combat HIV/AIDS, and attain universal access to sexual and reproductive health.

Identifying and meeting the challenges

Linking sexual and reproductive health and HIV/AIDS policies and services presents many challenges for those on the front line of health care planning and delivery. These include:^{xi}

- making sure that integration does not overburden existing services in a way that compromises service quality, by ensuring that integration actually improves health care provision
- managing the increased workload for staff who take on new responsibilities
- allowing for increased costs initially when setting up integrated services and training staff
- combating stigma and discrimination from and towards health care providers, which has

the potential to undermine the effectiveness of integrated services no matter how efficient they are in other respects

- adapting services to attract men and young people, who tend to see sexual and reproductive health, and especially family planning, as 'women's business'
- reaching those who are most vulnerable but least likely to access services, such as young people
- providing the special training and ongoing support required by staff to meet the complex sexual and reproductive health needs of HIV-positive people effectively
- motivating donors to move from parallel to integrated services, and sustaining support for integrated policies and services

Tools to make it happen

Several tools prepared by IPPF, UNFPA, UNAIDS and WHO offer guidance on how to link sexual and reproductive health with HIV/AIDS. These include:

- *Sexual and Reproductive Health and HIV/AIDS – a framework for priority linkages*^{xii}
- *Linking Sexual and Reproductive Health and HIV/AIDS – an annotated inventory*^{xiii}
- *Sexual and Reproductive Health of Women Living with HIV/AIDS – guidelines on care, treatment, and support for women living with HIV/AIDS and their children in resource-constrained settings*^{xiv}
- *Integrating HIV Voluntary Counselling and Testing Services*

into Reproductive Health Settings – stepwise guidelines for programme planners, managers and service providers^{xv}

- *Meeting the Sexual and Reproductive Health Needs of People Living with HIV*^{xvi}
- *Gateways to Integration – a series of case studies of country-level experiences on how to link and integrate services*^{xvii}
- *Reproductive Choices and Family Planning for People Living with HIV – Counselling Tool*^{xviii}
- *Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages: A Generic Guide*^{xix}

Turning theory into practice

The process of linking sexual and reproductive health and HIV/AIDS needs to work in both directions: this means that traditional sexual and reproductive health services need to integrate HIV/AIDS interventions, and also that programmes set up to address the AIDS epidemic need to integrate more general services for sexual and reproductive health. While there is broad consensus that strengthening linkages should be beneficial for clients, only limited evidence is published regarding real benefits, feasibility, costs and implications for health systems.

This publication presents one of a series of country experiences, set against a different public health, socio-economic and cultural background, embedded in radically different legal and health care environments and using different entry points as they strive to strengthen linkages between sexual and reproductive health and HIV/AIDS.

The case studies featured in this series have been chosen to demonstrate this two-way flow and to reflect the diversity of integration models. While these case studies focus primarily on service delivery components, structures/systems and policy issues are also important ingredients of the linkages agenda. The case studies are not intended to be a detailed critique of the programmes or to represent ‘best practice’ but to provide a brief overview that shows why the decision to integrate was taken, by whom, and what actions were needed to make it happen. The intention is to share some of the experience and lessons learned that may be useful to others who wish to consider actions to strengthen the integration of these two health care services. They are real experiences from the field, with important achievements but also with real limitations and shortcomings. One of these shortcomings lies in the nomenclature currently being used. There is currently no globally accepted definition of the terms ‘linkages’, ‘mainstreaming’ and ‘integration’ in the context of sexual and reproductive health and HIV. At times in these case studies the terms are used by different organizations in a variety of settings in different ways. While we propose the following definitions, it should be noted that the different implementing partners have not used these consistently:

Mainstreaming:

Mainstreaming HIV/AIDS means all sectors and organizations determining: how the spread of HIV is caused or contributed to by their sector, or their operations; how the epidemic is likely to affect their goals, objectives and programmes; where their sector/organization has a comparative advantage to respond – to limit the spread of HIV and to mitigate the impact of the epidemic and then taking action.

Linkages:

The policy, programmatic, services and advocacy synergies between sexual and reproductive health and HIV/AIDS.

Integration:

Refers to different kinds of sexual and reproductive health and HIV/AIDS services or operational programmes that can be joined together to ensure collective outcomes. This would include referrals from one service to another. It is based on the need to offer comprehensive services.

A case study from Serbia

Vital statistics at a glance

Estimated population (2008)	7,365,507
Adult population aged 15 to 49 (2007)	4,841,000
Life expectancy at birth:	
Men	70
Women	75
Crude birth rate (2007)	12.8/1,000 population
Total fertility (2006)	1.8
HIV prevalence rate in adults aged 15 to 49 (2007)	<0.2%
Estimated number of people living with HIV (2007)	6,400
Estimated number of adults aged 15 and over living with HIV (2007)	6,400
Estimated number of women aged 15 and over living with HIV (2007)	<1,500
Deaths due to AIDS (2007)	<100
Contraceptive prevalence rate (2005)	41.2%
Births attended by skilled health personnel (2006)	99%

Sources: Census of Population, Households and Dwellings. Statistical Office of the Republic of Serbia, 2008. Available at <http://webrzs.stat.gov.rs/axd/en/index.php>; Serbia: Epidemiological Fact Sheets on HIV/AIDS. UNAIDS, UNICEF, WHO, 2008 Update. Available at http://www.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_RS.pdf; Serbian Health Indicator Database. Institute of Public Health of Serbia "Batut" (2009). Available from www.batut.org.rs/english.html

Please note: This case study outlines the process the Institute for Students' Health used to integrate SRH and HIV programmes and services. It does not necessarily reflect the current response to HIV in Serbia.

Evolution of service provision: First steps toward integration

The Institute for Students' Health (ISH) – a government institution – was established in Belgrade in 1922 to serve a population of 6,000. Today, Belgrade has one of the largest student populations of any city in Europe. The ISH caters for a population of 110,000 students plus university staff and provides a wide range of curative and preventive health services. With many young people away from home for the first time, and engaged in or on the threshold of intimate relationships, sexual and reproductive health is a major focus. Students receive no sex education in school and this is a taboo subject in most homes, so the emphasis at the ISH is on equipping young people with the knowledge and skills to adopt healthy sexual behaviour. Between 2006 and 2008, 3,000 young people a year accessed a number of HIV prevention services – including voluntary counselling and testing – at the ISH Centre in Belgrade. The Centre also offers non discriminatory sexual and reproductive health and HIV services for key populations, such as men who have sex with men, sex workers and people who use drugs. From 2006 to 2008 the number of people who use

drugs accessing services at the Centre quadrupled and it became the preferred voluntary counselling and testing centre in Belgrade for men who have sex with men.

In 1988, the director of the Institute, an epidemiologist whose major academic interest is HIV, and a colleague set up the first HIV counselling centre in Serbia at the ISH. Whereas today around two-thirds of HIV infections are sexually transmitted, at that time the HIV epidemic in Serbia was relatively new and, as in neighbouring countries, was driven mainly by injecting drug use among young people. The two men had no specialist counselling training, but built on their personal experiences of working with young people, their commitment to the issue and an awareness that something had to be done.

Due to a number of factors, most importantly the political instability and conflict following the breakup of Yugoslavia in the early 1990s, the progress towards integration stagnated. Only in the late 1990s did the doctors recognize the need for closer collaboration with their colleagues offering other services at the ISH, such as treatment for sexually transmitted infections (STIs), gynaecology and family planning. Their colleagues welcomed the initiative as a way of better meeting the multiple needs of their clients, and together they developed new patterns of working. This involved sharing their specialist knowledge and skills with each other in an

informal training programme. Those who were comfortable dealing with HIV issues taught those who were more experienced working with other STIs, and vice versa. In this way everyone developed basic knowledge and understanding of each other's work whilst remaining clinically active within their specialist areas. This initiative also involved streamlining referrals, and meeting regularly to exchange information, share concerns and discuss cases.

Over the years this initiative has developed into an integrated programme of sexual and reproductive health and HIV services that reaches far beyond the ISH. It has drawn in a myriad of other players, and is a model of cooperation between governmental and non-governmental organizations. For example, the ISH partnered with various non-governmental organizations to train voluntary testing counsellors and provide voluntary counselling and testing services to some of the populations most at risk, such as sex workers and drug users. What makes this work particularly remarkable is that much of it was achieved under difficult circumstances. The Bosnian-Croatian-Serbian war in the 1990s saw the complete disintegration of a former way of life, the redrawing of national boundaries, and isolation from the international community. This led to a lack of political stability, high unemployment and increased levels of poverty. The improvement in the economic and political situation in Serbia – with the number of people living below the poverty line falling from 10.6% in 2002 to 8.8% in 2006^{xx} – has increased opportunities for integration.

STI/HIV Centre: A six step model of care

Building on the steps towards integration made in the late 1990s, the decision was made in 2002 to physically integrate sexual and reproductive health and HIV services and create a combined centre for HIV and STI prevention. The main reason for the decision was to better secure privacy for clients of the HIV clinic. The HIV clinic was moved to a small building behind the Institute with its own entrance – and the STI/HIV Centre became a reality. The Centre is equipped with two counselling rooms, and a reception area where large amounts of information materials and condoms are made freely available.

Step 1 – Upgrading skills

In the same year as the establishment of the STI/HIV Centre, when Serbia emerged from international isolation, staff at the HIV clinic were able to receive training in basic knowledge and skills for voluntary counselling and testing. This enabled them to set up services that conformed to international standards.

Today, nine people trained as counsellors work in shifts at the STI/HIV Centre. Some of the staff trained in counselling are doctors and nurses who also work at the ISH, and three are clinical psychologists from the International Aid Network, a local human rights non-governmental organization that works mainly with refugees. The team of counsellors is supported by a team of gynaecologists, dermatovenereologists and general practitioners from the ISH, which run specialist clinics at the Centre on different days.

Step 2 – Securing Funding

One of the challenges faced by the newly established STI/HIV Centre was to secure funding for its activities. Although the Centre is attached to the ISH, it initially received no government money, and was supported by donor funding channelled through the International Aid Network – a partner in the enterprise. The funding situation improved in 2007 when the ISH and International Aid Network signed a memorandum of understanding on cooperation and joint financing.

Step 3 – Expanding Services

Since its opening, the STI/HIV Centre has offered counselling and testing for HIV and Hepatitis B and C, and diagnosis and treatment of other STIs. Blood samples are sent to the pathology laboratory in the ISH and clients are asked to return for their results the same day or the next. Less than 0.3% fail to do so. This is a real indicator of the quality of the counselling and service provided and the importance of returning test results swiftly.

Though most clients access the Centre for its voluntary counselling and testing services, the staff use this as an opportunity to counsel clients on behaviour change, and as an entry point for other sexual and reproductive health services. The STI/HIV Centre has mechanisms in place to refer clients to the ISH next door for other services, such as family planning or mental health.

Step 4 – Mentoring Staff

The STI/HIV Centre at the ISH offers ongoing psychosocial support for people living with HIV as well as their partners, family and friends. The voluntary testing counsellor is often the only person who knows a client's status, and the only person to whom the client is able to confide. The work is inherently stressful, which led the Catholic Agency for Overseas Development to introduce the idea of regular group supervision for counsellors as a vitally important measure to protect their mental health.

No one wears a uniform or a white lab coat when working at the Centre. This is a deliberate policy to abolish hierarchy and to put clients more at ease when talking with health professionals. The subliminal message that everyone working at the Centre deserves equal respect is very important for team spirit, morale and group dynamics.

Step 5 – Reaching key populations

Capitalizing on the STI/HIV Centre, strengthened staff capacity and new partnerships, the ISH started to expand its activities beyond its traditional client base of students. As a government institution, the ISH would not have been able to do this alone, as it is mandated to provide services only for its target population of students. But one of the benefits of the partnership with the International Aid Network is that it allows the Centre to reach out to clients beyond this group. The Centre now runs programmes – directly or through affiliates such as the Yugoslav Association Against AIDS – for high school students, sex workers and young people with disabilities.

Step 6 – Building partnerships

Early on, the management of the STI/HIV Centre recognised the importance of working in partnerships with other organizations. And in fact there have been many benefits, including access to donor funding, delivering a comprehensive package of services for clients through referral systems, and reaching out to populations beyond their traditional client base.

At the clients' convenience: HIV counselling and testing at night

It is just before 8pm on Saturday evening. A group of doctors, nurses and psychologists, casually dressed, are sitting around or leaning against desks, arms folded, in a large room at the STI/HIV Centre. They are chatting, laughing, drinking strong coffee or fruit juice, and shelling peanuts. Through the open window comes the sound of rain pattering on pavements and a cool draught of air freshens the room after a sunny day. A delivery man comes in with big boxes of pizza. Outside in the waiting area, a TV is showing a football match, and a large low coffee table is covered with information leaflets. The seats around the wall are yet to be occupied.

This is the night testing clinic, which is open for voluntary counselling and testing from 8pm to midnight once a month. The service is widely advertised in the media, and within minutes of the doors opening, clients start to arrive. They are greeted informally before being ushered into a private room by one of the counsellors. At one point in the evening, a counsellor goes to

the waiting room with a box of condoms to replenish the supplies on the table. A young man sitting there, arms casually draped across the back of the chair, tells her with a smile: "We don't use those things, that's why we're here!"

By midnight, more than 40 clients have come for testing. They are mostly young, but not all students, and from a mixture of backgrounds. Just before the doors close, two young Roma arrive. This is a cause for quiet satisfaction. Roma are among the most marginalized and hard-to-reach populations in Serbia and the voluntary counselling and testing staff are trying to build a word of mouth reputation for kindness, respect and confidentiality that will reach out to marginalized groups such as these.

As it runs outside normal working hours, the night voluntary counselling and testing clinic is a good opportunity for people from other agencies who are training as counsellors to gain practical experience. Everyone contributing their expertise here is working on a voluntary basis.

Most of the people who come for night testing are in the age range of 16 to 30 years, and belong to population groups particularly vulnerable to HIV infection such as people who use drugs, men who have sex with men, and sex workers. By contrast, those who attend the regular day clinic tend to seek services to check their HIV status before marriage and include couples who want children, as well as young people whose behaviour puts them at risk of HIV. In the first half of 2005, 11 new HIV infections were diagnosed at the night clinic, all among men who have sex with men. This was twice as many new HIV infections as were detected in the whole of 2004.

Staff members working at the night clinic take the opportunity during counselling to advocate for behaviour change and also to encourage clients to make use of the sexual and reproductive health services available at the Centre.

From theory to practice

As the ISH is an institute for students, it uses every opportunity to invest in young people and get them involved in sexual and reproductive health services – not just as clients, but as service providers as well.

Young people as service providers

Serbia has a large network of youth peer educators, mainly trained by UNFPA and UNICEF, who work with a variety of non-governmental organizations. A mobile team of young people has been trained in counselling skills at the STI/HIV Centre. They take information and education to young people wherever they are, and members use a variety of strategies to communicate their message. They organize parties where condoms and information materials are distributed and there are competitions with prizes to test people's knowledge of HIV and sexual and reproductive health issues. As well as these outreach services, the youth mobile team runs a telephone hotline on HIV and sexual and reproductive health issues.

Addressing judgemental attitudes

An essential condition for working with clients is that counsellors examine and overcome their own judgemental attitudes. "I used to have a big problem with homophobia," admits one peer educator. He was forced to confront this by his fellow peer educators during impassioned discussions. But what has influenced him most to change his attitudes, he says, is working with marginalized young people and realizing how much they all have in common.

However, prejudice and the instinct to judge are so widespread that young peer educators and counsellors working with sensitive issues frequently face suspicion or hostility from the general public – sometimes even from their own families. Many find it hard to get permission from teachers to talk to children in schools.

And combating prejudice is only half the battle. Homosexual acts and drug use are illegal in Serbia and fear of prosecution also inhibits people from accessing services. Therefore the anonymity of the telephone service is welcomed by stigmatized people, such as those who use drugs and men who have sex with men, who find it particularly hard to access information and services.

Satellite clinic for high school students: Reaching vulnerable young people

Close to the ISH is a residence for high school students from all over Serbia, where the Institute has set up a satellite clinic for reaching vulnerable young people below university age. There is a special need to develop services for this population because in Serbia's traditional health care system, 14 to 18-year-olds who live away from home have particular difficulty accessing health services. The clinic has been given space by the residence administration but gets its medical supplies from the ISH, which is also a direct referral centre.

Head of the clinic is a general practitioner with special training in youth counselling and voluntary counselling and testing, who also volunteers at the STI/HIV Centre. Moreover, she is a mother of three teenage daughters herself. So when students arriving at the residence come in for their required medical check-up, she takes this opportunity to counsel them on sexual relationships, contraception and infection prevention, and to tell them about the Centre. She and her colleagues make sure that the clinic is an inviting place for young people, with freshly painted white walls, potted plants and colourful rugs, and lots of information materials they can take away.

Providing sexual and reproductive health services for minors raises ethical questions, but at present there are no specific laws in Serbia to guide service providers, and each institution has its own rules. Most are prepared to give information and counselling on contraception and HIV to minors without seeking parental consent, and some also provide contraceptives without involving parents or guardians in the decision. The ISH will perform an HIV test for a minor, but its protocol originally stipulated that it could only give a positive result to someone under-age in the presence of their parent or guardian, who would also receive post-test counselling. This initial policy was later changed so that voluntary counselling and testing for minors could take place with two counsellors, and that a positive result could be given to the child if both counsellors think it is in the child's best interest.

Raising awareness: Taking the message to where the students are

"Most young people arriving at university have very little knowledge about sexual and reproductive health," says the gynaecologist, who holds a clinic at the STI/HIV Centre. That is why he goes out to student residences, cafés and theatres – anywhere that students gather in their free time – to give presentations about family planning and STI prevention.

The main objective of these sessions is to tackle the issue of abortion which, although legal, is often procured secretly from poorly equipped practitioners leading to physical and psychological problems for one in three to one in five women. Abortion is commonplace in Serbia, with an incidence of around 82 per 1,000 women aged 15 to 49 years.^{xxi}

Assisted by a nurse, the gynaecologist starts the presentation with provocative questions designed to stimulate

audience participation, such as: "Do you agree that a man is not a man if he is a virgin?" They then describe the different methods of contraception, with the pros and cons for both pregnancy and STI prevention, illustrating their talk with examples and case histories to give the information a human face. They also make sure that the students know about the STI/HIV Centre and its services.

In 2004, the team reached over 1,600 young people in 41 presentations – a figure exceeded within the first six months of 2005. Attendance at the Centre always rises after one of these presentations. About four times a year the Centre will build on outreach information, education and communication activities by taking voluntary counselling and testing services out to 'Student City' – a dormitory complex in Belgrade that houses around 5,000 young people.

Outreach with sex workers: The 'Power of Prevention'

ISH was the initial home of the Yugoslav Association Against AIDS. This non-governmental organization was set up in 1991 by a group of doctors – including those working for the ISH, and the former professor of Public Health at Belgrade University – when they realized that, because of the war at that time, they were not going to get any more help from the international community in dealing with HIV in Serbia. There was official denial of the epidemic and at first they ran workshops with teachers, school children, doctors and a host of others to raise awareness of HIV and how to prevent its spread. The founding members ran the whole operation as volunteers using their own resources to fund activities. But in recent years the Yugoslav Association Against AIDS has won support from a number of foreign donors, and has been able to expand its training programme and develop other activities.

In September 2004, with funding from the Dutch government and technical support from SOAIDS, a Netherlands-based STI/HIV prevention organization, the Yugoslav Association Against AIDS started a programme to

deliver sexual and reproductive health and HIV services to female sex workers in Belgrade. Before the programme – known as the 'Power of Prevention' – was launched, SOAIDS took a group of eight people from the Association to see how outreach among sex workers is handled in Amsterdam, and to share their experiences. As a result, the programme started using a team of young outreach workers to make contact with sex workers in the city's 'hotspots'. The aim is to give the sex workers information, supplies and support to avoid unintended pregnancy and infection. The outreach workers talk with them, distribute information and condoms, and counsel them to seek health care, if required.

The STI/HIV Centre provides counselling and STI treatment services for sex workers. In addition, the Yugoslav Association Against AIDS has managed to motivate, inform and train a small core of doctors and nurses in three of the city's sixteen municipal clinics who will treat their clients on occasion. But they take professional risks in doing so as sex workers rarely possess the official health documentation that confirms their citizenship and entitlement to government services, so treating them

can be illegal. The Yugoslav Association Against AIDS has therefore bought a van that it has equipped as a mobile clinic, staffed by a doctor and a counsellor, which goes out to the hotspots to provide services directly. It has won support from a small hotel owner, who rents rooms to sex workers and their clients, to open a drop-in centre where they can get information, condoms and counselling. However, even the mobile clinic is taking risks: the law does not allow people working for non-governmental organizations to provide medical services, even if they are professionally qualified to do so, and there are very real possibilities that mobile clinic staff could be arrested. However, the staff rely on the fact that the recent national HIV strategy,^{xxii} which recognizes the need for 'harm reduction' among people selling sex, will afford some protection from prosecution.

Sex work is illegal in Serbia and police treatment of people engaged in sex work is harsh. Girls are afraid to carry condoms which might incriminate them, and are wary about trusting outreach workers who approach them. The Yugoslav Association Against AIDS has the tacit agreement of the police that they will keep away from the scene when the mobile clinic

or outreach teams are operating. And the organization recently held a training workshop for policemen and women to try to encourage greater understanding of and respect for sex workers and other vulnerable people living on the margins of society.

But changing entrenched attitudes and behaviour is a slow process and the outreach workers – who are mostly students carefully selected and trained by the Yugoslav Association Against AIDS – enter a world of palpable violence and fear when they go out to the hotspots twice a week. The Yugoslav Association Against AIDS insists that they always work in pairs, a male and female together, and that they report to their supervisor before leaving for and returning from the field. It is stressful work and the twelve-person outreach team meets in a room at the ISH every Wednesday evening for group supervision, during which they share experiences and seek advice from each other. At a recent meeting, for example, one team reported how they had been caught up in a police raid and had

had to make a snap decision about whether to run with the sex workers or stand their ground. Taking the view that to have stayed behind to talk to the police might have been seen as colluding with them, they ran with the girls. Outreach workers also frequently tell of the threat they feel from “pimps” observing them from the shadows as they talk with the sex workers.

Reliable information on sex work in Serbia is scarce, but the Yugoslav Association Against AIDS and its partners estimate that there are about 3,000 people engaged in sex work in Belgrade. The outreach workers are in regular contact with around 100 people in six of the known hotspots. The Yugoslav Association Against AIDS recognizes its limits and focuses its efforts on reaching out to sex workers. But it works closely with other non-governmental organizations in Belgrade that provide services for other marginalized people such as those who use drugs and men who have sex with men.

Reaching young people with disabilities

Special efforts have been made with the youth friendly services to reach out to excluded populations such as young people with disabilities. A group of doctors run workshops for parents of children with learning difficulties to discuss issues about sexuality and relationships, family planning and disease prevention, and the range of services available. They have also provided special services for hearing-impaired children. But these initiatives have been sporadic and difficult to sustain as government support and funding have been affected by political instability and frequent changes within ministries.

“Prejudiced? Me? But I’m a professional!”

Health staff tend to believe their training has equipped them to treat any patient, regardless of status or lifestyle, with the same professionalism. But they do not realise that their attitudes and prejudices are often apparent in subtle ways to their clients. Training workshops for health professionals in counselling or youth friendliness, therefore, always include representatives of stigmatized groups such as men who have sex with men, people who use drugs and sex workers, and participants are required to explore issues about prejudice and exclusion together as

equals. The training has had a remarkable effect on the ability of health professionals to communicate with, and support, young people of all persuasions.

The Yugoslav Association Against AIDS holds workshops for health professionals to prepare them for working empathetically with stigmatized people. These workshops are very effective at getting people to think deeply about the inhibitions, fears and prejudices that might come between themselves and their clients.

Expanding the model

Belgrade has 16 municipal clinics that provide basic sexual and reproductive health care, and the Centre is working, in collaboration with UNICEF, to introduce its model of integrated HIV and sexual and reproductive health services into these clinics. While UNICEF focuses on giving staff skills in communicating with children and adolescents, the Centre trains them in HIV and how to integrate this knowledge into their regular sexual and reproductive health work. To date, doctors and nurses running the adolescent sexual and reproductive health services in three municipalities have undergone training and have transformed their working practices. Three paediatricians and a gynaecologist have trained as voluntary testing counsellors, getting their practical experience by volunteering to work in the night voluntary counselling and testing programme. They carry out pre-test counselling at their own clinics before referring their young clients to the STI/HIV Centre to take an HIV test and receive post-test counselling.

The training and introduction of new services, especially for HIV, have involved a good deal of extra work for no additional pay, and there was some resistance to this at first. However, everyone who has taken up the challenge is pleased that they did.

Challenges: Organizational, structural and policy constraints

In addition to the tough socio-economic conditions in which they work, the ISH and its partners face a variety of challenges and constraints.

Organizational:

- The non-governmental organization sector is very new in Serbia. It has little grassroots support and its work is often controversial as it has grown up largely in the context of human rights issues and working with vulnerable groups. Also, as non-governmental organizations with outside support tend to pay slightly better salaries than local jobs, this sometimes causes resentment from the general public.
- There is no such thing as charitable status in Serbia, so non-governmental organizations pay high taxes on all donations, including non-cash items such as computers. This creates difficulties in negotiations with donors who are generally not happy about contributing indirectly to state finances.
- Fragmentation of funding is a problem. Donors tend to support discrete items in the budget, which makes fundraising and accounting difficult and time-consuming. To help alleviate this problem, some non-governmental organizations (including the Yugoslav Association Against AIDS) have formed a network that collaborates on key activities such as fundraising.

Policy and Legislative:

- The illegal status of sex work drives it underground and makes it hard to reach those engaged in sex work with information and services. It also inhibits sex workers from carrying condoms which might incriminate them. This has wider public health implications. Moreover, the tacit agreement health providers have with the police to respect their work provides minimal protection in Serbia where government officials change frequently.
- The policy environment regarding sexual and reproductive health and HIV is threadbare. There is no quality control of testing kits, condoms, drugs and so on, and there is a lack of regulations and guidelines on such matters as voluntary counselling and testing, and family planning. However, the national strategy to fight HIV, which involved a widely consultative drafting process supported by funding from the Global Fund to fight AIDS, Tuberculosis and Malaria, was accepted by the government in December 2004.
- Sex education is not on the school curriculum, although the ISH has long been advocating for this and has had intermittent tacit support from some government officials.

Structural:

- Stigma and discrimination inhibit support for work addressing the concerns of men who have sex with men, sex workers and people who use drugs.
- A lack of reporting systems have resulted in a shortage of the data often needed to support funding proposals.

Investing in the future: Conclusions and lessons learned

Despite a decade of war in the Balkans, and political and socio-economic conditions unfavourable to innovation and change, the Institute for Students' Health has been prepared to push out the boundaries to create a model of care that meets the needs of its target populations in a more convenient and user-friendly manner, whilst offering health professionals more effective and satisfying ways of working. Crucial to the achievements of the ISH have been vision, inspiring leadership and political will – such as the kind of commitment and passion that compel people to work for no pay and to fund their activities themselves, if necessary. Many health care providers comment that working with young people is inspiring because of their openness to change and because it is an investment in the future.

As a pioneer of integrated sexual and reproductive health and HIV services in Serbia, the ISH has many valuable lessons to share from its experience.

In order to integrate services it may be necessary for public sector health staff to go beyond the boundaries of their job descriptions. This requires clear objectives, diplomacy and willingness to make personal sacrifices.

The ISH staff who established and now work at the STI/HIV Centre give some of their time and skills free of charge. They have overcome a number of obstacles raised by their status as public servants by creating or working in partnership with non-governmental organizations that have a broader remit. The ISH takes pains to foster good relationships with the non-governmental sector in general by, among other things, providing office space to non-governmental organizations such as the Yugoslav Association Against AIDS, and making its meeting rooms available to various groups for workshops, group supervision and other activities.

When building capacity to provide integrated services, getting the various specialists to share their knowledge and skills with each other is an efficient and cost-effective method of training and serves also to enhance mutual understanding and a spirit of cooperation in multi-disciplinary teams.

The ISH has shown that, even when resources are extremely limited, building capacity to provide integrated services does not need to present an insurmountable obstacle. The Institute has found that abolishing the traditional hierarchical structure among staff enhances the process of skills sharing and team building, and is good for morale. None of the staff wear a uniform or a white coat at the STI/HIV Centre. This makes for a more relaxed atmosphere that helps put clients at ease as well as sending out the subliminal message that everyone working there is of equal status and deserves equal respect.

Work in the sensitive field of sexual and reproductive health and HIV is inherently stressful and measures to protect service providers from burnout are essential, both for the health of the individual and the sustainability of the programme.

All staff involved in counselling, whether at the STI/HIV Centre or as members of the sexual and reproductive health and HIV outreach teams, come together weekly for group supervision in which members of the same team share their experiences, concerns and insights. These are formal sessions, facilitated by a professional psychologist, psychiatrist or counsellor. Individual supervision is also available for staff needing it. Caring for the care-givers is an important principle at the ISH. Therefore supervision is now a systematic and integral part of HIV and sexual and reproductive health services, and is taught in the Institute's training programmes for counsellors.

Because of taboos and personal inhibitions, people are often reluctant to seek out sexual and reproductive health and HIV information and services, so providers need to use their imagination to reach potential clients.

Simply providing services is not enough to ensure that the people who need them will use them. This is especially so with sexual and reproductive health and HIV services where the issues are so sensitive. Service providers need, therefore, to be proactive and give thought to how they reach potential clients. Taking education programmes to where students gather, and running telephone counselling services, are among the strategies used to good effect by the ISH to encourage people to attend. Making services as convenient as possible to clients is another way of overcoming barriers to access, and here the night-time voluntary counselling and testing sessions have been a major success.

Working effectively with vulnerable people, especially from stigmatized groups, requires service providers to examine their own attitudes critically and overcome harmful prejudices.

Marginalized people such as sex workers, men who have sex with men and people who use drugs are especially vulnerable to HIV and other sexual and reproductive health problems. Gaining their trust and confidence in health services means, first and foremost, that service providers treat them with respect. An effective way to promote this is to bring health professionals and representatives of stigmatized groups together as equals in training programmes. Another way is to help health workers, through training, to be comfortable with the language and expressions used by marginalized groups to describe their behaviour.

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Endnotes

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Despite a decade of war in the Balkans, and political and socio-economic conditions unfavourable to innovation and change, the Institute for Students' Health has been prepared to push out the boundaries to create a model of care that meets the needs of its target populations in a more convenient and user-friendly manner whilst offering health professionals more effective and satisfying ways of working. As a pioneer of integrated sexual and reproductive health and HIV services, the Institute for Students' Health has many valuable lessons to share from its experience.