RAPID ASSESSMENT
OF SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES

IPPF International Planned Parenthood Federation

UNFPA

World Health Organization

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

This summary highlights the experiences, results and actions from the implementation of the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages* in Benin[1]. The tool – developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives in 2009 – supports national assessments of the bi-directional linkages between sexual and reproductive health (SRH) and HIV at the policy, systems and services levels. Each country that has rolled out the tool has gathered and generated information that will help to determine priorities and shape national plans and frameworks for scaling up and intensifying linkages. Country experiences and best practices will also inform regional and global agendas.

RECOMMENDATIONS

What recommendations did the assessment produce?

- **Planners and decision makers** should: develop national integration guidelines outlining the roles of all actors; ensure coordination mechanisms for partners and ministries involved in SRH and HIV; advocate with technical and financial partners to support integrated programming; involve the Family, Education and Youth Ministries and civil society in promoting integration; support the Ministry of Health (MOH) to lead on integration; strengthen the provision of SRH and HIV services for young people and key populations; strengthen the involvement of young people in the design and implementation of services; adapt national family health guidelines to include integrated content on SRH and HIV; ensure the consistent availability of products related to SRH and HIV services; and develop a minimum package of integrated SRH and HIV services.
- **Donors and partners** should: ensure the continuous availability of relevant consumables, materials etc; support capacity building for integrated service delivery; provide technical support for the development of guidelines and a minimum package; and improve the allocation of support to ensure coverage of all health zones.
- **Coordinators and programme managers** should: Develop systems, tools, training and a monitoring mechanism to support integration; build the capacity of implementers, including civil society and youth groups; and disseminate guidelines for integrated service delivery.
- **Service providers** should: expand the outreach and focus on 'bridge' interventions, such as vaccination and antenatal care; and strengthen collaboration with civil society organisations.

1. This summary is based upon: *Etude Rapide de l'Intégration de la Santé Sexuelle et de la Reproduction et du VIH/SIDA*, Ministère de la Santé, Benin, and UNFPA, December 2009.

PROCESS

1. Who managed and coordinated the assessment?

- The MOH decided to implement the assessment, which was scheduled following training in Dakar in 2008.
- The MOH led the assessment, with technical and financial support from UNFPA; and further technical support from members of a monitoring committee. The budget was managed by the MOH and UNFPA Benin.

2. Who was in the team that implemented the assessment?

- The team involved the Government of Benin, MOH, National AIDS Programme (NAP), National AIDS Committee (NAC), associations of people living with HIV (PLHIV), NGOs (including ABPF, OSV Jordan, RABeJ/SD, REBAJ/PD), communities, UNFPA, WHO, UNICEF, UNAIDS, World Bank, PSI, Ministries of Development, Family, Youth and Education, Youth Network, Plan Benin, health providers, clients, governmental and non-governmental funding organizations (USAID, DANIDA, GIZ, AFD, BTC, SDC, PISAF, CRS, World Education, AWARE, Croix Rouge Béninoise, and CARITAS).

3. Did the desk review cover documents relating to *both* SRH and HIV?

- The desk review included 36 documents, covering the main national strategy and policy documents on SRH and HIV.

4. Was the assessment process gender-balanced?

- All stages of the assessment involved men and women. For example, for the research, each field team had one man and one woman.
- Men and women were involved in all levels, including: political/policy-maker level; health system level; and operation/service-provider level.

5. What parts of the Rapid Assessment Tool did the assessment use?

- A team of local SRH and HIV experts adapted and validated the tool to the realities of the Benin context – making changes to ensure a better understanding. The revised tool was pre-tested by the research teams, with further changes made before starting the data collection.
- The data collection took place within 15 days and the data analysis within a further 15 days.
- The assessment addressed all three components of the tool: policy, systems, operational.

6. What was the scope of the assessment?

- Overall, the assessment achieved a balance between SRH and HIV. It had a national scope – addressing actors involved in SRH and HIV in the health system and at the community level.
- Service data was collected from six of the 34 health zones, selected on a rational and random basis to ensure representativeness, taking into account urban, semi-urban and rural areas. Time and resources were inadequate for the assessment to cover the whole country.
- The qualitative component of the survey involved interviews with 224 people (64 policy-makers, 27 donors and 133 individuals). The quantitative component reached 214 respondents (85 providers and 129 clients in SRH and HIV services).

7. Did the assessment involve interviews with policy-makers from *both* SRH and HIV sectors?

- The assessment involved: policy interviews with national and regional decision-makers and partners; and system-level interviews with regional-level decision-makers.
- Overall, 64 policy-makers were interviewed (including civil society, ministry officials and politicians) and 27 donors, international NGOs and UN agency representatives.
- The respondents were male and female, including leaders of civil society organizations and officials of public and private services (mainly the National Assembly and Ministries for Health, Youth, Family and Education).

8. Did the assessment involve interviews with service providers from *both* SRH and HIV services?

- 85 service providers were interviewed, including men and women. They were doctors, midwives and nurses working in health centres and at sites providing HIV services.

9. Did the assessment involve interviews with clients from *both* SRH and HIV services?

- 129 service users participated in exit interviews and 133 people participated in focus groups.
- The service users were mostly female (81.4 per cent), with less than half aged 29 years or under. One in three was interviewed in an urban, semi-urban or rural setting respectively.

10. Did the assessment involve people living with HIV and key populations?

- Civil society and PLHIV were involved in the design and conduct of the assessment.
- 133 community members were interviewed, including PLHIV, civil society groups, women's associations, youth groups, truck drivers, agricultural workers, sex workers and traditional chiefs.

FINDINGS

1. Policy level

National policies, laws, plans and guidelines:

- Policy instruments protect the right to health, including a ban on female genital mutilation and legislation protecting PLHIV from discrimination and guaranteeing access to treatment.
- SRH comes under the Directorate of Family Health (MOH). HIV comes under the NAC.
- Links between SRH and HIV are established in different ways. For instance:
  - Laws on female genital mutilation, gender-based violence, SRH and HIV make clear reference to the links.
  - Linkages are defined in guidelines for SRH, prevention of mother to child transmission (PMTCT), reduction of maternal and child mortality, family health, sexually transmitted infection (STI)/HIV treatment and antenatal HIV and syphilis screening.
  - The National HIV Strategy emphasizes the importance of joint programming on SRH and HIV and ensuring that HIV and STIs are addressed in programmes for young people.
- Gender inequality is not sufficiently addressed in health-related legislation. Stakeholders believe that gender inequity in access to services is not a major problem. More problematic is the low level of male engagement in SRH and HIV and in health more generally.
- Despite laws to protect PLHIV from discrimination, stigma is prevalent in health facilities. Legislation against gender-based violence is poorly enacted since victims tend to stay silent. There is little public awareness of the legislation.
- The National HIV Strategy identifies key populations, but respondents state that they are seldom reached by specific, targeted programmes.

Funding and budgetary support:

- According to donors, there is considerable financial support available for SRH and HIV programming, to the extent that these resources are not always fully expended.
- A key barrier to integrated approaches is that the costs of human resources, equipment and consumables are often funded separately.
- Funding streams for SRH and HIV are separate, especially those aimed at civil society. According to respondents (other than donors), donor priorities tend to focus on HIV.
- Donor preferences to share geographic zones militate against integration – as, if different interventions are funded in different zones, it is hard to achieve even coverage of programming.

2. Systems level

Partnerships:

- Four categories of partners work on SRH: government agencies (3), UN agencies (6), bilateral donors (6) and institutional/NGO

projects (many). Most of these also work on HIV.

- According to donors, there is no formal SRH and HIV integration. But there is functional integration between some interventions.
- Stakeholders gave different answers when asked if there is a technical group for integration.
- Civil society is instrumental in defending PLHIV rights and is active in both SRH and HIV. But the sector in general and PLHIV in particular have weak capacity – linked to stigma and a lack of funding. It is implied that PLHIV are considered beneficiaries rather than actors.
- SRH and HIV programmes involve young people in limited ways, such as by consulting them in needs assessments. They are not major actors in SRH and HIV programmes.

Planning:

- SRH planning and delivery is decentralized through the MOH, whereas HIV is 'vertical'. There is no joint SRH and HIV planning at the central level, though collaboration is seen to be improving. The planning model is one of 'collaboration' rather than 'integration'. It is focused on some key intersections (such as PMTCT) rather than an overall integration.

Human resources and capacity building:

- One in three doctors are trained in all five SRH components. Condom provision is the area where fewest are trained (19 per cent) and pre-/post-test counselling the most (38 per cent).
- Four per cent of nurses are trained in gender-based violence issues and 31 per cent in HIV prevention counselling. One in four has comprehensive SRH skills. Auxiliary nurses have low levels of training on SRH and HIV, apart from in relation to pre-/post-test counselling.
- For most other providers, fewer than five per cent are trained in each SRH and HIV intervention, with one exception: levels of training in test counselling are around 40 per cent in all health positions.
- HIV capacity among health care workers is generally low, except among midwives.
- For now, there is no established training package that addresses SRH and HIV together.

Logistics, supply and laboratory support:

- Answers on these issues were not included in the report – despite being addressed in the questions in the sample questionnaire (in an annex).

Monitoring and evaluation:

- Answers on these issues were not included in the report – despite being addressed in the questions in the sample questionnaire (in an annex). But the assessment indicated that, at a decentralized level, monitoring of SRH and HIV are increasingly carried out in a joint way.

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3. Services level

A. SERVICE PROVIDER PERSPECTIVES

SRH and HIV service availability:

- 51 per cent of the providers involved in the assessment said that all five SRH components were available in their facility. 85 per cent said at least three were available. 63 per cent said their facilities provided services in relation to gender-based violence and 96 per cent provided STI treatment.
- Only three per cent of providers provide all nine HIV services. 60 per cent provide six of the services and 30 per cent provide fewer than five. The most common service is testing (in 95 per cent of facilities). Condoms are available in 61 per cent, while 32 per cent have key population services and 14 per cent provide home-based care.

HIV integration into SRH services:

- The HIV service most commonly found in SRH services is HIV testing – in 94 per cent of cases. PMTCT is provided in 75 per cent of cases. HIV care and treatment, psychosocial support, positive prevention, information and condoms are provided in 60–70 per cent of SRH services. Home-based care and key population programmes are provided in just over 20 per cent.
- There are differences across SRH services. In family planning, HIV service integration is lower, with testing in 72 per cent and condoms in 58 per cent. Condoms are only provided in 61 per cent of STI prevention services, and PMTCT only in 68 per cent of maternal, newborn and child health (MNCH) services.
- In around 40 per cent of cases, requests for HIV-related services are referred out from SRH services. The proportion is lower for gender-based violence services, but this may be because these

services are generally not highly available (therefore referrals are not possible).

- A degree of integration is occurring despite the lack of formal policies and guidelines.
- Generally, where HIV interventions are provided by SRH services, they are available from the same provider on the same day (80 per cent of cases). Referrals to another provider in the same facility are between 18 and 25 per cent, and referrals out to another facility happen in 37–42 per cent of cases, depending on the service. 68 per cent of providers say they follow up on cases that are referred out.
- The main factor facilitating integration is training and capacity building on HIV – around half of SRH providers have received this. Very few (27 per cent) said that they had partnerships with PLHIV groups to strengthen their HIV work. Fewer than 20 per cent of providers said that they have monthly meetings with HIV organizations and only six per cent have agreements with HIV partners.

SRH integration into HIV services:

- The degree to which the five core SRH interventions are available in HIV services ranges from 65 per cent (for gender-based violence services) to 94 per cent (for STI treatment and prevention).
- It is rare for SRH interventions to be available within home-based care and key population services – probably because these two services are themselves not widely available.
- When SRH services are available within HIV services, they are often available in the same facility on the same day. Depending on the service, 14–35 per cent of cases are referred out.

Overall perspectives on linkages in SRH and HIV services:

- According to respondents, there are a number of barriers to effective integration:
  - Issues related to SRH are easier to discuss than those related to HIV at the community level – perhaps making SRH an easier 'entry point'.
  - Some providers cited technical differences between the two types of intervention – for instance in relation to 'protection' – as being barriers to integration.
  - HIV-specific challenges around stigma and confidentiality make HIV more complex.
  - Very few providers report having guidelines to facilitate integrated service delivery.
  - 70 per cent of providers said a lack of equipment and training are major barriers to integration.
- According to providers, the largest constraints to SRH and HIV integration are: lack of equipment for the provision of integrated services; lack of staff training; low staff morale; and lack of space for the provision of private and confidential services.
- But providers are enthusiastic about the positive impact integration might have. 86 per cent believe it would increase effectiveness, although it would also increase workload, time per patient and equipment and material needs. Most also believe integration would help reduce stigma.
- Providers emphasized that, in SRH services, HIV services are often provided despite the lack of formal guidelines. PMTCT provision within MNCH is common.
- Key areas that would help improve integration are the strengthening of civil society involvement and the monitoring of referrals.

B. SERVICE USER PERSPECTIVES

- Most (67 per cent) of the clients interviewed had come for maternal/neonatal care services.
- 40 per cent of respondents stated that they were offered additional information or services to those that they came for. Many reported receiving advice on vaccination, HIV, contraception and child health. 12 per cent of clients were referred to other services.
- 80 per cent of the clients interviewed were very or fairly satisfied with the service they had received.
- In terms of client preferences, 81 per cent said they would prefer to have all services provided in the same facility and by the same provider – to cut their travel time and costs.
- Despite the preference for an integrated approach, many clients were concerned that it could increase waiting times, reduce efficiency and potentially compromise confidentiality.

LESSONS LEARNED AND NEXT STEPS

1. What lessons were learned about how the assessment could have been done differently or better?

- Stratifying the findings of the assessment by type of location could further help planners to take suitable action. Also, the data in the report would be easier to interpret if denominators and numerators were provided.
- The involvement of civil society and PLHIV in the assessment could have been significantly improved, providing a different perspective on the issues addressed.
- One challenge is that the same providers seem to have been interviewed for SRH and HIV-based questions. In reality, it is likely that very few were specific SRH or HIV providers.

2. What 'next steps' have been taken (or are planned) to follow up the assessment?

- Editing and disseminating the report of the assessment.
- Holding two workshops to develop a guidance document/national strategy on SRH and HIV integration, with the participation of all stakeholders.
- Organizing a workshop to validate the guidance document/national strategy, with the participation of all stakeholders.
- Training 150 service providers (doctors and nurses) from 30 facilities in the five health areas covered by UNFPA on SRH and HIV. Also including civil society, NGOs and youth associations.
- Implementing the guidance document/ national strategy in the five health areas covered by UNFPA.
- Holding two coordination meetings to monitor the implementation of the guidance document/national strategy through the existing mechanism.

3. What are the priority actions that are being taken forward as a result of the assessment, at the:

- **policy level?**
- **systems level?**
- **services level?**

Policy level:

- Resource mobilization for SRH and HIV integration.

Systems level:

- Development and validation of guidance document/national strategy on SRH and HIV integration (through workshops involving all stakeholders).

Services level:

- Training of 150 service providers (doctors and nurses) from 30 facilities in the five health areas covered by UNFPA on SRH and HIV. Also including civil society, NGOs and youth associations.
- Implementing the guidance document/ national strategy in the five health areas covered by UNFPA.
- Following up, scaling up and evaluating the implementation of the guidance document/national strategy.

4. What are the funding opportunities for the follow-up and further linkages work in the country?

- It is expected that funds allocated to the health sector will increase.
- The pooling of funds is in progress – a process that could support SRH and HIV integration.
- SRH and HIV integration will be incorporated into the drafting of Benin's proposal to Round 10 of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Abbreviations

ABPF	Association Béninoise pour la Promotion de la Famille
AFD	Agence Française de Développement
AIDS	acquired immune deficiency syndrome
AWARE	Action for West Africa Region HIV-AIDS project
BTC	the Belgian development agency
CRS	Catholic Relief Services
DANIDA	Danish International Development Agency
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit – the German technical cooperation organization formerly called GTZ
GNP+	Global Network of People Living with HIV
HIV	human immunodeficiency virus
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
MNCH	maternal, newborn and child health
MOH	Ministry of Health
NAC	National AIDS Committee
NAP	National AIDS Programme
NGO	non-governmental organization
PISAF	Projet Integré de Santé Familiale - Integrated Family Health Programme
PLHIV	people living with HIV
PMTCT	prevention of mother to child transmission
PSI	Population Services International
SDC	Swiss Agency for Development and Cooperation
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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