Rapid Assessment of Sexual and Reproductive Health and HIV Linkages

Ghana
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 Ghana. 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?

Policy

- All policies that maintain a separate but equal approach to SRH and HIV integration (National Population Policy) and those that are silent on SRH and HIV integration (Workplace HIV/AIDS Policy, National Gender and Children Policy, National Education Sector Policy) should be updated during the next review or update to clearly include SRH and HIV integration.

- Policies and guidelines for most-at-risk populations (MARPs) and gender-based violence (GBV) should be developed, while guidelines for antiretroviral therapy (ART), safe motherhood and prevention of mother-to-child transmission (PMTCT) should be updated to capture all dimensions of SRH and HIV integration.

- Wider dissemination of all policies on SRH and HIV integration should be carried out targeting all relevant sectors and groups.

Systems

- The capacity of civil society organizations (CSOs) – including people living with HIV (PLHIV) – to participate in partnerships, especially at the regional and national levels, should be strengthened.

- The participation of SRH staff in HIV planning, management and administration (and vice versa) should be strengthened. Integrated budgeting of SRH and HIV programmes should be instituted at the national level to improve SRH and HIV linkages.

- All cadres of health staff, the media, police, judiciary, non-governmental organizations (NGOs), PLHIV, and private sector require training in SRH and HIV in order to implement a rights-based programming approach.

- Materials for pre- and in-service training (including curricula) should be updated, harmonized, and distributed widely to all pre-service institutions, and to all levels of the health care and other relevant sectors.

The logistics management system to support SRH and HIV integration needs to be instituted, especially at the regional and district levels.

A human resource development plan for Service Delivery Points (SDP) laboratories should be developed to build capacity to promote SRH and HIV integration at all levels. An inventory of equipment should be undertaken in all SDP laboratories at all levels, and gaps filled in line with a well-developed plan.

SRH indicators in HIV programmes and HIV indicators in SRH programmes may need to be expanded to capture client satisfaction, HIV status, and SRH and HIV integration.

Service provision

SRH services still need to be reoriented to accommodate PLHIV and those vulnerable to HIV, as well as to incorporate specific services for key populations.

Essential HIV services need to be reoriented to accommodate SRH and reproductive rights and choices, and sexuality.

Collaboration mechanisms between HIV and SRH programmes and community groups need to be strengthened; and the use of formal memorandum of understanding (MoU) arrangements needs to be encouraged.

Essential HIV services such as prophylaxis and treatment of HIV and opportunistic infections (OIs), home-based care (HBC), services for key populations and psychosocial support need to actively integrate essential SRH services.
1. Who managed and coordinated the assessment?

The Assessment was managed and coordinated by Drs C. Gardiner and S. Eliason.

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

A national Rapid Assessment Team consisting of representatives of multilateral organizations (UNAIDS, UNFPA, UNICEF, WHO); bilateral donors (UK Department for International Development/DFID); ministries, departments and agencies working on SRH and HIV (Ministry of Health/Ghana Health Services, Ghana AIDS Commission, National AIDS Control Programme/NACP); NGOs (Planned Parenthood Association of Ghana/PPAG), the Ghana National Association of People Living with HIV, youth and other vulnerable groups.

Six research supervisors and 12 research assistants were recruited from districts and trained on data collection using the Rapid Assessment Tool. Six groups of data collectors were formed, with each group consisting of a supervisor and two data collectors assisted by a resident Regional Population Officer. Data collectors carried out the provider and client exit interviews under the oversight of a supervisor.

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

Yes, forty-five (45) national and international SRH- and HIV-related documents were reviewed, including laws [7], policies [10], national guidelines/strategic operational plans [7], service delivery protocols [8], assessments [9] and other documents [4].

4. Was the assessment process gender-balanced?

No. The Assessment Team, which was the same as the review team, was made up of 4 males and 15 females. The relatively low proportion of male exit clients did not allow for gender cross-tabulation of results. Of 220 clients interviewed, there were 37 male and 180 female (3 unrecorded).

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

The Rapid Assessment Tool was adapted and used to obtain qualitative and quantitative information.

6. What was the scope of the assessment?

The aim was to assess HIV and SRH bi-directional linkages at the policy, systems and service levels. The specific objectives were to assess:

- the effectiveness of linkages between SRH- and HIV-related policies, national laws, and operational plans and guidelines;
- the extent to which systems support effective linkages of SRH and HIV;
- the extent of bi-directional integration.

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

Yes. National-level policy-makers and managers from 35 international and national organizations – including multilateral and bilateral agencies, NGOs, CSOs, ministries, departments, agencies, and parliament – were selected based on their level of involvement in SRH and HIV issues, to discuss and validate the findings of the desk reviews at a one-day stakeholder meeting.
8. Did the assessment involve interviews with service providers from both SRH and HIV services?
Yes. A purposive sampling of 6 out of 10 regions was selected, including one region in the Northern Zone (Upper East), two regions in the Middle Zone (Ashanti and Eastern) and three regions in the Southern Zone (Greater Accra, Central and Western) to ensure adequate representation across the country. Two (2) districts were randomly selected from each region (12 districts total), followed by random selection of 5 facilities per district (total 60 facilities). Two service providers (total 120) from SRH and HIV services were randomly selected and interviewed from each facility.

9. Did the assessment involve interviews with clients from both SRH and HIV services?
Yes. Four clients from each of the 60 SRH and HIV services (n=240) were randomly selected, of whom 220 agreed to be interviewed. Of the 220, 213 of the interviews were able to be used in the analysis. Just over half the respondents (119/213) were exiting from SRH services (family planning/FP, maternal and newborn care) and just over 10 per cent (25/213) from HIV-related services (STI management, HIV counselling and testing/HCT, and HIV management). The remainder were exiting from a variety of general outpatient services.

10. Did the assessment involve people living with HIV and key populations?
Two representatives of the Ghana National Association of People Living with HIV participated as Assessment Team members. In addition, youth and other vulnerable groups participated in and monitored the study’s implementation. PLHIV were included in the client exit interviews.
1. Policy level

Strengths:
- SRH service delivery operational plans, guidelines and protocols (FP, safe motherhood and RTI) and HIV-related protocols (STI, voluntary counselling and testing/VCT, PMTCT and ART) are in line with these policies.
- Tuberculosis (TB) protocols address both HIV and SRH issues.
- Operational plans for the education sector effectively link SRH and HIV information.
- Post-exposure prophylaxis (PEP) guidelines, incorporated in the revised ART guidelines, have been revised to include survivors of rape and abuse.

Weaknesses:
- Other policies maintain a ‘separate but equal’ approach to SRH and HIV linkages (e.g. the National Population Policy 1994) or are silent on the issue (e.g. the National Gender and Children Policy 2004, the National Education Sector Policy 2006, and the HIV/AIDS Workplace Policy 2004). There are no policies for or operational guidelines on key populations; and operational guidelines for ART, PMTCT and safe motherhood do not address all HIV or SRH components.
- The Criminal Code criminalizes sex work, homosexuality and injecting drug use.
- Social and community attitudes act as barriers to addressing the needs of key populations, impede programmatic efforts to link SRH and HIV for these populations, and contribute to stigma and discrimination.

Opportunities:
- The National Strategic Plan (NSP) 2011–2015 and the National Population Council (NPC) Workplan 2011–2013 both advocate for SRH and HIV integration. The NSP also outlines strategies for reaching PLHIV with SRH services and for strengthening implementation of the four-pronged PMTCT approach.
- The Health Sector Medium-Term Plan 2011–2013 promotes integrated health service delivery systems.
- The Constitution stipulates the protection and preservation of Fundamental Human Rights and Freedoms, including respect for human dignity and equality and freedom from discrimination for citizens “whatever his race, place of origin, political opinion, colour, religion, creed or gender”, supporting access to SRH and HIV services by key populations.

2. Systems level

Strengths:
- Development partners, including public, private and civil society organizations, support SRH and HIV programme integration through the Partners Forum, thematic working groups, technical working groups and task forces at the national level, and multi-sectoral working groups at regional and district levels. Planning, management and administration (with the exception of budgeting) support bi-directional linkages; and development partners are funding initiatives to support bi-directional linkages. SRH funding continues to support HIV integration in SRH programmes under the national RH framework.

Findings

There are no clinical GBV management guidelines.
• At the regional and district levels, staff are involved in SRH and HIV programmes (dual roles) and collaborate in SRH and HIV programme management and implementation, including coordination, monitoring, integrated supervision of activities and budgets. All categories of health institutions are involved in integrated SRH and HIV services: government facilities [Ministry of Health/ MoH–Ghana Health Service/GHS], NGOs [PPAG, World Vision], private sector, faith-based organizations, and community-based organizations (minimally).

• SRH training materials and curricula for pre- and in-service public sector health institutions at the programme and service delivery levels include HIV prevention, treatment and care. Similarly, HIV training materials and curricula include SRH topics. The education sector’s School HIV ALERT Programme integrates SRH and HIV in basic school and pre-teacher training curricula, and dissemination of information, education and communication materials to schools. Out-of-school youth is targeted through behaviour change communication interventions, including peer education, youth-friendly services, SRH and FP education.

Weaknesses:

• The involvement of CSOs, including PLHIV, is most apparent at the district level, and focuses on advocacy, awareness education and counselling, and care and support. The capacity of PLHIV organizations and CSOs to participate in partnerships needs to be strengthened. At the national level, SRH staff participate in HIV planning, and HIV staff participate in SRH planning, management and administration, although improvement is needed.

• Integrated budgeting is yet to be achieved. Budgets, though complementary, are managed separately, undermining integration and promoting vertical programmes.

• All cadres of health staff, the media, police, judiciary, NGOs, PLHIV and the private sector require training on SRH and HIV for the implementation of a rights-based approach. For example, HIV-related stigma and discrimination both towards key populations and among service providers need to be addressed.

• Staff retention, workload, burnout, and task shifting for integrated services are major challenges. While integrated pre- and in-service training materials exist, not all regional and district institutions have them, with those available mostly for community outreach cadres (nurses, mobilizers and counsellors).

• Training materials are not harmonized and the regularity with which they are updated is unclear, their availability for pre- and in-service training is poor, and there is inadequate coverage of materials for all cadres of health care workers.

• Logistics management systems are weak and do not adequately support integrated SRH and HIV services. Shortages of drugs, supplies and transport are the major barriers at regional and district levels. Most SDP laboratories cover SRH and HIV; however, gaps exist in human resource capacity, equipment and types of tests conducted, depending on the level of care.

Monitoring and evaluation (M&E):

M&E systems support integrated SRH and HIV programmes through the use of an integrated supervisory checklist; however, SRH indicators in HIV programmes and HIV indicators in SRH programmes may need to be expanded to capture client satisfaction, HIV status and integration.

Opportunities:

• A critical mass of development partners and national organizations are ‘champions’ for integrated SRH and HIV programming.

• The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is increasingly funding proposals focusing on SRH- and HIV-related programmes.

• The Health Sector Medium-Term Plan 2011–2013 addresses staffing needs including recruitment, deployment, retention and task shifting in line with the MoH’s Human Resource Development Strategy.
3. Services level

Strengths:
• More than 80 per cent of SRH services offer HIV prevention information, VCT, provider-initiated testing and counselling (PICT), and condoms, and more than 80 per cent of HIV services offer FP and STI management.
• Some 54 per cent of SRH services have been reoriented to accommodate PLHIV and those vulnerable to HIV. Integration occurs through the same provider in a single facility with few off-site referrals except by SRH services for psychosocial support, prophylaxis and OI treatment. Follow-up on referrals is 80 per cent.
• Prevention for and by PLHIV is offered by more than 66 per cent of facilities. Guidelines and protocols for integrated services are available and used in more than 66 per cent of institutions.

Weaknesses:
• Collaboration mechanisms between HIV and SRH programmes and community groups are weak, lacking MoUs.
• Less than 20 per cent of HIV services have been reoriented to accommodate SRH, and reproductive rights, choices and sexuality. Prevention and management of GBV is available in only 50 per cent of SRH services and 40 per cent of HIV services.
• Less than 30 per cent of OI prophylaxis and treatment, key populations, HBC and psychosocial support services have integrated essential SRH services.

Opportunities:
• Expansion of protocols for FP and home visiting for community health nurses attached to child welfare clinics to address weaknesses in HIV integration in SRH services, particularly for PLHIV.
• Prevention of abortion and post-abortion care services could accommodate prevention of unintended pregnancies in HIV-positive women, and care and support for HIV-positive mothers and the family.

Service provider perspectives:
• Essential SRH and HIV services are unavailable in all health facilities, complicating staff training needs.
• The staff shift (roster) system, National Health Insurance Scheme (NHIS)-related issues (accreditation of facilities as clinics and hospitals, the range of services offered, treatment protocols, staff distribution and remuneration policies) and the referral policy all constrain integrated services.
• Low motivation was cited as the greatest constraint to offering integrated SRH and HIV services, followed by staff shortages, space and time.

Service user perspectives:
• The majority of clients expressed strong satisfaction with the level of services they received on the day due to the way in which they were treated (63/220), the friendly, caring attitude of staff (46/220) and the perceived quality of service (18/220).
• Services received exceeded services sought by almost a third (26 per cent), indicating a level of provider-initiated care and service integration. This occurred in FP, STI prevention, HCT, treatment preparedness, HIV prevention, condom services, PICT, psychosocial support, nutrition support and routine gynaecological examinations. This was not the case with maternal and newborn care, where it appears that fewer clients received services sought.

Twenty (20) per cent (44/220) of clients reported being referred for services other than those they sought, supporting the inference of a level of service integration through a single provider. Ninety-two (92) per cent of clients reported that they had received the services they wanted. Reasons for the client’s failure to receive a service included cost, unavailability of the service, embarrassment, and lack of time of the service provider.

With regard to preference for SRH and HIV service location, the majority of clients (79 per cent) wanted services in the same location, citing transportation cost and quick service (56/140), a positive impact on stigma and discrimination reduction (21/140), and accessibility (15/140). The most commonly cited improvement in services that clients would like to see were infrastructural improvements, increased staffing ratios, and increased staff competence.
LESIONS LEARNED & NEXT STEPS

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

- Inadequate time for interviewers to reschedule visits to optimize service provider and client interaction, e.g. some providers were absent and certain services were not offered on the day of interview.
- The relatively low proportion of male clients did not allow for gender analysis.
- Convenience sampling and the small sample size may affect generalizability of results.
- Inappropriate/unusable responses from some service providers and clients affected the analysis by further reducing the limited sample size.
- Inadequate funding limited the number of health facilities visited and number interviewed in each.

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

Policy level:

- Include SRH and HIV integration in reviews of national policies, including population, gender and children, education sector, and workplace. Responsible bodies include: MoH, Ministry of Women and Children’s Affairs (MoWAC), Ghana AIDS Commission (GAC), Ministry of Education (MoE), Ministry of Employment and Social Welfare (MoEsw) and NPC.

- Develop key populations and GBV policies and guidelines. Responsible bodies include: MoH, MoWAC, GAC, MoEsw, NPC and NACP.

- Include all aspects of SRH and HIV integration and increase target groups for PEP in next updates of ART, PMTCT and safe motherhood guidelines. Responsible bodies include: GHS, GAC and NACP.

- Disseminate more widely all SRH and HIV integration policies to all relevant sectors. Responsible bodies include: MoH/GHS, GAC, MoE, MoEsw and MoWAC.

Systems level:

- Build the capacity of CSOs/NGOs, PLHIV, judiciary, health staff, media, police, military, and private sector on SRH and HIV integration and rights-based programming. Responsible bodies include: GAC, MoH, Ministry of Defence, Ministry of Information and Ghana Employers Association.

- Institute logistics management system that supports SRH and HIV integration in all relevant sectors. Responsible bodies include: MoH/GHS, MoWAC, GAC, NACP, MoE, and MoEsw.

- Update (to include issues of integration, harmonization and dissemination) in- and pre-service training materials and curricula for all levels of the health system and all relevant sectors. Responsible bodies include: MoH/GHS, MoWAC, GAC, NACP, MoE and MoEsw.

Service level:

- Reorient SRH and HIV services to accommodate PLHIV and key populations, SRH, and reproductive rights, choices and sexuality. Responsible bodies include: GHS, GAC, NACP, CSOs and NGOs.

- Strengthen collaboration between SRH and HIV programmes and community groups. Responsible bodies include: GHS, GAC, NACP, CSOs and NGOs.

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

In view of the next steps set out above, the priority is to bring all key stakeholders together to develop an action plan to guide the implementation of the recommendations from the various levels.

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

Development partners provide the overwhelming majority of funding for SRH and HIV programmes. The United States Agency for International Development (USAID), DFID, IPPF/PPAG, UNAIDS, WHO, UNFPA and the GFATM are providing funding support for bi-directional linkages. USAID, UNFPA, UNICEF, DFID, the Danish International Development Agency (DANIDA), WHO and IPPF all fund SRH- and HIV-related programmes using programme-specific funding channels. Other opportunities to engage donors on SRH and HIV linkages include USAID’s Global Health Initiative and WHO’s Global Health Sector Strategy for HIV 2011–15.
Lesson Learned & Next Steps

Abbreviations

AIDS acquired immunodeficiency syndrome
ART antiretroviral therapy
CSO civil society organization
DFID UK Department for International Development
FP family planning
GAC Ghana AIDS Commission
GBV gender-based violence
GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria
GHS Ghana Health Service
GPN+ Global Network of People Living with HIV
HBC home-based care
HCT HIV counselling and testing
HIV human immunodeficiency virus
ICW International Community of Women Living with HIV/AIDS
IPPF International Planned Parenthood Federation
MARP most-at-risk population
MoE Ministry of Education
MoESW Ministry of Employment and Social Welfare
MoH Ministry of Health
MoU memorandum of understanding
MoWAC Ministry of Women and Children’s Affairs
NACP National AIDS Control Programme
NGO non-governmental organization
NHIS National Health Insurance Scheme
NPC National Population Council
NSP National Strategic Plan
OI opportunistic infection
PEP post-exposure prophylaxis
PITC provider-initiated testing and counselling
PLHIV people living with HIV
PMTCT prevention of mother-to-child transmission (of HIV)
PPAG Planned Parenthood Association of Ghana
RH reproductive health
RTI reproductive tract infection
SDP Service Delivery Points
SRH sexual and reproductive health
STI sexually transmitted infection
TB tuberculosis
UNAIDS Joint United Nations Programme on HIV/AIDS
UNFPA United Nations Population Fund
UNICEF United Nations Children’s Fund
USAID United States Agency for International Development
VCT voluntary counselling and testing
WHO World Health Organization

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