RAPID ASSESSMENT
OF SEXUAL AND
REPRODUCTIVE HEALTH
AND HIV LINKAGES
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 Sudan. 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?**

- Increase knowledge and establish SRH and HIV linkages at all managerial levels, including national (Federal Ministry of Health/FMOH and UN agencies), state and local-level Ministry of Health/MOH leadership and facility staff. The focus of training materials developed will differ in Blue Nile and South Darfur regions based on assessment findings.
- Focus on strengthening the quality of existing SRH and HIV integrated activities (prevention of mother-to-child transmission/PMTCT, sexually transmitted infections/STIs, promotion and distribution of condoms) at the facility-level supported by clear guidelines and Standard Operational Procedures (SOPs).
- Develop an integrated SRH and HIV intervention package, including SOPs and monitoring and evaluation (M&E) indicators, for key populations.
- Address HIV stigma in reproductive health (RH) outlets against HIV-positive and HIV-negative populations.
- Formally establish and expand the scope of the SRH and HIV Technical Working Group (TWG) so that it acts as an umbrella for all SRH and HIV TWGs to improve coordination of partners.

**Assessment tool**

- Assessment tools should be shared in a modifiable format, e.g. PDF and Word formats.
- The assessment tool needs to be reviewed and shortened.
- Data should be entered in a qualitative analysis software programme for faster analysis.
- The proposed timeline (two months) to carry out the assessment is too short, given workloads and the need to identify people willing to meet for long periods, and should be extended.

**Assessment findings**

**Policy:**

- Advocate for and undertake training on linkage and integration.
- Identify and map all stakeholders involved in SRH and HIV activities.
- Strengthen the policy-making process for SRH and HIV issues by involving other stakeholders (e.g. religious leaders, judiciary system, respected political and community leaders) to address issues such as family planning (FP), availability and acceptability of condoms, and rights of people living with HIV/PLHIV.

---

1. This summary is based upon: SRH/HIV Linkages in Blue Nile and South Darfur States, Sudan Assessment Report. Health Alliance International-Sudan Office, 2011.
• Establish coordination mechanisms, e.g. planning and developing comprehensive SRH and HIV annual plans.
• Strengthen the current PMTCT programme – guideline dissemination and implementation with regular supervision to ensure standardized quality of service (M&E and logistical systems).
• Involve clients and people living with HIV in the SRH and HIV TWG.

**Systems:**
• Develop an SRH and HIV strategy that includes condom promotional programming and provide a package of services for key populations that is adapted and sensitive to the legal and cultural context.

• Support and strengthen the process of integrated M&E systems for current vertical programmes.
• Support and strengthen the process of integration of logistical systems for current vertical programmes.

**Service delivery:**
• Support and strengthen existing PMTCT services through provision of SOPs and M&E forms.
• Learn from and expand family planning and HIV integration model by United Nations Population Fund (UNFPA) and Health Alliance International (HAI).
• Train RH and HIV staff in HIV stigma and integrated approach to care.
1. Who managed and coordinated the assessment?

- Dr Wisal Mustafa Hassan, a public health specialist with experience in both RH and HIV programming, coordinated the assessment.

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

- In addition to the coordinator, the assessment team comprised: Dr Wisal Mustafa, Hamid Idrees, Amira Elfadil and Mohamed Tawfig. A Federal Sudan National AIDS and STI control Programme (SNAP) officer also took part. During field visits, meetings were either facilitated or arranged, or data collection undertaken by a Federal SNAP officer, a HAI technical officer, Sudan Family Planning Association (SFPA) counsellors, and a consultant, with occasional representation from state AIDS and STI control programmes. Drs Suzan, Ahmed and Abdul Razig worked on data entry, analysis and refining the report. Four SFPA staff members in South Darfur (3 counsellors and the branch director) were trained to use the assessment tool.

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

- Yes. Fourteen documents (policies, strategies, laws, guidelines, surveys, situation analysis, MOH data, M&E forms, training materials, guidelines and protocols) covering both SRH and HIV were reviewed.

4. Was the assessment process gender-balanced?

- The researcher team was gender-balanced, comprising of two males and two females. Interviews were carried out with 17 policy-makers (9 males and 8 females), 60 service providers (40 females and 20 males), 11 sex workers (all female), 4 men who have sex with men (MSM), 4 staff (all female) and 17 female clients. Nine facility-based group discussions of males and females also took place (not mixed).

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

- The generic rapid assessment tool on linkages developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives was further adapted following on from the version used for the assessment carried out by HAI in Khartoum and Kassala States. The adaptation process included a rearrangement of the order of questions for better flow, and the omission and/or rephrasing of some questions for simplification. This process took almost two weeks.

6. What was the scope of the assessment?

- In 2010, UNFPA contracted HAI to carry out an SRH and HIV rapid assessment in Khartoum and Kassala States, develop an SRH and HIV TWG, and pilot SRH and HIV integrated activities in eight sites. This sensitized both SRH and HIV programmes on the importance of linkages. The TWG identified other states for implementation of the rapid assessment tool (Blue Nile, South Darfur and Gedaref). In 2011, SFPA as an active member of the SRH and HIV TWG expanded the assessment process to Blue Nile and South Darfur States.
7. Did the assessment involve interviews with policy-makers from both SRH and HIV sectors?  
• Yes. Interviews were carried out with: 17 policy-makers (9 South Darfur, 8 Blue Nile) from different directorates from state MOHs (planning, curative, preventive, pharmacy, RH and HIV, political), health advisor to Wali (governor), to developmental partners (UN agencies, non-governmental organizations/NGOs and international NGOs/INGOs representatives) and civil society (PLHIV associations).

8. Did the assessment involve interviews with service providers from both SRH and HIV services?  
• Yes. Service providers were selected from both RH and HIV outlets from different types of facilities (hospitals and health centres – NGO, private and public) in each state. In total, 60 RH and HIV providers from 9 facilities (5 groups in South Darfur, 4 groups in Blue Nile) were interviewed.

9. Did the assessment involve interviews with clients from both SRH and HIV services?  
• Yes. Seventeen clients from facilities were visited (i.e. both SRH and HIV services in Blue Nile [9] and South Darfur [8]). Services visited included antenatal care (ANC) [12], nutrition [2], antiretroviral therapy (ART) [2], gynaecology [1] and postnatal care [2].

10. Did the assessment involve people living with HIV and key populations?  
• Yes. Interviews were carried out with: 16 members of key populations (5 female sex workers and 4 MSM in Blue Nile and 6 female sex workers from South Darfur) as well as six people living with HIV in Blue Nile and 2 in South Darfur. PLHIV associations in Damazine and Nyalla were involved in the group discussions. For reasons of confidentiality, the MSM were screened off during interviews with MOH and NGO to protect their identity.
FINDINGS

1. Policy level

- Both RH and HIV programme policies include HIV and SRH with varying emphasis. For example, the RH policy addresses HIV as part of adolescent RH, HIV testing as part of pre-marital health care, and condom use alongside distribution of contraceptives in family planning clinics to married couples. The HIV policy includes routine HIV testing as part of STI management, maternal health care, and youth-friendly health/non-health services, and addresses gender-based violence (GBV) (e.g. rape) and the use of condoms as HIV prevention strategies for protecting HIV-positive clients and those affected by HIV.

- Policies are not supported politically and are directed solely at the public sector. Most policy-makers were unclear on bi-directional linkages and integration. The only identified linkages were the national SRH policy and SFPA strategy. Most policy-makers reported national or organizational HIV policies; however, policies remain unknown at the community level, with a lack of prioritization and the RH needs of people living with HIV remaining unaddressed.

Legal environment to support RH and HIV interventions:

- Laws hindering access to services by key populations include the Public Order General Act, Shari’aa laws, and laws criminalizing sex work and MSM, as well as the Humanitarian Aid Commission which restricts NGOs’ distributing condoms and working with key populations. Laws that facilitate HIV interventions include the Women’s Protection Law and the anti-discrimination provisions under the Labour Act. The National Assembly has not passed the PLHIV Law which includes anti-discrimination provisions. There is no minimum legal age for marriage or accessing SRH services, and family planning services are only offered to married couples.

SRH and HIV integration in operational plans and guidelines:

- Reproductive health and HIV programme plans are vertical. The PMTCT guideline is the principal operational guidance to increase SRH and HIV linkages in addition to guidelines on post-exposure prophylaxis (PEP) for rape victims and information, education and communications (IEC) materials and training. The National Health Strategy 2012–2016 provides an opportunity for integration, restructuring MOH departments, and unifying M&E and logistic systems.

2. Systems level

Human resources:

- The main constraints are poor skills, staff shortage and turnover, staff incentives to accept rural postings, supervision, unclear terms of reference (ToRs), demotivation and poor working environments. In addition, HIV stigma among health workers and the lack of teaching aids for awareness raising among clients are the main constraints to integration. Training is needed to improve the understanding of linkages and integration at all levels.

- Civil society had no active role in SRH programming; however, in the case of HIV programming, civil society was reported to be active in reaching key populations, raising community awareness, advocacy, and supporting PLHIV groups, coordination and planning. A minority of respondents mentioned that PLHIV, key populations and youth are involved in activities, including awareness raising, data collection, analysis, planning, implementation and evaluation.

Logistics system:

- Most respondents agreed that the logistics system hinders effective service integration due to complicated procedures, weak organisational capacity for forecasting demand, vertical funding and programmes, and poor supervision.
Laboratory support:
- HIV tests are provided in specialized centres, including voluntary counselling and testing (VCT) and ART, with few laboratories offering RH and HIV tests, including insufficient stocks of RH diagnostic tests.

Monitoring and evaluation systems:
- There were missed responses on whether the current M&E system captures the results of HIV integration in SRH programmes.

Finance:
- The main sources of funds for RH and HIV are the government, National Health Insurance, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNDP, UNFPA, UNICEF, WHO, MDTF, USAID, JICA, CIDA, CHF, CDF, World Vision, Danish Fund, INGOs and NGOs e.g. Merlin, Islamic Relief Worldwide, Patient Help Fund, SFPA and Turath. Sources for SRH and HIV linkages include government, UNICEF, UNFPA, WHO, UNDP, GFATM and SFPA. Donors are perceived as supporting vertical HIV and SRH activities. The major champions supporting SRH and HIV linkages (technical, financial or both) identified are UNICEF and UNFPA, though most technical working groups are non functional or do not address SRH and HIV linkages.

3. Services level
   A. SERVICE PROVIDER PERSPECTIVES

       • SRH and HIV service providers were generally unaware of policies and changes in guidelines but were supportive of integration. Concerns included increased workload and implementation costs. The majority of respondents rated service integration as poor. Examples of integration include PMTCT services in governmental facilities and NGOs e.g. SFPA, Muslim Aid and Rufaida Health Foundation raising awareness.

   HIV facility assessment results
- Three facilities (Nyalla Teaching Hospital and SFPA in South Darfur and Damazine General Hospital in Blue Nile) were assessed:
  - All facilities were providing some HIV and SRH service components. However, comprehensive services were lacking, for example, SFPA was not providing ART or offering condoms.
- In terms of key populations, Nyalla Hospital was offering all SRH services except maternal, newborn and child health (MNC and ANC) and ANC to female sex workers and internally displaced people (IDP); SFPA was providing all SRH services through mobile clinics; and Damazine Hospital did not address key populations' needs.
- There was no routine provider-initiated testing and counselling (PITC) for women attending ANC or tuberculosis (TB) and STI patients.
- None of the health providers recognized the need for ANC services for people living with HIV.
- SRH and HIV services were located in the same service site, provided by the same person in both Nyalla Hospital and the SFPA centre, while Damazine Hospital referred clients to on-site services, though without any system for follow-up. All facilities offered SRH services to the general population on the same day that HIV prevention and information services were offered.
- Most services had made efforts to integrate SRH into PMTCT programmes. Constraints identified included the lack of training for counsellors and difficulties in implementing PITC protocols by doctors. Facilitating factors included draft PMTCT guidelines and the SFPA policy. Benefits of integrated services cited included reduced costs and stigma, and increased efficiencies weighed against increased workload, time spent per client, and privacy/confidentiality.

   SRH outlets assessment results
- All seven SRH facilities assessed were providing maternal and newborn care (MNC and STI services. The latter were mostly integrated within other services and only one facility offered stand-alone services. Most of the facilities assessed were providing family planning services (5/7) and care of unsafe abortion and management of post-abortion care (4/7). Fewer facilities (1–2/7) were providing nutrition and health education, rape management, vaccination or female genital mutilation (FGM) awareness. Services delivered differed by site, e.g. some Blue Nile facilities offered gender-based violence management, while in South Darfur none offered such services.
HIV services integrated within RH 
services ranged from counselling 
and testing (5/7) using mainly PITC 
(more common in South Darfur), HIV 
prevention to the general population 
(4/7), condom provision (4/7), and PLHIV 
care (3/7). PMTCT services varied (e.g. 
Prongs 1 and 3 of a four-pronged PMTCT 
strategy were offered in most facilities [4 
and 5/7 respectively], Prong 2 was less 
common (3/7), and Prong 4 was offered 
in only one facility [1/7].

HIV services were mainly offered by 
one provider or different providers in 
the same site. There was no referral 
follow-up mechanism except patient 
feedback. Half of the facilities reported 
being HIV-positive-friendly and offered 
free services such as X-rays and other 
investigations, and coordinated some 
activities with PLHIV associations, 
though services have not been 
reoriented to address PLHIV needs.

Service providers had weak knowledge 
of current policies and guidelines. At 
the facility level, issues include HIV test 
kit stock-outs, stigma among health 
care providers (doctors were identified 
as more resistant and reluctant to 
 Implement PITC in South Darfur), space, 
lack of privacy and untrained staff.

B. SERVICE USER PERSPECTIVES

General population

The main beneficiaries of SRH services 
are women. Interviewed clients do not 
have good knowledge of SRH or HIV 
services provided, but were supportive 
of SRH and HIV integration. Most clients 
(11/17) preferred SRH and HIV integrated 
services at the same facility with an 
equal number preferring integrated SRH 
and HIV services from one provider [7] or 
same-site [6]. The benefits of same-site 
services on one day or services delivered 
by one provider include reduction in 
transportation costs and other fees, 
fewer visits, reduction in waiting time 
and effort; and increased understanding 
between client and provider.

Only three clients were referred to 
SRH or HIV services unavailable in the 
facility. Unavailable services ranged 
from information/awareness sessions 
about pregnancy and abortion, vitamin 
supplements, natural delivery and 
caesarean section, expected care 
from health providers (doctors), 
vaccination, health education, nutrition, 
STI management, HIV services, and 
ultrasound.

Key populations

Female sex workers and MSM 
interviewed were part of an HIV 
behavioural survey or were peer 
educators. It was expected that these 
groups would be knowledgeable about 
HIV and services. Most had undergone 
an HIV test (except sex workers with 
a limited number of sexual partners). 
Constraints to accessing services 
included: cost, attitude of partners, 
doctor–patient relationship, non-
motivated and inexperienced providers 
in the teaching hospital, contraceptives 
only offered to married women and 
available to men, STIs, and questions 
about sexual behaviour(s), waiting time 
for investigations, and non-availability 
of condoms. With regard to SRH and 
HIV integration models, all but one 
respondent group (in South Darfur) 
preferred SRH and HIV services in 
separate facilities due to stigma, 
whereas in Blue Nile all respondents 
preferred services in one place due to 
cost effectiveness and convenience. This 
finding, together with decreased risk 
perception among female sex workers, 
indicates higher levels of HIV-related 
stigma and incorrect knowledge of HIV 
transmission in South Darfur.
LESSONS LEARNED & NEXT STEPS

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

Limitations of this assessment include:
- The limited diversity of the assessment team.
- The representativeness of the key populations interviewed.
- Focus group discussions methodology:
  - The moderator had less control over the process and was not able to keep participants focused on the topic.
  - Individuals did not express their views as they were bound by the cultural context.
- Time constraints and conflicts in interviewees’ schedules limited the involvement of representatives of organizations.

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

A dissemination meeting recommended:
- Study the Blue Nile model (as a success story) of SRH and HIV integration.
- Share findings of assessment with all partners and present the at higher levels of government.
- Hold a meeting for HIV and RH staff from MOH at different level to instigate joint planning.
- Share, develop and utilize SRH and HIV annual plan developed in Cairo meeting.
- Develop an SRH and HIV strategy with focus on introducing syphilis testing in ANC.
- Follow-up meeting of TWG on SRH and HIV integration priorities and recommendations.

Partnerships and capacity building:
- Involve SNAP in the RH partner forum.
- Involve universities in the TWG and SRH and HIV researches.
- Develop a capacity-building plan for NGOs in order to outline roles of all partners for better accountability and performance.
- Plan for seminars on awareness raising among health care providers for stigma reduction.

3. What are the priority actions that are being taken forward as a result of the assessment, at policy, systems and services levels?

Based on the recommendations the following steps were proposed:
- Compilation of previous findings with findings of this assessment.
- Mapping of all partners implementing SRH and HIV integrated activities.
- Holding a TWG meeting to discuss and share findings of both assessments, share success stories, experiences in implementation, list priority areas and modify/endorse annual plan proposed by partners.
- Develop an SRH and HIV strategy with stakeholders.
- Hold an advocacy and sensitization meetings with FMOH, state MOH and local health management teams to increase knowledge on SRH and HIV linkage and integration as a part of developing a national health strategy.
- Strengthen the quality of existing PMTCT, FP and HIV linkage pilot exercise, HIV and STI services, and key population intervention package through different methodologies available.
- Hold annual meetings to share findings and progress on SRH and HIV integration.

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

There is a donor shift to integration; for example, GFATM supports country proposals with integrated approaches.
Abbreviations

AIDS    acquired immune deficiency syndrome
ANC    antenatal care
ART    antiretroviral therapy
CDF    Community Development Fund
CHF    Common Humanitarian Fund
CIDA    Canadian International Development Agency
FGM    female genital mutilation
FMoH    Federal Ministry of Health
GFATM    Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP    Global Network of People Living with HIV
HAI    Health Alliance International
HIV    human immunodeficiency virus
ICW    International Community of Women Living with HIV/AIDS
IDP    internally displaced persons
IEC    information, education and communication
INGO    international non-governmental organization
IPPF    International Planned Parenthood Federation
JICA    Japan International Cooperation Agency
M&E    monitoring and evaluation
MDTF    Multi-Donor Trust Fund
MNC    maternal and newborn care
MNCH    maternal, newborn and child health
MoH    Ministry of Health
M5M    men who have sex with men
PEP    post-exposure prophylaxis
PiTC    provider-initiated testing and counselling
PLHIV    people living with HIV
PMTCT    prevention of mother-to-child transmission (of HIV)
RH    reproductive health
SFPA    Sudan Family Planning Association
SNAP    Sudan National AIDS and STI Control Programme
SOP    standard operational procedure
SRH    sexual and reproductive health
STI    sexually transmitted infection
TB    tuberculosis
ToR    terms of reference
TWG    technical working group
UNAIDS    Joint United Nations Programme on HIV/AIDS
UNDP    United Nations Development Programme
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

FOR FURTHER INFORMATION, PLEASE CONTACT:
Dr Eihab Ali Hassan, Director, Sudan National AIDS Control Programme (SNAP), Federal Ministry of Health, Khartoum, Sudan
Tel: +249 912 302 096. Email: manager@snap.gov.sd

© 2011 IPPF, UNFPA, WHO, UNAIDS