



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 Lebanon*<sup>1</sup>. 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 level

- Advocacy, particularly among directors and supervisors, on the importance, effectiveness and usefulness of SRH and HIV integration – to gain further commitment and understanding.
- Re-examining and generating knowledge from the institutions that reported provision of integrated services.

#### 1. Systems level

##### Partnerships:

- Partnering with youth and key populations (men who have sex with men, intravenous drug users and people living with HIV – PLHIV) and providing these groups with a more proactive role in the response to SRH and HIV.
- Strengthening partnership with PLHIV to increase their capacity and visibility at national and community levels.

##### Planning and programming:

- Reviewing and upgrading the reproductive health (RH) programme and the National AIDS Control Programme (NACP) to harmonize integration of HIV in both.
- Strengthening and supporting joint planning and programming of SRH and HIV initiatives.
- Encouraging and reinforcing collaboration between SRH and HIV programme management (coordination and monitoring activities, integrated budgets, etc.).

##### Human resources and capacity building:

- Identifying and training all related human resources not providing integrated SRH and HIV services.
- Developing and agreeing core training guideline principles and values (such as confidentiality, gender sensitivity, male involvement, etc.) for integration.
- Identifying, reviewing and developing training materials/curricula on SRH that include HIV prevention, treatment and care at programme- and service-delivery levels, and including them as part of the pre-service and in-service training. And vice versa for materials on HIV that include SRH.

1. This summary is based upon the report: *Assessment of Linkages between Sexual and Reproductive Health and HIV in Lebanon*, UNFPA, American University of Beirut, Republic of Lebanon Ministry of Public Health and the National AIDS Control Program in Lebanon, April 2010.

## RECOMMENDATIONS CONTINUED

### Logistics and commodities:

- Equipping both SRH and HIV service-delivery points with necessary commodities (i.e. medications, contraceptives, supplies and equipment).
- Ensuring provision of voluntary counselling and testing (VCT) kits, especially to remote areas through the Ministry of Public Health (MOPH), particularly the NACP.

### Monitoring and evaluation :

- Developing and adopting a monitoring and evaluation scheme to capture progress, identify bottlenecks and record results of integration in both SRH and HIV programmes. The mechanism will include 1) a structure, 2) a set of indicators, 3) a supervisory mechanism, and 4) a data collection system.

### 2. Service level

#### Service provider level:

- Discussing/agreeing on the core list of HIV services to be integrated in SRH services, and vice versa.
- Developing/activating a mechanism for service-delivery points to offer HIV services within SRH, and vice versa.
- Developing/operationalizing a follow-up mechanism for referrals.
- Developing collaboration between community-based HIV networks/ organizations and SRH organizations.
- Advocating and creating awareness among service providers on how SRH services can accommodate clients with HIV needs.
- Developing protocols and guidelines that support integrated services.
- Developing the capacities of service providers on the different levels of integration in the different levels of service provided.

#### Service user level:

- Raising service users' awareness of their rights to quality services.
- Improving the marketing of services to clients – to increase their use.

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# PROCESS

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## 1. Who managed and coordinated the assessment?

- The assessment was carried out by an Implementing Partner – the Rafic Hariri School of Nursing at the American University of Beirut. The Partner was selected on the basis of a thorough assessment of four potential entities and endorsed by the MOPH represented by both the Reproductive Health Project and the NACP.
- The assessment received support, guidance and funding from UNFPA in collaboration with the NACP.

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

- The core team from the Implementing Partner consisted of a principal investigator, two consultants and one research assistant. Five graduate assistants were recruited and trained to conduct the service-level interviews, with data collection carried out over a two-month period.

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

- Before the assessment, a review was carried out of previous available SRH studies, documents and reports in Lebanon. Of the 96 documents reviewed, none referred to SRH and HIV integration.
- The desk review covered government bodies and non-governmental organizations (NGOs) involved in SRH and HIV policy-making and programme planning. It examined their relevant policies, plans, constitutions, procedures and guidelines for evidence of SRH and HIV integration and attention to key related issues (such as human rights, gender, and stigma and discrimination).
- Documents reviewed were from: MOPH including the RH project, and the NACP, UNFPA, WHO, Lebanon Family Planning Association, Armenian Relief Cross in Lebanon, Helem (Lebanese Protection of Lesbian, Gay, Bisexual and Transgender people) and Soins Infirmiers Développement Communautaire.

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## 4. Was the assessment process gender-balanced?

- The assessment team included only one male graduate assistant. However, a gender balance was achieved in the panel of experts that revised the assessment tool and among the researchers, service providers, experts in SRH and HIV and service users.
- The assessment addressed issues relating to both women/girls and men/boys.
- 91.7 per cent of the service users interviewed were women. Only nine men were interviewed at HIV or VCT centres.
- No men were interviewed at SRH services due to socio-cultural factors.
- The advisory committee for the assessment had a gender balance among its members.

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

- From the *Rapid Assessment Tool* the policy section was used for stakeholder interviews and the desk review. The systems section was used for interviews with directors and supervisors (with some questions targeting SRH services, some HIV/VCT services and some both). The service section was divided into three: service providers at SRH services; service providers at HIV/VCT services; and all clients after receiving services.
- The Arabic version of the tool was evaluated for its cultural appropriateness and clarity by a team representing the MOPH RH project, NACP, UN agencies, research experts and NGOs, including those working on SRH and HIV, key populations and PLHIV.
- A full day technical meeting was organized, with changes made to the tool.
- Five graduate assistants were recruited and trained in how to obtain informed consent and conduct the interviews with service directors and supervisors, providers and clients. Prior to those interviews, a national day was held for the key stakeholders, directors and supervisors and service providers of the selected services. This launched the

assessment, started the process of data collection and promoted the importance of SRH and HIV integration.

- The interviews were based on informed consent, assuring confidentiality and anonymity.

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## **6. What was the scope of the assessment?**

- The assessment aimed to: assess SRH and HIV bi-directional linkages at policy, systems and service-delivery levels; identify gaps between SRH and HIV linkages at all levels; and contribute to developing a country-specific action plan to forge and strengthen linkages.
- The assessment was designed as a cross-sectional descriptive survey.
- The interviews targeted 45 services (28 SRH and 17 HIV/VCT).
- The assessment was national and covered the six main regions (Greater Beirut, Mount Lebanon, the North, Bekaa, Nabatiye and the South), with the largest percentage of service-level participants (23.3 per cent) from Mount Lebanon. More of the participants were from NGO facilities (76.3 per cent) compared to government (23.7 per cent), which represents the reality of service use in the country.

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

- Interviews were carried out with national policy-makers and NGO leaders. These included directors and senior representatives of: MOPH RH project, NACP, WHO, Lebanon Family Planning Association, Lebanese Association for Obstetrics and Gynecology, Soins Infirmiers Développement Communautaire, Helem, Oum El Nour (NGO working on drugs prevention), Lebanese Council to Resist Violence Against Women, and Think Positive (representing PLHIV).
- Telephone interviews were carried out with staff from the Ministry of Social Affairs, Ministry of Education and Higher Education, UNICEF, NGOs and Y-PEER network.

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

- Interviews were carried out with 47 directors and supervisors of services (29 SRH, 18 HIV/VCT). Their backgrounds included nursing, medicine, midwifery, psychology and social work.
- Interviews were carried out with 63 service providers: 40 from SRH services (mostly physicians and nurses, but also others such as midwives and social workers) and 23 from HIV/VCT services (mostly social workers, but also midwives, psychotherapists and laboratory technicians).

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

- Clients coming for SRH or HIV/VCT services on the day that the facility was visited by the assessment team were asked if they would voluntarily participate in the assessment.
- Interviews were carried out with 109 clients (84 from SRH services and 25 from HIV/VCT).
- Most of the clients (91.7 per cent) were female, mainly from SRH services; all male clients were from the HIV/VCT services.
- The clients averaged 34.5 years old, with the largest proportions coming from the South (25.9 per cent) and Mount Lebanon (24.1 per cent).

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

- The stakeholder interviews included one with Helem and another one with Think Positive.
- Client interviews were conducted with sex workers, abused women and PLHIV.

# FINDINGS

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## 1. Policy level

### National policies, laws, plans and guidelines:

- The desk review identified no clear national laws, programmes, policies, plans or procedures related to SRH and HIV integration. A few booklets and documents related to HIV – including ones by Soins Infirmiers Développement Communautaire and the NACP – refer to links between HIV and areas of SRH, such as sexually transmitted infections (STIs).
- The HIV/AIDS National Strategic Plan 2004–09 refers to SRH within its intervention priorities, in terms of promoting safe sex, condom use and other prevention measures.

### Funding and budgetary support:

- The service providers particularly reported a lack of financial support (as well as technical and training/educational support).

### National stakeholder perspectives:

- All of the 14 national stakeholders showed strong support for SRH and HIV services being integrated and in one package. The benefits were seen to include increased quality and reduced costs. Some had concerns about the process of integration, with challenges including service providers' lack of willingness to be trained and poor monitoring and evaluation processes specifically for integration.

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## 2. Systems level

According to the interviews with 47 directors and supervisors of SRH and HIV services:

### Partnerships:

- SRH directors and supervisors identify their major partner as the MOPH (85 per cent) and less frequently mention the Ministry of Social Affairs, doctors, nurses and NGOs. HIV/VCT directors and supervisors identify the NACP and, less frequently, the MOPH and NGOs, including Soins Infirmiers Développement Communautaire.

- Nearly a third of directors and supervisors say there are no 'champions' for action on SRH and HIV integration. Where 'champions' were identified, they were the MOPH and NACP.
- More HIV/VCT directors and supervisors (61.1 per cent) reported having a multi-sectoral technical group working on linkages compared to SRH directors and supervisors (24.1 per cent).
- Significant differences were seen in relation to civil society. Over half (54.4 per cent) of SRH centres' directors and supervisors – compared to just 16.8 per cent of HIV/VCT centres directors and supervisors – considered the role of civil society in SRH and HIV programming to be very limited. 31 per cent of SRH directors and supervisors – compared to 76.5 per cent of HIV/VCT directors and supervisors – report the involvement of groups of civil society (including youth, PLHIV and key populations).

### Planning:

- Only 31.9 per cent of directors and supervisors report joint planning of HIV and SRH programmes. Only 28.3 per cent report collaboration within programme management. However, much higher levels of collaboration are reported within coordination and monitoring of activities.
- Among SRH directors and supervisors, 51.7 per cent say there is no or limited integration of HIV into SRH services. 34.4 per cent report integration into awareness, prevention and counselling, and 17 per cent say there is strong integration.
- Among HIV/VCT directors and supervisors, 44.8 per cent say there is no or limited integration of SRH into HIV services. 22.4 per cent report integration into awareness, prevention and counselling and 22.4 per cent say there is strong integration.
- Directors and supervisors report that SRH and HIV integrated services are largely provided by the government (cited by 35.7 per cent) and NGOs (29.4 per cent), with very small numbers by faith-based organizations and private sector. 18.9 per cent report that no institutions provide such services.

### Human resources and capacity building:

- Very few directors and supervisors can identify the highest priorities for training needs, but, where cited, they include awareness raising about integration. The majority believe that needs are highest among physicians and nurses (followed by others, such as midwives and counsellors) and in health service delivery points (followed by clinics and hospitals).
- About a third of directors and supervisors know of training materials on SRH that address HIV, and vice versa.

### Logistics, supply and laboratory support:

- Most directors and supervisors (78.7 per cent) report that laboratory facilities serve both SRH and HIV services.

### Monitoring and evaluation:

- There is little attention to monitoring indicators for integration. Directors and supervisors of HIV/VCT services report higher monitoring of services for clients receiving SRH services (44.4 per cent) compared to those of SRH services for clients receiving HIV services (just 10.3 per cent).
- Monitoring data is much more likely to be disaggregated at HIV/VCT than at SRH services.

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## 3. Services level

### A. SERVICE PROVIDER PERSPECTIVES:

#### HIV integration into SRH services:

According to the interviews with 40 SRH service providers:

- The SRH service most often provided by the SRH service is control/prevention of STIs (reported by 95 per cent), followed by family planning (90 per cent) and maternal, newborn and child health (MNCH) (80 per cent). Post-abortion care is reported to be provided at 47.5 per cent and prevention/management of gender-based violence (GBV) at 30 per cent of facilities.
- The HIV services that are most often integrated within general SRH services are condom provision (35 per cent), provider-initiated HIV counselling and testing and HIV prevention for the general population (both 30 per cent). Much lower levels were reported for services such as treatment for PLHIV (7.5 per cent), prevention for/by PLHIV (7.5 per cent) and HIV information/services for key populations, such as sex workers and men who have sex with men (both 5 per

cent). Almost half of SRH providers (47.5 per cent) reported no integration of HIV services.

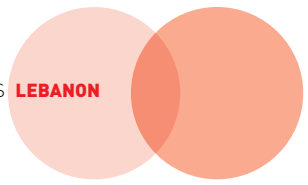
- In terms of some type of HIV integration into specific SRH services, this was most commonly seen in STI prevention (57.5 per cent) and family planning (52.5 per cent), followed by MNCH and prevention/management of GBV (both 40 per cent). Overall, levels of integration into specific SRH services were low. Where they occurred, they were most likely to focus on provider-initiated HIV testing and counselling and HIV prevention for the general public.
- In terms of methods to modify SRH services to accommodate the HIV needs of clients, 45 per cent reported no methods available and few others could name specific methods (such as training staff and linking with PLHIV networks – both identified by just 2.5 per cent). The majority (90 per cent) reported that there is no structural collaboration with NGOs working on HIV.
- The main barrier to SRH and HIV integration was identified as cultural issues (37.5 per cent), with lower numbers citing lack of awareness, lack of support (financial, government and equipment) and lack of coordination.
- The main facilitators of integration were identified as awareness raising (30 per cent) and support (25 per cent) (financial, government and equipment). 37.5 per cent could not identify a facilitator.

- The impacts of SRH and HIV integration were considered to include increasing: the need for equipment, supplies and drugs (92.5 per cent); time spent with a client (72.5 per cent); cost of services on the facility (67.5 per cent); efficiency of services (67.5 per cent); and workload of providers (57.5 per cent).

#### SRH integration into HIV services:

According to the interviews with 23 HIV/VCT service providers:

- The HIV services most frequently offered at HIV/VCT services are condom provision (reported by 91.3 per cent of providers), HIV VCT (82.6 per cent), HIV prevention for the general population (78.3 per cent) and psychosocial support (65.2 per cent). Notably, they also provide services to key populations, including intravenous drug users (47.8 per cent), men who have sex with men (34.8 per cent) and sex workers (47.8 per cent).



- The SRH services most often integrated into general HIV/VCT services are control/prevention of STIs (78.3 per cent), followed by family planning (45.5 per cent), MNCH and prevention/management of GBV (both 39.1 per cent). Only 13 per cent reported no integration of services.
- In relation to specific HIV/VCT services, levels of some type of SRH integration appeared to be highest within HIV counselling and testing, and lowest within home-based care.
- In terms of modifying HIV services to accommodate the SRH needs of clients, 39.1 per cent reported that they followed the recommendations of the NACP, but few named specific methods. 30.4 per cent said that there was no structural collaboration with NGOs working on HIV.
- The largest barrier to SRH and HIV integration was seen as cultural issues and lack of support (financial, government and equipment). Both were identified by 21.7 per cent.
- The main facilitators of integration were seen as awareness (26.1 per cent), followed by support (financial, government and equipment) and qualified multidisciplinary teams.
- SRH and HIV integration was perceived to impact on many service levels: efficiency of services (76.2 per cent), workload of providers (76.2 per cent), need for equipment, supplies and drugs (66.7 per cent), time spent with clients (61.9 per cent) and cost of services to the facility (47.6 per cent). Integration was also perceived to decrease stigma for HIV service users (52.4 per cent).

## B. SERVICE USER PERSPECTIVES

According to the interviews with the 109 clients:

- The main reason for visiting SRH services was 'other services' (41.7 per cent) and MNCH (36.9 per cent). For HIV/VCT services, it was HIV counselling and testing (64 per cent) and HIV prevention (20 per cent). Most clients (97.2 per cent) received the service that they came for.
- Most clients (67 per cent) said they would prefer to receive SRH and HIV/VCT services from same facility. 22 per cent would prefer to receive them from different facilities and 11 per cent had no preference.
- The main benefits of receiving both services from the same facility were seen as: reduced transport costs (identified by 45 per cent of clients), reduced trips to facility (35.8 per cent), improved efficiency of services (33 per cent), reduced fees (32.1 per cent), opportunity to access additional services (29.4 per cent), reduced waiting time (26.6 per cent) and reduced stigma related to HIV (20.2 per cent).
- A much higher proportion of HIV/VCT service users (64 per cent compared to 34.5 per cent) preferred receiving both services from the same facility. These clients also gave greater emphasis to the benefits of building trustworthy relationships and ensuring continuity of care.
- The disadvantages of receiving SRH and HIV services from the same facility were seen as: stigma and discrimination (11.9 per cent), decreased quality of services (10.1 per cent) and less confidentiality (8.3 per cent). Many clients (46.8 per cent) reported no disadvantages.
- Quite low numbers of clients received SRH and HIV/VCT support beyond the service that they came for. The highest levels related to STI management (36 per cent of clients) and sexuality (35 per cent).
- In both SRH and HIV/VCT services, most clients (73 per cent and 72 per cent) were satisfied with their care.



# LESSONS LEARNED AND NEXT STEPS

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

- Involving more male clients in the assessment could have provided important input on issues affecting men/boys and gender perspectives.
- The limited engagement of NGOs in the assessment (often due to lack of perception of the relevance of integration to their operations or not finding time for interviews) hindered the input of a key sector, including in relation to issues affecting PLHIV and key populations.
- Where many stakeholders, including directors and supervisors, were unfamiliar with the concept of SRH and HIV integration, the tool and approach could have been further adapted to introduce the subject with more clarity prior to the assessment process.
- There is a general impression among the directors and supervisors and service providers that initiatives that are started are not followed up and, as such, lose meaning due to loss of continuity. Therefore, it is important to follow up on the results of the assessment (in terms of further examining the facilitators of integration) and to implement the recommendations.

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

- A national dissemination day was held where stakeholders of all sectors and all groups/individuals with direct interest and involvement were invited to share and discuss the results of the assessment. A press release was circulated to the media.
- A pamphlet was developed giving the 'at a glance' status of SRH and HIV integrated services, based on the assessment, for distribution to all relevant services and related organizations.

## 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:

- Disseminating the assessment results and findings among stakeholders and decision-makers – and demonstrating that linkages can lead to improved health outcomes and cost effectiveness.
- Using evidence to promote integration in development frameworks and sector strategies.
- Conducting more operational research (especially in understudied areas) to demonstrate that SRH and HIV integration can reduce stigma and discrimination.

### Systems level:

- Strengthening supply management, including RH commodity security.
- Strengthening the health information system for generating robust indicators and data on the cost effectiveness of bi-directional linkages between SRH and HIV.
- Enhancing the referral system.

### Services level:

- Promoting the scaling up of the primary health care package that integrates SRH and HIV.
- Integrating SRH and HIV services within the youth-friendly service package being piloted in several health service delivery points.
- Developing the capacity of youth-friendly service providers on the importance of integration.

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

- Advocacy to mobilize domestic funding for programming for SRH and HIV integration.
- Strengthening of the partnership between the SRH programme and NACP programme, and between the government and non-governmental sectors, to agree on common priorities, interventions and resource allocation for SRH and HIV integration.

## Abbreviations

<b>AIDS</b>	acquired immune deficiency syndrome
<b>GBV</b>	gender-based violence
<b>GNP+</b>	Global Network of People Living with HIV
<b>Helem</b>	the Arabic acronym for the NGO Lebanese Protection of Lesbian, Gay, Bisexual and Transgender People
<b>HIV</b>	human immunodeficiency virus
<b>ICW</b>	International Community of Women Living with HIV/AIDS
<b>IPPF</b>	International Planned Parenthood Federation
<b>MNCH</b>	maternal, newborn and child health
<b>MOPH</b>	Ministry of Public Health
<b>NACP</b>	National AIDS Control Programme
<b>NGO</b>	non-governmental organization
<b>PLHIV</b>	people living with HIV
<b>RH</b>	reproductive health
<b>SRH</b>	sexual and reproductive health
<b>STI</b>	sexually transmitted infection
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>VCT</b>	voluntary counselling and testing
<b>WHO</b>	World Health Organization

FOR FURTHER INFORMATION, PLEASE CONTACT:  
UNFPA Lebanon, [info-lebanon@unfpa.org](mailto:info-lebanon@unfpa.org)