Rapid Assessment of Sexual and Reproductive Health and HIV Linkages

COTE D’IVOIRE
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 Cote d’Ivoire. 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.

1. This summary is based upon: Evaluation Rapide sur l’Intégration du VIH et la Santé Sexuelle et de la Reproduction, Cote d’Ivoire, Kouadio Kapet Guillaume (Consultant), November 2009.

RECOMMENDATIONS

What recommendations did the assessment produce?

• Making effective linkages between SRH and HIV-related policies and national laws, such as the National HIV Law.
• Ensuring that operational plans and guidelines are developed to facilitate implementation.
• Strengthening systems to support effective SRH and HIV linkages in the areas of management, networking, strategic thinking and planning, human resources and supply.
• Defining a national policy that clearly defines the norms for integrating SRH into HIV services and vice versa.

• Ministry of Health to establish and operationalize a national SRH and HIV task force by the end of 2010.
• Strengthening the capacity of people living with HIV (PLHIV) networks in advocacy for universal access to high-quality SRH and HIV services that integrate human rights and gender.
• Forming a task team to examine and advise on how SRH and HIV can be best integrated (i.e. what areas of both should and could be linked).
• Examining how the public/private sector could complement each other in interrelation to SRH and HIV integration.
1. Who managed and coordinated the assessment?
- The assessment was coordinated by the Monitoring and Evaluation Department of the Ministry of AIDS, in collaboration with the Ministry of Health, and Ministry of Defence.
- UNFPA supported the assessment and managed the budget. Technical support was provided by UNFPA, WHO, UNAIDS and the President’s Emergency Plan for AIDS Relief (PEPFAr).
- The report was published in November 2009.

2. Who was in the team that implemented the assessment?
- The assessment was informed by a group involving 20 people representing respectively: Ministry of AIDS; Ministry of Health/national reproductive health (RH) programme; national care and support programme for PLHIV; Ministries of Education, Planning and Family Affairs; NGO network; PLHIV networks; and national IPPF.

3. Did the desk review cover documents relating to both SRH and HIV?
- The desk review examined 11 documents. These included the Constitution, RH policy, roadmap to reduce maternal/child/infant mortality, Integrated Management of Childhood Illnesses strategy, national RH strategy, national policy on HIV treatment, National Health Development Plan, National AIDS Strategy and National Prevention of Mother to Child Transmission (PMTCT) Strategy, National Strategy on Gender-Based Violence (GBV), and the national plan to safeguard/secure SRH and HIV commodities.

4. Was the assessment process gender-balanced?
- The overall assessment team involved 10 women and 10 men. Each team had at least one man and one woman.
- For both service providers and clients, more women were involved than men.
- The assessment addressed issues of women/girls and men/boys through group discussion on national RH, HIV, GBV policy documents and legislation, and how these address vulnerability.

5. What parts of the Rapid Assessment Tool did the assessment use?
- Data collection tools were developed for the assessment, validated and pretested by a committee. They are annexed in the report and were: group discussions on policy and systems covering all of the headings in the tool; service provider interviews, mainly on operational integration; and client interviews on service usage and satisfaction.
- The researchers also collected statistics on service usage in each of the facilities visited.
- All tools were used. Some were adapted to the national context to facilitate interpretation.

6. What was the scope of the assessment?
- The assessment focused equally on SRH and HIV.
- The assessment was implemented in a period of eight weeks.
- 20 health facilities were involved: 10 working on SRH and 10 on HIV. They represented a mix of services. For example: for HIV, they addressed testing, PMTCT and comprehensive HIV facilities; for SRH they addressed sexually transmitted infections (STIs), family planning, youth centres, school and university health services and antenatal care (ANC)/delivery/postnatal.

7. Did the assessment involve interviews with policy-makers from both SRH and HIV sectors?
- The policy aspects of the assessment targeted managers and partners working on SRH and HIV. These included directorates of the Ministry of AIDS, Ministry of Health and Public Hygiene, Ministry of Education, Ministry of Planning and Development, Ministry for Women’s, Family and Social Affairs, United Nations (UN) agencies and NGOs, including the PLHIV network.
- No policy makers were interviewed, due to the limited time available. However, the representatives of each ministry were of a senior level.
8. Did the assessment involve interviews with service providers from both SRH and HIV services?

- Two providers were interviewed in all but one of the 20 facilities targeted, totalling 39 people.
- 28 per cent of the providers were male and 72 per cent female.

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

- About 10 service users were interviewed in each of the facilities targeted (213 in total).
- Of the 213 clients interviewed, 134 (63 per cent) were women and 79 (37 per cent) were male.

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

- Representatives from the PLHIV network were involved in the focus group discussion.

FINDINGS

1. Policy level

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

- Some laws are relevant to both SRH and HIV, such as on female genital mutilation and GBV. A draft law on HIV protecting PLHIV has been presented to the government for adoption. It is under examination.

- Bi-directional SRH and HIV linkages are outlined in key national policy/strategy documents:
  - Living with HIV is specified in the RH strategy, which details HIV services to be provided within RH. It focuses on reducing the incidence of HIV, STIs and risky abortions among young people, and targets reduced HIV transmission (including PMTCT) and treatment for PLHIV. The plan defines integration points such as HIV counselling and testing in ANC; training SRH providers on voluntary counselling and testing (VCT) and PMTCT; supplies and equipment for testing and PMTCT; HIV prevention in family planning; addressing HIV in SRH communication programmes; HIV testing and care in school/university health facilities; and training health workers in rural areas to support antiretroviral (ARV) adherence.
  - The plan for integrated management of childhood illnesses gives details of HIV-related interventions and paediatric treatment for HIV.

- In the HIV care policy, women’s health and STI treatment are priority interventions. It includes systematic HIV and syphilis testing for pregnant women and promotion of ANC. Improvement of obstetric care, access to contraception, STI treatment and care for victims of GBV is also detailed.

- The National AIDS Strategy outlines SRH aspects that are priorities for its goals, in particular STI treatment and prevention and care in relation to GBV.

- In addition to broad strategic and policy support for integration, there are service protocols for integration. For example, those for PMTCT, treatment for victims of GBV and ANC all include testing for HIV and syphilis.

- Although intersections exist in many of the main policy and strategy documents, there is no formal mechanism for joint planning of SRH and HIV programming.

**Funding and budgetary support:**

- SRH services are principally funded by the government and receive additional support from UN agencies, as well as some development partners. HIV programmes receive a large proportion of external funding, in particular from the PEPFAR, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), World Bank and UN agencies.
• At the national level, SRH and HIV linkages are supported by UN agencies. At the implementation level, civil society plays a role, particularly those working with most-at-risk groups including PLHIV, sex workers and men who have sex with men (MSM).

2. Systems level

Planning:
• Joint planning for SRH and HIV does not occur, but there is ‘joint’ implementation at facilities. SRH experts often contribute to the design/monitoring of HIV programmes and vice versa.

Human resources and capacity building:
• The number of health care personnel is insufficient – which impacts on SRH and HIV. Health care workers have high workloads and are unevenly distributed across the country.
• Pre-service training is of high quality, with attention to: stigma and discrimination, gender, male participation, attitudes to key populations, confidentiality, youth-friendly services and reproductive rights. But in-service training may not keep pace with changes in policies.
• Training for community health workers is often separate for SRH and HIV. But training for teachers involved in school-based sex education covers both SRH and HIV.

Logistics, supply and laboratory support:
• Logistics and supply are managed through the public health pharmacy. Stock-outs of drugs and consumables occur – affecting SRH and HIV programming. No specific information was provided on ways in which integration occurs within the logistics and supply system.
• Laboratories do not all have the means to do SRH- and HIV-related tests, except for those in specialized referral institutions. It is rare to find all of the relevant tests in one facility.

Monitoring and evaluation (M&E):
• There are no indicators on SRH and HIV integrated programming or ‘joint’ HIV and SRH indicators. However, the national M&E guideline includes both SRH and HIV indicators.

3. Services level

A. SERVICE PROVIDER PERSPECTIVES

HIV integration into SRH services:
• None of the 10 SRH facilities provide all five SRH services. Most provide STI prevention and treatment, maternal, newborn and child health (MNCH) and family planning. About half provide services to prevent unsafe abortion. The lowest number provides services related to GBV.
• Most of the facilities providing SRH services also provide at least one HIV service. The most common are testing, treatment and PMTCT. None was involved in home-based care and very few had targeted services for key populations. Of those providing testing, most provided voluntary and provider-initiated testing.
• In family planning facilities, many also provided care and treatment to PLHIV and testing, while some also provided condoms, PMTCT and psychosocial support. Where an additional HIV service was provided, in most cases this was by the same provider on the same day. If not available from the same provider, it was generally available the same day in the same facility.
• With facilities providing STI treatment, the largest number also did HIV testing. Provision of other HIV services was lower, particularly targeted services for key populations. Where an additional HIV service was provided, in most cases this was by the same provider on the same day. In a small minority of cases, facilities referred cases to another facility for the service.
• In facilities providing MNCH, most did HIV testing and provided PMTCT, while only a small number provided HIV prevention information. In most cases, the service was provided by the same provider on the same day. In the remainder, the referral was to another provider in the same facility on the same day.
• As noted, services for prevention and care in relation to GBV were only provided in a small number of facilities (three of those sampled). In these, two provided HIV information and two provided treatment, psychosocial support and testing. In most cases, it was possible for the same provider to deliver the HIV service on the same day.
Within facilities providing services to prevent risky abortions, less than half provided testing and information, while one provided condoms and none provided PMTCT services.

SRH integration into HIV services:

- Of the 10 HIV facilities in the assessment, all provided HIV testing, while the majority provided treatment, psychosocial support and PMTCT.
- In HIV facilities, almost all provided family planning services and half provided STI treatment. Maternity services and those to prevent unsafe abortion were provided in three facilities, while none provided treatment for GBV. One did not offer any SRH components.
- In the facilities providing HIV testing, almost all provided treatment for STIs, while many provided family planning and MNCH. GBV services were provided by a small number. In most cases, the SRH service was provided by the same provider on the same day.
- In treatment services, most also provided STI treatment and under half provided family planning and MNCH. In half of the cases, providers provided the SRH service on the same day. In a small minority of cases, SRH requests were referred out to another facility.
- Of the four facilities involved in home-based care services, one provided family planning and MNCH services and three provided STI services.
- Half of the providers of psychosocial support provided family planning and MNCH, while almost all also provided STI services. In about a third of cases, the SRH service was provided by the same provider on the same day and, in a smaller number of cases, dealt with via referral to another facility.
- Almost all HIV facilities providing condoms also provided STI services, family planning and MNCH, while a much smaller number provided services related to abortion prevention and GBV. In most cases, the service was provided by the same provider on the same day. In a small minority of cases, it was referred out.
- In PMTCT services, almost all were involved in providing MNCH services and three-quarters in family planning. Provision of the other services was minimal, although in most cases the SRH service was provided by the same provider on the same day.

B. SERVICE USER PERSPECTIVES

- Of the clients interviewed that had come for SRH services, half had come for MNCH, 16 per cent for STI treatment and the remainder for other services.
- 84 per cent of SRH clients said they preferred to receive HIV and SRH services in the same place and from the same provider – to reduce cost/time and improve quality. Others feared that integration might increase waiting times. While most felt it would reduce stigma and enhance confidentiality, 11 per cent felt stigma might occur if referrals were made to an HIV provider in the same facility.
- Client satisfaction was around 80 per cent. Most confirmed that providers had brought up HIV-related services such as testing, condoms and PMTCT. The key area for improvement (cited by 30 per cent of respondents) was HIV-related information.
- Among the clients attending for HIV services, 84 per cent said that they preferred to receive SRH services within the same facility and 62 per cent from the same provider – so as to reduce cost and the number of trips. Some also felt it would increase service quality, although a minority (16 per cent) felt the opposite. Some feared that integration could increase stigma and compromise confidentiality.
- 80 per cent of HIV clients said that they were satisfied or very satisfied with the service. According to respondents, providers introduced different issues – such as vaccination and family planning – among other topics not directly related to HIV. Many clients did not state any areas for improvement. Those that did cited the number of health personnel.
LESSONS LEARNED AND NEXT STEPS

1. What lessons were learned about how the assessment could have been done differently or better?
   - The report sometimes shows inconsistencies in figures. For example, analysis of HIV services states that none provide services related to GBV and half provide STI treatment. But the stratified analysis implies that the availability of both is much higher.
   - Although the assessment report contains percentage values throughout, the number of facilities sampled for each of SRH and HIV was only 10. The analysis often looks at sub-groups, such as those that provide SRH and GBV services (just three facilities). As such, the percentages are not necessarily indicative. Also, while two providers were interviewed for each facility, they sometimes gave conflicting answers about services.
   - Although civil society, including PLHIV and those working with key populations, were mentioned by stakeholders as key to SRH and HIV linkages, little information is given on this. For example, civil society groups are not included in the facility-level analysis.
   - The report does not include quantitative data on the coverage of health care workers or their levels of training in SRH and HIV (as in Annex 4 of the Rapid Assessment Tool).

2. What ’next steps’ have been taken (or are planned) to follow up the assessment?
   - Activities undertaken:
     1) technical meeting, with dissemination of assessment findings to implementing partners and stakeholders; 2) support to implementing partners in order to integrate SRH and HIV activities in their work plans; 3) workshop on strategic reflection for integration of SRH and HIV, with drafting of document on guidelines to strengthen integration of HIV and SRH.
   - Planned activities:
     - National dissemination of the results of this analysis on HIV and SRH linkages and main recommendations with a plan of action developed for the Ministries of Health and AIDS and key stakeholders.

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:**
   - Developing a strategy for SRH and HIV integration.
   - Developing a national guide for service delivery, defining SRH-family planning-HIV integration.
   - Developing integrated financing of activities.

   **Systems level:**
   - Formalizing the coordination and consultation platform for SRH and HIV integration.
   - Based on the assessment, defining an operational plan for SRH and HIV integration.

   **Services level:**
   - Strengthening the capacity of service providers in SRH and HIV integration.
   - Providing support to service providers on integration, including in-service training.
   - Ensuring a common Reproductive Health Commodity Security plan, including nationally approved quantities, for examples for ARTs and reagents.
   - Carrying out community mobilization for SRH and HIV integrated services.

4. What are the funding opportunities for the follow-up and further linkages work in the country?
   - To ensure full national participation and positioning of prongs 1 and 2 for PMTCT, a national team (composed of the Ministry of Health, Country Coordinating Mechanism and PLHIV) participated in a meeting in Kenya on strengthening the inclusion of SRH and HIV integration within Round 10 proposals to the GFATM. This contributed to Cote d’Ivoire’s re-programming for Round 10 to include an SRH and HIV component.
## Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
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<tr>
<td>ANC</td>
<td>antenatal care</td>
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<td>ARV</td>
<td>antiretroviral</td>
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<td>EU</td>
<td>European Union</td>
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<td>FBO</td>
<td>faith-based organization</td>
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<td>GBV</td>
<td>gender-based violence</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GNP+</td>
<td>Global Network of People Living with HIV</td>
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<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>ICW</td>
<td>International Community of Women Living with HIV/AIDS</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>MNCH</td>
<td>maternal, newborn and child health</td>
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<td>MSM</td>
<td>men who have sex with men</td>
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<td>NGO</td>
<td>non-governmental organization</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PLHIV</td>
<td>people living with HIV</td>
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<td>PMTCT</td>
<td>prevention of mother to child transmission</td>
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<td>RH</td>
<td>reproductive health</td>
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<td>SRH</td>
<td>sexual and reproductive health</td>
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<td>STI</td>
<td>sexually transmitted infection</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>VCT</td>
<td>voluntary counselling and testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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