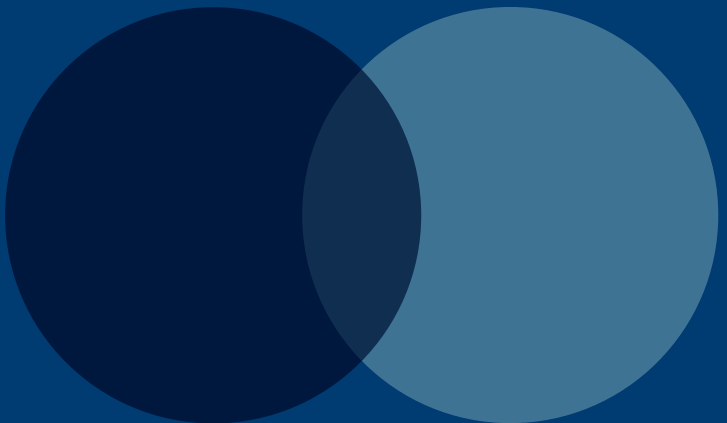




RAPID ASSESSMENT
OF SEXUAL AND
REPRODUCTIVE HEALTH
AND HIV LINKAGES



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 Pakistan¹. 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?

The assessment recommended that action should address:

- **Non-existence of national multi-sectoral working group on SRH and HIV linkages.** A collaborative group is needed, involving people living with HIV (PLHIV) and key populations, to support the development of policies and laws, advocate for integration, mobilize resources, etc.
- **Weak coordination on SRH and HIV between the Ministries of Health and Population Welfare.** Strong coordination is needed between the main government agencies working at all levels relating to policy, planning, programmes and service delivery.
- **Absence of national laws to facilitate implementation of SRH and HIV policies.** The members of the National and Provincial Assemblies already involved in HIV prevention could play an important role in preparing and approving relevant laws.
- **Allocation of funds for SRH and HIV linkages.** Funds are required for materials, training of service providers, procurement of equipment and monitoring and evaluation (M&E) activities. Donors and the Ministries of Health and Population Welfare could pool their resources for integration.
- **Single national curriculum for integrated services.** The Ministries of Health and Population Welfare should develop one curriculum to train SRH and HIV service providers on integration.
- **Phased integration of SRH and HIV services.** This should start from the programme level, with the services that can be more easily integrated and a focus on high prevalence areas and groups most at risk.

1. This summary is based upon: *Rapid Assessment of Sexual and Reproductive Health and HIV Linkages*, Pakistan, November 2009.

PROCESS

1. Who managed and coordinated the assessment?

- The assessment took place in 2009 led by the Ministry of Health (MOH) National AIDS Control Programme (NACP). It received technical and financial support from UNFPA.
- The process was supervised by an assessment team, comprising: Government (National and Provincial AIDS Control Programme); UN and other agencies (UNFPA, UNAIDS, UNODC, UNICEF and Packard Foundation); civil society, including PLHIV (Pak Plus Society, Gender and Reproductive Health Forum) and communities (sex worker groups).

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

- The Assessment Team involved 34 people, consisting of policy-makers, programme managers and development partners. These included organizations focused on SRH and HIV, PLHIV networks and representatives from key populations and service users.

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

- The review included a desk and electronic literature review of key national policies and frameworks on health, HIV, population, reproductive health (RH) and integration.
- The documents reviewed included: National Health Policy 2001, draft National Health Policy 2009, National HIV/AIDS Strategic Framework 2007–12, National HIV/AIDS Policy (final draft) 2007, Population Policy of Pakistan 2002, draft strategy paper 'Implementing reproductive health services package', and the framework on integration of HIV services within SRH/family planning (FP) and maternal, newborn and child health (MNCH) services.
- The electronic review included Pub Med, Medline, Google, Google Scholar and websites relating to SRH, linkages and SRH and HIV integration (including www.hivandsrh.org).

4. Was the assessment process gender-balanced?

- The assessment involved both men and women.
- The interviews targeted both male and female service providers.

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

- Alongside interviews, data was also collected through administration of separate, adapted questionnaires among policy-makers (8), programme managers (12), development partners (7), NGOs (10), PLHIV groups (2), services providing HIV, maternal, newborn and child health (MNCH), family planning (FP) and SRH services (25) as well as service users that attend the same facilities (25). Different questionnaires from the *Rapid Assessment Tool* were used to answer the main questions on policy, system and service delivery.

6. What was the scope of the assessment?

- Within the time and cost constraints, the assessment focused on the federal level and one province.

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

- Informal in-depth interviews were conducted with 10 key informants, including with SRH and HIV experts, representatives of UN and donor agencies (such as UNFPA, UNAIDS, USAID, World Bank, DFID, Packard Foundation) and PLHIV. These aimed to gain an understanding of the situation and information on major champions of policy, financial and technical support for SRH and HIV integration.
- The assessment used questionnaires targeting: eight policy makers (including federal/provincial government secretaries, director generals of health and population welfare ministries, Country Coordination Mechanism (CCM) and private and professional organizations); 12 programme managers (including for national/provincial HIV programmes, tuberculosis (TB), MNCH centres, SRH centres, family centres, mobile service units and regional training centres); nine donors and development partners (including UNAIDS, UNFPA, WHO, UNICEF, World Bank, DFID, USAID, EC and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)); and 12 civil society groups (including PLHIV organizations, national/international NGOs and key populations, including

people that use drugs, sex workers, men who have sex with men (MSM), hijras or transgender, and youth).

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

- The 25 service providers included doctors, nurses, counsellors, community midwives, paramedics and women's health workers from public, private and non-profit sectors.
- SRH interviewees were from centres for: MNCH, family planning, SRH, family welfare, mobile services, regional training, sexually transmitted infections (STIs), abortion and gender-based violence (GBV). HIV interviewees were from centres for: voluntary counselling

and testing (VCT), treatment, HIV care and support, prevention of mother to child transmission (PMTCT) and services for key populations.

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

- The assessment targeted 25 service users from a range of SRH and HIV services [see above].

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

- The assessment involved PLHIV organizations and key populations, including people that use drugs, sex workers, MSM, hijras and youth.

FINDINGS

1. Policy level

National policies, laws, plans and guidelines:

- Overall, both SRH and HIV national strategies support linkages.
- The document 'Reproductive Health Services Package' states that reproductive tract infections (RTIs), STIs and HIV are important RH issues. The Ministries of Health and Population Welfare will integrate RTI services into facilities for MNCH and HIV. But the package does not describe the method and extent of integration. It advocates for funds for HIV services, emphasizes services for women and recognizes the role of men. The Population Policy (2002) provides for its implementation.
- The National HIV Strategic Framework (2007–12) supports integration and, in its guiding principles, frames HIV as a multi-dimensional issue that requires integration into existing programmes. It acknowledges gender inequality, with gender mainstreaming a guiding principle.
- The final draft of the National AIDS Policy (2007) addresses integrating HIV with services for RH, MNCH, STIs, FP and other areas, such as TB. It recognizes the rights and SRH needs of PLHIV. The care and support programme for PLHIV includes STI treatment and condoms. PMTCT services have been integrated

into MNCH at selected tertiary care hospitals. It recognizes the rights of key populations and recommends strategies for service provision.

- In 2007, the NACP developed STI management guidelines to pilot the integration of HIV with SRH, family planning and MNCH. The Ministry of Population Welfare has developed a curriculum on HIV and STI integration for regional training centres.
- The Population Policy does not mention the SRH needs of PLHIV and key populations. It cites government policy to only provide SRH services to married couples.
- There has been little progress on laws to support linkages. There has been no legislative action to protect SRH rights, particularly of women, PLHIV and key populations. But two bills were recently passed on domestic violence and sexual harassment of women at workplaces.

Funding and budgetary support:

- The main sources of funding for SRH include the Ministries of Health and Population Welfare, district governments and donors (such as UNFPA, UNICEF, USAID and DFID). The main sources for HIV include the Ministries of Health (National/Provincial AIDS Control Programmes) and donors and UN agencies (such as World Bank, CIDA, USAID, UNFPA, UNICEF, UNODC and GFATM).

- There has been little funding for linkages. UNFPA has been the main source, with support also from the Packard Foundation. The Ministries of Health and Population Welfare do not specifically fund linkages; neither does the World Bank (a major donor for HIV).

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2. Systems level

Partnerships:

- Major SRH partners include Ministries of Population Welfare, government MNCH services, national MNCH programme, UN agencies (UNFPA, UNICEF, WHO), donors (DFID, USAID, EC, Packard Foundation) and NGOs (Marie Stopes Society, Family Planning Association of Pakistan, Population Council, Green Star and PAVNAH).
- Major HIV partners include the National/Provincial AIDS Control Programmes, UN agencies (UNAIDS, WHO, UNICEF, World Bank), donors (GFATM, USAID, DFID) and international and national NGOs (FHI, PNAC, Pakistan Society, Nai Zindagi, Bridge, ICSP and Pak Plus Society).
- Major stakeholders for both SRH and HIV programmes support integration. The approach is championed by the National AIDS Control Programme, Ministries of Population Welfare, UNFPA, UNICEF, USAID, and Packard Foundation.
- In 2007, the National AIDS Control Programme developed a framework to pilot HIV integration in SRH, FP and MNCH. It also started a two-year project to integrate STIs/HIV in public health care (in 12 facilities at the primary, secondary and tertiary levels).
- Guidelines for SRH and HIV integration have been developed by a Technical Working Group. But there is no multi-

sectoral working group for integration, contributing to lack of coordination.

- There is almost no involvement of PLHIV in SRH programmes. Of the PLHIV groups interviewed, none had ever been contacted by SRH programmes or relevant ministries/agencies to find out their SRH needs. With HIV programmes, PLHIV are involved in planning, but not in implementation.
- Young people, sex workers, people that use drugs and MSM are also not involved in SRH responses. They are involved in HIV, but, due to low capacity, have only a very limited role.

Planning:

- There is no joint planning of SRH and HIV programmes, except for the Reproductive Health Package which was jointly developed by the Ministries of Population Welfare and Health.
- The National HIV/AIDS Steering Committee has wide representation, including the Ministry of Population Welfare, but it has not met for several years. The National HIV Strategic Framework was developed with multi-sectoral support, including SRH programmes.
- There is no collaboration between SRH and HIV programmes for management/implementation.
- Some SRH services (such as STI prevention/management and condoms for prevention of unintended pregnancy) have been integrated into HIV planning. Some HIV services (such as HIV counselling and testing and PMTCT) have been integrated into SRH planning.

Human resources and capacity building:

- Materials developed by the Ministry of Population Welfare's regional training centres include attention to HIV prevention and are used for family planning doctors and paramedics.
- The NACP has developed national guidelines (2006) on STI management to train health care providers. It developed PMTCT guidelines in 2008.
- The largest challenges relating to staff for SRH and HIV services are quality and workloads.

Logistics, supply and laboratory support:

- The assessment identified logistics and supplies as challenges for effective service delivery of integration. It also identified that laboratory facilities could serve the needs of both HIV and SRH services and that the availability of rapid testing kits/simple testing procedures are vital.

Monitoring and evaluation:

- There is no M&E system for SRH and HIV linkages.

3. Services level**A. SERVICE PROVIDER PERSPECTIVES****HIV integration into SRH services:**

- **HIV counselling and testing:** This is integrated into some SRH services. 10 per cent of the MNCH centres have VCT services integrated to a degree, providing counselling and testing/referral for testing. 20 per cent of FP clinics provide HIV counselling and referral for testing. Most STI clinics provide HIV counselling, while 25 per cent also provide testing, and the remainder referral for testing. All medical officers of STI clinics are trained in HIV counselling and testing.
- **Condom promotion/provision for disease prevention (HIV, STIs):** About 25 per cent of service providers at MNCH centres and FP clinics state that they promote/provide condoms for disease prevention. Both MNCH and FP clinics only provide male condoms. Almost all STI clinics promote/provide condoms for prevention of STIs and HIV.
- **PMTCT:** PMTCT has been integrated at selected tertiary care hospitals (6) within SRH services in obstetrical departments. PMTCT strategies include HIV prevention among women and their partners, prevention of unintended pregnancy among women living with HIV, PMTCT and care and support for mothers living with HIV and families. PMTCT clinics refer clients for other HIV services.
- **Specific HIV information/services for key populations:** No MNCH centres or FP clinics provide specific HIV services to key populations. But about 50 per cent of STI clinics provide HIV information, STI treatment and referrals for antiretroviral (ARV) treatment to such groups.
- **HIV care and support and ARV treatment and prophylaxis for opportunistic infections for PLHIV:** These services are not available in any of the MNCH, FP and STI centres.

SRH integration into HIV services:

- **Prevention and management of STIs:** This is integrated in almost all HIV services to some extent. All VCT centres and ARV centres provide STI prevention/management to clients, with trained staff and medicines available. PMTCT clinics do not provide STI management, but refer clients to other facilities. All drop-in centres for key populations provide

STI prevention/treatment services, with trained staff and drugs available. The NACP has developed guidelines for the syndromic management of STIs and has trained master trainers.

- **FP services:** There is little integration of FP into HIV services. VCT, ARV and drop-in centres for key populations refer clients only for FP. PMTCT centres provide services, including counselling for FP, provision of condoms for prevention of unintended pregnancy and referral to other facilities for surgical services. PLHIV and key populations have no access to SRH services to address their specific needs.
- **Prevention/management of abortion, post-abortion care and GBV:** These services are not integrated, although some VCT centres provide counselling and referrals for people who have experienced GBV.
- **MNCH:** These services were not available in any HIV facility. Clients are referred to MNCH centres, but most of these are not able/willing to assist HIV positive mothers and their babies.

B. SERVICE USER PERSPECTIVES**HIV integration into SRH services:**

- About 20 per cent of the service users interviewed (after exiting SRH facilities) received at least one HIV service and a referral to at least one more HIV service. The HIV services they received included HIV counselling and testing, condoms for disease prevention and HIV education. The referral services included care and support, HIV treatment and PMTCT.
- 90 per cent of the service users preferred to receive SRH and HIV services at the same facility. The majority also preferred to have the same provider for both services. They cited the benefits as including easy accessibility, reduced waiting time and reduced HIV-related stigma.
- Only 5 per cent of the service users were 'very satisfied' with the services they received, while 55 per cent were 'mostly satisfied', 20 per cent 'dissatisfied' and 20 per cent did not answer.

SRH integration into HIV services:

- About 80 per cent of service users interviewed (after exiting VCT and ARV centres) received STI prevention/treatment services, while about 25 per cent received FP services, including condoms. Clients of PMTCT centres were referred for STI prevention and treatment.

LESSONS LEARNED AND NEXT STEPS

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

- Due to time constraints, some aspects of the assessment were not comprehensively addressed. Examples include: in the policy section, a detailed analysis of issues relating to access/coverage of services (particularly in relation to key populations); and, in the services section, providers' overall perspectives on integration, including constraints and impacts.
- The report of the assessment could have benefited from greater attention to the views of service users. For example, the fact that only five per cent of clients exiting SRH facilities were 'very satisfied' raises the need for a comprehensive study using both qualitative and quantitative methods to explore wider issues of the quality and accessibility of services.

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

- Planned follow-up to the assessment included three advocacy/planning workshops in 2010 (two provincial and one national). These planned to:
 - Sensitize stakeholders on SRH and HIV integration at various levels.
 - Share the findings of the assessment.
 - Enable action planning for promoting integration at various levels.
 - Promote resource mobilization for integration at various levels of service delivery.

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:

- The final draft of National AIDS Policy addresses integration of HIV with services for RH, MNCH, STIs, FP and other programmes, such as hepatitis and TB. It also recognizes the rights and SRH needs of PLHIV. During the provincial and national advocacy/planning workshops, the policy will be promoted for subsequent take-up and approval by policy-makers.

Systems level:

- Promoting coordination among government, agencies, donors, civil society and other stakeholders on SRH and HIV integration efforts – adopting a multi-sectoral approach.
- Promoting functional coordination between the Ministries of Health and Population Welfare .
- Involving key populations – such as people that use drugs, female sex workers, MSMs, prisoners, hijras and PLHIV in the development of SRH and HIV integration.

Services level:

- Promoting the development of functional SRH and HIV bilateral linkages in a phased manner.
- Adding services which bring little or no cost implications to existing services.

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

- The National HIV/AIDS Strategic Framework for 2007–12 and National/Provincial AIDS Control Programmes fully promote SRH and HIV integration and provide opportunities for resource mobilization.

Abbreviations

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral
CCM	Country Coordination Mechanism
CIDA	Canadian International Development Agency
DFID	UK Department for International Development
EC	European Commission
FHI	Family Health International
FP	family planning
GBV	gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+	Global Network of People Living with HIV
ICSP	Infection Control Society of Pakistan
HIV	human immunodeficiency virus
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
M&E	monitoring and evaluation
MNCH	maternal, newborn and child health
MOH	Ministry of Health
MSM	men who have sex with men
NACP	National AIDS Control Programme
PLHIV	people living with HIV
PMTCT	prevention of mother to child transmission
PNAC	Pakistan National AIDS Consortium
RH	reproductive health
RTI	reproductive tract infection
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
UNODC	United Nations Organization of Drugs and Crimes
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WHO	World Health Organization

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