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 Senegal. 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: Évaluation rapide de l’intégration du VIH et de la santé sexuelle et de la reproduction au Sénégal, UNFPA, November 2011. The summary does not necessarily represent the decisions or the stated policy of UNFPA, UNAIDS, WHO or IPPF.

RECOMMENDATIONS

What recommendations did the assessment produce?

Policy level:
• Establishing a technical working group to develop a national consensus definition of SRH and HIV integration, addressing the different levels of the health system.
• Developing an advocacy plan for better integration of SRH and HIV policies and services aimed at health authorities.

Systems level:
• Strengthening the integration of SRH and HIV planning mechanisms.
• Strengthening the integration of SRH and HIV monitoring and evaluation (M&E) by identifying relevant indicators and revising data collection tools.
• Documenting and promoting the experience of providing integrated SRH and HIV services for adolescents.

• Developing operational guidelines for gender-based violence (GBV), incorporating medical, and social and legal components.
• Integrating essential HIV drugs and commodities into the SRH Commodities Security Plan and improving the supply chain management system at all levels.

Services level:
• Educating clients and the general population on the availability of integrated SRH and HIV services in health facilities.
• Increasing the awareness of clients and the general population about the content of SRH– and HIV-related laws, as well as the use of condoms for dual protection.

It has been suggested that a comprehensive implementation plan be developed for 2012–2016, in order to facilitate implementation of these recommendations.
1. Who managed and coordinated the assessment?
UNFPA/CO Senegal and UNFPA/SRo, in support of the government of Senegal, provided technical and financial support for the Rapid Assessment (RA).

2. Who was in the team that implemented the assessment?
The assessment was undertaken by Mr K.G. Kouadio, international consultant, and Dr K. Seck, national consultant. For data collection, eight teams were established and trained. The international consultant undertook the quantitative analysis, with the national consultant undertaking the qualitative analysis.

Dr Mamadou Bocar Daff Director of Reproductive Health and Dr Abdoulaye Sidibe Wade Head of the Division for the Fight against HIV / AIDS and their teams also participated in the implementation of the assessment.

3. Did the desk review cover documents relating to both SRH and HIV?
Yes. In total, 27 documents were reviewed, including policy documents and guidelines on SRH (7) and HIV (9), as well as HIV- [1] and SRH-related [2] laws, sector-wide policies and strategies [2], the Constitution, Family and Penal Codes, and national assessments/statistics [3].

4. Was the assessment process gender-balanced?
No. While the data collection team was in general gender-balanced, there were more female than male participants interviewed. Gender distribution was as follows:
• Assessment team: both the international and national consultants were male; in each of the eight data collection teams there was 1 man and 1 woman.
• Participants meeting principally to discuss SRH and HIV linkages policy level issues: 21, including 15 female and 6 male.
• Participants meeting principally to discuss systems-related issues: 15, including 13 female and 2 male.
• Service providers: 30, including 25 female and 5 male.
• Clients: 277, including 256 female and 21 male.

5. What parts of the Rapid Assessment Tool did the assessment use?
The Rapid Assessment methodology was followed in its entirety, although the data collection tools were adapted to the cultural context [e.g. wording of questions].

6. What was the scope of the assessment?
To conduct a RA of SRH and HIV linkages and integration in order to improve bi-directional linkages at the policy, systems and service delivery levels. The specific objectives were to:
• assess the level and effectiveness of existing links between SRH and HIV policies, national legislation, operational plans and guidelines;
• show which systems aid or impede effective links between SRH and HIV;
• highlight the level of bi-directional SRH and HIV service integration;
• identify the weaknesses and gaps impeding bi-directional SRH and HIV linkages; and
• recommend measures to improve bi-directional SRH and HIV service integration.
7. Did the assessment involve interviews with policy-makers from both SRH and HIV sectors?

Yes. Two meetings were held at which:

- 21 participants met to discuss SRH and HIV linkages issues relating to policies, funding, budget support and partnership. Representatives included staff from the Ministry of Health (MoH) HIV/STI (sexually transmitted infection) and SRH Divisions, Dakar Medical Region, Ministry of the Family, donor agencies and development partners (Family Health International/FHI, UNFPA and UNICEF), Council of Organizations Fighting AIDS in Senegal (COSSEN), people living with HIV, sex workers and other civil society networks and organizations, as well as representatives from a number of medical and/or teaching facilities.
- 15 participants met to discuss SRH and HIV linkages-related operational, management, planning, administration, human resource, capacity-building, logistics, supply, laboratory support and M&E issues. Representatives included people from the MoH HIV/STI and SRH Divisions, Dakar Medical Region, Ministry of Education, UNFPA and COSSEN.

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

Yes, 30 service providers, including the head of the point of service, were interviewed from a total of 16 randomly selected facilities, including eight (8) SRH and eight (8) HIV service facilities run by the MoH, civil society organizations (CSOs) and faith-based organizations. Two centres visited did not have a service provider available for interview. The 16 facilities were drawn from the regions of Dakar, Kaolack, Fatick, Saint-Louis, Tambacounda, Kaffrine, Thiès, Matam, Louga, Diourbel and Kolda.

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

Yes, 277 clients were interviewed from a total of 16 facilities, including eight (8) SRH service sites (n=168) and eight (8) HIV service sites (n=109).

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

In part.

- At the meeting to discuss SRH and HIV linkages policy level issues, one representative each from the national network of people living with HIV and Association AWa [an association for sex workers] participated.
- There is no information on whether HIV-positive and/or key population clients were interviewed, as there was no question requesting such disaggregation.
1. Policy level

Strengths:

- The existence of the National Health Development Plan (2009–2018), supporting SRH and HIV programme and service integration.
- Existing SRH and HIV policies and strategies support bi-directional linkages, although there is no SRH and HIV integration plan or strategy per se.
- The existence of SRH and HIV-related laws, with some bi-directional linkages included in both SRH- and HIV-related laws.
- The existence of an Integrated Services Package for SRH, HIV, malaria and tuberculosis (TB) as part of a health systems strengthening (HSS) project supported through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) Round 10.

Weaknesses:

- The lack of a national consensus definition of SRH and HIV integration, addressing the different levels of the health system.
- The lack of a national advocacy strategy for SRH and HIV integration policies and services.

Legal framework:

- While there are both SRH- and HIV-specific laws, there is no law which directly addresses SRH and HIV integration.
- While the broad-based HIV/AIDS Law No. 2010-03 protects people living with HIV from discrimination, its dissemination and awareness of its content is low.
- With regard to key populations, including men who have sex with men, sex workers and people who use drugs, the Penal Code (1965) criminalizes these populations. In the case of sex work, the Penal Code is supplemented by Decree 62037, 16 August 1962, and Act No. 69-27, 23 April 1969. Act 69-27 makes provision for minors under 21 years of age engaged in sex work or who have been commercially sexually exploited (i.e. under 18 years of age) to be brought before Juvenile Courts [Article 327bis].
- The Penal Code (1965) prohibits female genital mutilation.

2. Systems level

Strengths:

- Existing SRH and HIV integration initiatives in relation to prevention of parent-to-child transmission (PPTCT) and implementation of the Integrated Services Package.
- The Adolescent Promotion Project based in Adolescent Counselling Centres is a good example of integration.
- A relatively significant level of SRH and HIV integration in public health training.
- The existence of SRH and HIV manuals and training guides.
- The existence of a network of non-governmental organizations (NGOs) working in SRH and/or HIV.
- SRH and HIV are integrated into primary and secondary school education programmes.

Weaknesses:

- Lack of coordinated SRH and HIV planning mechanisms.
- Lack of documentation of SRH and HIV integration approaches for adolescents and young people, particularly the Adolescent Promotion Project.
- Lack of holistic GBV operational guidelines that incorporate medical, social and legal components.
- Lack of integration of HIV commodities in the SRH Commodities Security Plan, which has led to stock-outs of essential drugs and reagents.
- Lack of an integrated SRH and HIV M&E system at the central and regional levels.

Partnerships:

The main partners in the development of SRH programmes: UNFPA, United States Agency for International Development (USAID), UNICEF, Japan International Cooperation Agency, African Development Bank, WHO, IntraHealth Senegal, a consortium of NGOs [Child Fund, World Vision and Plan Senegal] under USAID’s Community Health Program, Bill & Melinda Gates Foundation, Association Sénégalaise pour le Bien-Etre Familial (ASBEF), Initiative pour le...
Leadership Ministériel (Ministerial Leadership Initiative), Ipas Senegal and Lux-Development.

- HIV programmes: GFATM, USAID, FHI, UNFPA, UNICEF, ESTHER, UNAIDS, the African Council of AIDS Service Organizations (AFRICAOSO) and National Alliance Against AIDS (Alliance Nationale Contre le Sida/ANCS).

CSOs play a variable role in SRH and HIV planning and implementation. CSOs have relatively low involvement in SRH, although ASBEF contributes to the provision of services, and other CSOs are involved in awareness raising and advocacy. In the HIV response, CSOs play a more important role, particularly networks of people living with HIV. Furthermore, despite capacity building, people living with HIV networks have limited planning coordination and leadership capacity.

Coordination:

Operational planning for the health sector is based on the Medium-Term Sector Expenditure Framework (2012–2014) and annual work plans; however, SRH and HIV activities are not integrated, as they are incorporated into different sectoral objectives:

- Reduction of maternal and infant morbidity and mortality [SRH]; and
- Improving the performance of the sector in HIV prevention and the HIV response.

There is no joint SRH and HIV programmatic planning except for contraceptives, in particular condoms. Furthermore, SRH and HIV programme managers are not systematically included in planning of the other’s programmes, with the exception of PPTCT, which provides a framework for joint planning by the SRH and HIV/STI Divisions, including sharing of results with all partners. For example, the SRH Division has a representative on the group of PPTCT experts and participates in meetings. In addition, GFATM proposal development provides an opportunity for collaboration and joint planning.

SRH and HIV programmes are implemented vertically at the central and regional levels. For example, PPTCT is managed by the HIV programme, and maternal and child health (MCH) is managed by the SRH Division.

Human resources and capacity development:

- Human resource availability is the MoH’s main constraint, including for SRH and HIV programmes. There is a National Human Resources Development Plan (2011) to be implemented post-2012.
- While there is a relatively significant level of SRH and HIV integration in public health training, the overall lack of qualified staff limits the capacity to extend integrated services.
- Training is to be strengthened through a GFATM Round 10 HSS project through which a guide on standards and protocols for SRH, HIV, TB and malaria programmes has been developed for the training curricula.
- SRH and HIV have been integrated into primary and secondary education.

Logistics:

- Logistics systems are a constraint, due to communication problems.
- In general, for SRH, there are frequent and extended stock-outs for reasons unrelated to integration. For HIV, the national and regional drug supply systems work well.
- Condom procurement is integrated through the national drug supply system.

Monitoring & evaluation:

SRH and HIV data management is not integrated in the National Service of Education and Information for Health (SNEIPS), which is responsible for studies and statistical surveys, data collection and analysis, as well as epidemiological surveillance. HIV programmes have a parallel data management system. With SRH and HIV integration, there are efforts to create integrated data reviews. For SRH services, new HIV-related indicators include the total number of women who have received an offer of HIV counselling and testing (HCT), who have undergone HCT, or who have received an offer of syphilis testing. For PPTCT, integration-related indicators are provided for in the National AIDS Strategic Plan (2011–2015).
Funding:
Support for SRH and HIV bi-directional linkages is mostly provided through UNFPA, UNICEF and the GFATM. Other sources include the government, communities, private sector (for-profit and not-for-profit), and technical and financial partners.

3. Services level

Strengths:
• The existence of trained health staff for SRH and HIV services.
• SRH clients’ favourable view of SRH and HIV service integration at the same facility.
• The existence of programmes that are aimed at meeting the needs of young people and adolescents.
• The existence of a health information system.

Weaknesses:
• Lack of knowledge by the general population and implementers of the SRH- and HIV-related legal framework.
• Low awareness by the general population of the availability of SRH and HIV integrated services, including condoms for dual protection.

SERVICE PROVIDER PERSPECTIVES:
• Of the 15 SRH service providers, all reported providing family planning (FP), STI prevention and management, and MCH; 60 per cent reported providing prevention of unsafe abortion and 33 per cent GBV-related services. In terms of integrated HIV-related services, 80 per cent provide condoms and awareness raising on contraception, with 67 per cent providing PPTCT, positive prevention, and HIV treatment.
• Of the 15 HIV service providers, all reported providing HCT, 93 per cent reported providing PPTCT, with 87 per cent providing condoms. In terms of integrated SRH-related services, 80 per cent reported providing MCH and prevention and management of STIs, 60 per cent reported providing prevention of unsafe abortion, 47 per cent FP and 33 per cent GBV-related services.

SERVICE USER PERSPECTIVES:
• In the case of SRH services, the majority of clients came for MCH (61.3 per cent), while 17.3 per cent sought FP, 14.3 per cent routine gynaecological examinations, and 2.4 per cent STI management. Clients indicated that they had received FP (36.5 per cent), HCT (29.9 per cent) and vaccination (16.8 per cent). Three quarters of clients (73.5 per cent) were satisfied or very satisfied with the service(s) received.
• In the case of HIV services, the largest percentage of clients came for MCH (34.3 per cent), while 13.9 per cent sought FP, 8.3 per cent HIV treatment and care, 8.3 per cent routine gynaecological examination and 7.4 per cent STI management. Clients indicated that they had received FP (24.1 per cent), vaccination (19.4 per cent), and condoms to prevent unplanned pregnancy (13.9 per cent). Over 80 per cent of clients (81.5 per cent) were satisfied or very satisfied with service(s) received.
• The majority of clients, including 81.5 per cent of SRH service clients and 56.5 per cent of HIV service clients, preferred receiving both SRH and HIV services at the same health facility. Reasons given included reduced travel, transport costs, and service delivery costs. Disadvantages cited were increased risk of breach of confidentiality, increased costs, fear of stigmatization and discrimination, and reduced quality of services.
• 75.4 per cent of SRH service clients and 57.3 per cent of HIV service clients preferred to receive health services from the same provider. Advantages given included reduction in the number of visits, travel cost and waiting time, and improved quality. Disadvantages cited included loss of confidentiality, service providers too busy, increased costs, fear of stigmatization and discrimination, increased waiting time, and reduced quality of services.
1. What lessons were learned about how the assessment could have been done differently or better?

Challenges during the assessment included:

- Late recruitment of the national consultant due to the failure to correctly anticipate the time required for preparation and to undertake the literature review.
- Administrative delays and duplication due to failures in initial planning. For example, group discussions which were initially planned to be held during the international consultant’s country visit were not held until three weeks after he left the country.
- Weak involvement of stakeholders in the policy level group discussions, due to scheduling issues.

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

Steps taken:

- Collaboration between the SRH and HIV programmes has been reinforced through the GFATM Round 10 HSS project promoting an Integrated Services Package for SRH, HIV, malaria and TB.
- The Centre de Traitement Ambulatoire [Outpatient Treatment Centre] has implemented an SRH programme for people living with HIV, and has issued a new publication on youth SRH, including HIV.
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?

- Documenting the Adolescent Promotion Project based in Adolescent Counselling Centres as a good practice example of SRH and HIV integration.
- Integrating essential HIV commodities for SRH and HIV services into the SRH Commodities Security Plan, and improving the management of inputs at all levels.
- Sensitizing the general population, and in particular young people, on both the content of SRH- and HIV-related laws, and condom use as a means of dual protection.

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

In relation to implementing the RA recommendations, the authorities intend to use the 2013 annual work plan as a funding opportunity with partners such as UNFPA and the GFATM.
Abbreviations

AIDS  acquired immune deficiency syndrome
ASBEF  Association Sénégalaise pour le Bien-Etre Familial
COSSEN  Council of Organizations Fighting AIDS in Senegal
CSO  civil society organization
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
HCT  HIV counselling and testing
HIV  human immunodeficiency virus
HSS  health systems strengthening
ICW  International Community of Women Living with HIV/AIDS
IPPF  International Planned Parenthood Federation
M&E  monitoring and evaluation
MCH  maternal and child health
MoH  Ministry of Health
NGO  non-governmental organization
PPTCT  prevention of parent-to-child transmission (of HIV)
RA  rapid assessment
SRH  sexual and reproductive health
STI  sexually transmitted infection
TB  tuberculosis
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
USAID  United States Agency for International Development
WHO  World Health Organization

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