RAPID ASSESSMENT
OF SEXUAL AND
REPRODUCTIVE HEALTH
AND HIV LINKAGES

TOGO
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 Togo¹. 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 Togo, UNFPA, November 2011.

### RECOMMENDATIONS

**What recommendations did the assessment produce?**

**Policy level:**
- Advocating with authorities and all SRH and HIV stakeholders to make integration a national priority.
- Developing standards and procedures for the provision of integrated SRH and HIV services, including: types of services to be provided by facility; roles, responsibilities and skill requirements for staff; and logistics, supply and equipment requirements by service and facility.
- Undertaking to review the missions, roles and responsibilities of the Family Health Division of the Ministry of Health (MoH) and the National Programme to Combat AIDS/STIs [sexually transmitted infections] (PNLS/ISTI) with respect to SRH and HIV integration.

**Systems level:**
- Developing clear SRH and HIV integration guidelines for key populations, including sex workers, people who use drugs, young people, men who have sex with men, people in detention, etc.
- Raising stakeholder awareness of bi-directional SRH and HIV.
- Establishing a joint supervisory SRH and HIV integration mechanism.
- Establishing a technical working group on SRH and HIV integration, composed of MoH experts in SRH and HIV, and in service delivery and monitoring and evaluation (M&E), as well as development partners and civil society organizations (CSOs).
- Increasing the number of staff skilled in SRH and HIV.
- Revising pre- and in-service training curricula to include new norms and standards on SRH and HIV integration, and training SRH and HIV providers.
• Training all SRH and HIV providers and students using revised curricula, and strengthening the capacity of secondary school teachers to use revised curricula.
• Adapting health faculty infrastructure, e.g. allocating adequate space and equipment, including laboratory equipment, to provide integrated SRH and HIV services.
• Resourcing facilities with adequate and ongoing supplies and commodities to provide integrated SRH and HIV services.
• Reviewing M&E tools to incorporate SRH and HIV integration.
• Agreeing on SRH and HIV integration indicators and incorporating them into national data collection tools and analysis.

Service delivery level:
• Where a woman has tested HIV-positive or negative at a prevention of parent-to-child transmission (PPTCT) centre, the rapid assessment (RA) recommended organizing awareness raising campaigns to encourage the husband and/or co-spouse(s) to undergo HIV counselling and testing (HCT).
• Increasing the awareness of clients and the general population on the content of SRH and HIV laws.
• Educating clients and the general population on the availability of integrated SRH and HIV services in health facilities.
• Educating clients on domestic violence and support services.
1. Who managed and coordinated the assessment?
The UNFPA Sub-Regional Office (Dakar) and Togo Country Office, in support of the government of Togo, provided technical and financial support for the RA.

2. Who was in the team that implemented the assessment?
The RA was undertaken by Mr K. G. Kouadio, international consultant, and Dr K. M. Douti, national consultant. For data collection, eight teams were established and trained. Data analysis was undertaken by the international consultant.

3. Did the desk review cover documents relating to both SRH and HIV?
Yes. A total of 39 documents were reviewed, including policy documents and guidelines on SRH (13) and HIV (14) as well as the Constitution, HIV-related (1) and SRH-related (2) laws, United Nations Development Action Framework Plan, sector-wide policies and strategies (3), and various associated guidelines, standards and notes (3).

4. Was the assessment process gender-balanced?
It is not possible to provide a definitive response.
- Assessment team (2 + 16 people): both the international and national consultants were male; and within each of the eight data collection teams there was one man and one woman.
- Policy-level meetings (69 participants): no gender disaggregation was available.
- SRH service providers (16): 2 male and 14 female.
- HIV service providers (16): 4 male and 12 female.
- Clients interviewed (406): 41 male and 365 female, reflecting the fact that more females than males access health care, particularly SRH and HIV services.

5. What parts of the Rapid Assessment Tool did the assessment use?
The RA Tool was adapted to the local context.

6. What was the scope of the assessment?
To conduct an RA on 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/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:
- 35 participants met to discuss SRH and HIV linkages-related issues, including policies, funding, budget support and partnership. Representatives included staff from the PNLS/IST, Ministry of Health, MoH directorates and divisions (Family Health, Primary Health Care, Human Resources, Planning and Research, Statistics, Finance, Information, Education and Communication/IEC), other health actors (National Commission for the Health of Women and Children, and SRH and HIV providers), other ministries (Economy and Finance, Advancement of Women, Education, Security, Justice, Youth and Sport), UNFPA, Association Togolaise pour le Bien-Etre Familial [ATBEF] and other CSOs.
• 34 participants met to discuss SRH and HIV linkages-related operational, management, planning, administration, human resources, capacity building, logistics, supply, laboratory support and M&E issues. Representatives included staff from PNLS/IST, Ministry of Health, MoH directorates and divisions (Family Health Division, Pharmacies, Laboratories and Equipment, Human Resources, Planning and Research, Statistics, IEC), National Reference Centre, other health actors (National Blood Transfusion Centre, and SRH and HIV supervisors and providers), other ministries (Advancement of Women, Education, Youth and Sport), UN agencies (UNAIDS, UNFPA, UNICEF), ATBEF, people living with HIV (PLHIV) and other CSOs.

8. Did the assessment involve interviews with service providers from both SRH and HIV services?
Yes, 32 service providers, including the head of the point of service, were interviewed from a total of 16 randomly selected facilities, including MoH, CSO and faith-based organization facilities: 8 SRH service sites (n=16) and 8 HIV service sites (n=16) from a purpose sample of facilities drawn from the Maritime, Plateaux, Central and Kara Regions and Lomé-commune.

9. Did the assessment involve interviews with clients from both SRH and HIV services?
Yes, 406 clients were interviewed from a total of 16 facilities, including 8 SRH service sites (n=271) and 8 HIV service sites (n=135).

10. Did the assessment involve people living with HIV and key populations?
Yes, at the second meeting during the policy-level process one representative from the national network of people living with HIV participated. There is no information on whether clients interviewed included PLHIV or key populations.

FINDINGS

1. Policy level
Strengths:
• The national 10-Year Health Policy (2011), Health Development Plan (2009–2013) and the Standards for Health District (2002) are oriented towards an SRH and HIV integration approach. The latter provides for the integration of SRH and HIV in the Minimum Package at the service delivery level.
• Some other SRH and HIV policies and guidelines refer to linkages.

Weaknesses:
• The lack of an advocacy strategy to obtain the support of leaders to promote the integration of SRH and HIV policies and services.
• Lack of overarching policy, standards and procedures for integrated SRH and HIV services.
• Lack of an SRH and HIV integration guide or manual.
• Lack of SRH and HIV integration guidelines for key populations, including sex workers, people who use drugs, young people, men who have sex with men, people in detention, etc.
• Lack of precision within the MoH of the roles and functions of the Family Health Division and the PNLS/IST with regard to SRH and HIV integration.
Laws:
• Law No. 2010/018 on the protection of individuals with regard to HIV and AIDS protects PLHIV from discrimination.
• There is no law that directly addresses SRH and HIV integration.
• There are no legal or regulatory restrictions on access to SRH and HIV services.
• There is a lack of knowledge among the general population and implementers regarding the legal framework relating to SRH and HIV.
• As regards key populations, including men who have sex with men, sex workers and people who use drugs, the legislative framework is limited to the Penal Code.
• The country’s laws are complemented by the Penal, Persons and Family, and Child Codes.

2. Systems level

Strengths:
• Both the SRH and HIV programmes are operational, and bi-directional integration has begun.
• There is an extensive network of health facilities offering maternal and perinatal health services.

Weaknesses:
• A low level of integration of PPTCT in maternal and child health (MCH) services.

Coordination and partnerships:
There is a network of non-governmental organizations (NGOs) working in SRH and/or HIV, with CSOs playing an important role in planning and implementation of SRH and HIV interventions, including development, implementation and M&E. As a result of their strong involvement and dynamism, CSOs hold the position of Vice President of the Country Coordinating Mechanism. CSOs are involved in SRH and HIV services for associations of people with disabilities and youth, although as regards PLHIV, the emphasis is on HIV services. The capacity of organizations and networks of PLHIV for coordination and leadership is still very low, though they have capacity in relation to strategic planning, programme implementation and community-based communication.

Planning, management and administration:
• There is no joint SRH and HIV planning mechanism with programmes operating vertically. For example, PPTCT is managed by the HIV programme and MCH is managed by the SRH service (Family Health Division). At the regional and district level, each programme or activity (SRH, HIV, PPTCT, malaria and TB) has a focal point. This multitude of focal points makes collaboration difficult.
• There is no joint supervisory SRH and HIV integration mechanism, except in PPTCT and family planning (FP). Interventions are implemented vertically with a multitude of focal points, resulting in coordination difficulties at the regional level and between focal points. Similarly, supervision is fragmented, with separate training resources, the contents of which do not facilitate integration.

Staffing, human resources and capacity development:
• The principal issue in the health sector is the lack of human resources, including for SRH and HIV integration.
• The level of skills on SRH and HIV integration is low.
• Both SRH and HIV training manuals provide ongoing training and SRH and HIV components.
• The in-school training at the primary school level includes SRH and HIV.
• There is a low level of SRH and HIV integration in secondary school curricula: i.e. SRH is not integrated and only an HIV manual has been developed.

Logistics:
• There is inadequate health infrastructure and equipment to carry out integrated SRH and HIV services, e.g. laboratory activities are limited at the hospital level and more limited at the health centre and clinic level.
• Although there is a plan for the supply of essential drugs, including SRH and HIV products, the logistics supply system is not integrated.
Monitoring and evaluation:

- Statistics management tools for SRH and HIV integration activities are inadequate.
- The M&E system is fragmented, with data collected by individual programmes and not sent to the Division of Health Studies and Research Information.
- Possible SRH and HIV integration indicators identified during the RA include:
  - access to condoms for men who have sex with men and sex workers;
  - the number of HIV-positive women who received FP information to avoid unplanned pregnancies;
  - the number of women and men screened for HIV during antenatal consultations; and
  - the percentage of young people having their first sex before 15 years of age.

Funding:

- There are several sources of funding for SRH and HIV, including the government, communities, private sector (profit and non-profit), and technical and financial partners.
- The main partners for SRH programmes are the government, UNFPA, the United States Agency for International Development (USAID), the United Nations Children’s Fund (UNICEF), WHO, the United Nations Development Programme (UNDP), the European Union (EU), Plan Togo, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), GAVI Alliance, West African Health Organization, Islamic Development Bank (IDB), ECOWAS Bank for Investment and Development (EBID), World Bank, the Agence Française de Développement (AFD), the Danish International Development Agency (DANIDA), IPPF, Population Services International (PSI), Action for West Africa Region (AWARE), ATBEF and Women in Law and Development in Africa (WILDAF).
- The main partners for HIV programmes are UNFPA, USAID, UNICEF, UNAIDS, WHO, GFATM, GAVI Alliance, UNDP, EU, IDB, EBID, World Bank, AFD, German International Cooperation (GIZ), DANIDA, Clinton Foundation, GlaxoSmithKline, and ESTHER.
- Support for bi-directional SRH and HIV links is mostly from UNFPA, UNICEF and GFATM.

3. Services level

Strengths:

- Integration of HIV activities has begun on the periphery of SRH services, including HCT, condom provision and PPTCT.
- Integration of SRH services in HIV services has begun.
- The majority of SRH clients are favourable to bi-directional service integration in the same establishment.
- There are specific SRH and HIV programmes directed at young people, as well as at sex workers, migrants and men who have sex with men.

Weaknesses:

- Weak integration of HIV in SRH services.
- Incomplete integration of SRH in HIV services.
- Low male involvement in SRH and HIV activities, especially PPTCT.
- Low levels of interaction between service providers and clients on domestic violence, particularly within SRH services.
- Lack of knowledge by the general population and implementers of the legal framework about SRH and HIV.
- Low awareness among the general population on the availability of integrated SRH and HIV services, including the use of condoms as a form of dual protection.
- Dissatisfaction expressed by some clients about service quality, particularly within HIV services.
A. SERVICE PROVIDER PERSPECTIVES:

- Of the 16 SRH services, 94 per cent reported providing STI prevention and management, 88 per cent FP, 75 per cent maternal and perinatal health, and 64 per cent prevention of unsafe abortion services. In terms of integrated HIV-related services, 81 per cent provided HCT, 69 per cent condoms and 50 per cent PPTCT.

- Of the 16 HIV services, 94 per cent reported providing HCT, 88 per cent psychosocial support, 81 per cent positive prevention, and 75 per cent treatment and care and PPTCT. In terms of integrated SRH services, 75 per cent reported providing maternal and perinatal health, 63 per cent FP, and 56 per cent services related to gender-based violence and/or to prevention of unsafe abortion.

B. SERVICE USER PERSPECTIVES:

- In the case of SRH services, 65.3 per cent of clients came for maternal and perinatal health services, while significantly fewer sought FP (19.2 per cent), condoms (11.6 per cent), and STI management (8.1 per cent). Clients indicated that they had received HIV-related services, including HCT (16.6 per cent), PPTCT (12.5 per cent) and prevention (11.4 per cent). Over 87 per cent of clients (87.4 per cent) were satisfied or very satisfied with services received, while 7.8 per cent were very unsatisfied.

- In the case of HIV services, 28.9 per cent of clients came for HIV treatment and care, while 23 per cent came for HCT and 22.2 per cent for maternal and perinatal health services. Clients indicated that they had received SRH-related services, including maternal and perinatal health (21.5 per cent), FP (8.2 per cent) and prevention of unsafe abortion services (3.7 per cent). Seventy-two (72) per cent of clients were satisfied or very satisfied with services received, while 13 per cent were very unsatisfied.

- The vast majority of clients, including SRH (87.8 per cent) and HIV (83 per cent), preferred receiving both SRH and HIV services at the same health facility. Reasons advanced included reduced travel costs, a reduced number of visits to the health facility, as well as access to complementary services, improved service efficiency and a decrease in service delivery costs. Disadvantages cited were increased waiting time, service providers too busy, loss of confidentiality, increased risk of stigma and reduced service quality.

With regard to receiving SRH and HIV services from the same provider, feelings were mixed, with 52.8 per cent and 43 per cent of SRH and HIV clients respectively preferring not to receive health services from the same provider. However, 35.1 per cent of SRH clients and 40.7 per cent of HIV clients did prefer to receive health services from the same provider. Advantages cited included a reduction in the number of visits to the health facility, reduced travel costs and waiting times, improved service quality and access to complementary services. Disadvantages cited included service providers being too busy, increased waiting times, reduced service quality and loss of confidentiality.
1. What lessons were learned about how the assessment could have been done differently or better?

Challenges during the RA included:

- Some stakeholders undertaking other activities during the assessment period, which meant that it was not possible to mobilize all stakeholders for the policy discussion meetings;
- The period for data processing and analysis being too short, due to the need to communicate with the international consultant to validate results.

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

Planned next steps include:

- Finalizing an action plan to put the RA recommendations into practice
- Evaluating integration needs in seven districts.

3. What are the priority actions that are being taken forward as a result of the assessment, at the:

   Policy level:
   - Policy dialogue and engagement.

   Systems level:
   - Strengthening of SRH and HIV programme collaboration through regular consultations.
   - Identification of assistance needs for the integration process.

   Services level:
   - Integration of FP in some support services for PLHIV.
   - Offering integrated SRH and HIV services (IEC/Behaviour Change Communication, HCT, STI management, FP, condoms) to adolescents, youth and sex workers in eight districts and in Lomé (i.e. in UNFPA programme intervention areas and others).

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

Funding opportunities include:

- Fonds Français de l’Initiative MUSKOKA.
- GFATM.
## Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AFD</td>
<td>Agence Française de Développement (the French Development Agency)</td>
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<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
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<td>ATBEF</td>
<td>Association Togolaise pour le Bien-Etre Familial (Togo Association for Family Welfare)</td>
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<td>AWARE</td>
<td>Action for West Africa Region</td>
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<td>CSO</td>
<td>civil society organization</td>
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<td>EBID</td>
<td>ECOWAS Bank for Investment and Development</td>
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<td>EU</td>
<td>European Union</td>
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<td>FP</td>
<td>family planning</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>HCT</td>
<td>HIV counselling and testing</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>IEC</td>
<td>information, education and communication</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>MCH</td>
<td>maternal and child health</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>PLHIV</td>
<td>people living with HIV</td>
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<td>PNLS/IST</td>
<td>Programme National de Lutte contre le SIDA et les IST (National Programme to Combat AIDS/STIs)</td>
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<td>PPTCT</td>
<td>prevention of parent-to-child transmission</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>RA</td>
<td>rapid assessment</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>TB</td>
<td>tuberculosis</td>
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<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV/AIDS</td>
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<td>United Nations Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WILDAF</td>
<td>Women and Law in Development</td>
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