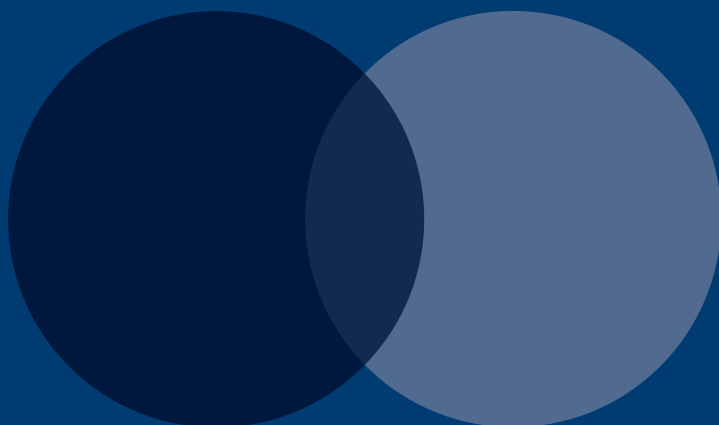




RAPID ASSESSMENT
OF SEXUAL AND
REPRODUCTIVE HEALTH
AND HIV LINKAGES



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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 India*¹. 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

- **Establish a task force and cross-programme working groups to strengthen bi-directional linkages:** Set up a task force consisting of representatives from the National AIDS Control Organisation (NACO) and the National Rural Health Mission (NRHM) to oversee and monitor the integration plan. Set up a national integration working group, including representatives from donors, civil society groups, including key populations and, in particular, networks of people living with HIV (PLHIV), and technical experts. The working groups and task forces should meet at regular intervals, analyse the state of integration, and work towards formulating policy, strengthening programmes and advocacy initiatives, and mobilizing resources. This will also strengthen the existing NACO and NRHM coordination mechanism.
- **Generate evidence around SRH and HIV linkages:** The Ministry of Health and Family Welfare (MOHFW) with support from bilateral and multilateral donors should commission a study at national level to understand the specific gaps in service provision, in order to develop evidence-based planning and model integration programmes.
- **Advocate for national laws and civil and legal rights in order to facilitate SRH and HIV linkages:** Introduce the HIV/AIDS Bill in Parliament and get it passed in order to ensure protection of the health and rights of PLHIV and key populations. Ensure uniformity between age of consent laws for sexual intercourse and for HIV testing.

- **Create synergies through allocation of funds:** NACO and NRHM are two separate vertical programmes under the MOHFW, with the biggest challenge being allocating, disbursing and reporting on funds for integration-related line items. Therefore, allocating appropriate financial resources for SRH and HIV integration is key to successful programming.

Systems

- **Undertake and document pilot projects:** India is a vast country and health is a state matter; therefore staggered intervention, taking diversity and other health indicators into consideration, will help create different models of SRH and HIV integration, which should be documented.
- **Support systems strengthening:** Strengthen NACO's and NRHM's monitoring and evaluation (M&E) systems to generate data on integrated indicators. Introduce common national manuals and modules for building the capacity of service providers and programme implementers on improving infrastructure, logistics, and adequate funding. Work towards developing integrated medical curricula.

Service provision

- **Strengthen integrated services at government and private service facilities and introduce integrated SRH and HIV services at all levels:** This will increase overall service efficiency, decrease stigmatization of SRH and HIV clients, save time, reduce expenditure, maintain confidentiality and build rapport with service providers.

1. This summary is based upon: *Sexual and Reproductive Health and HIV Linkages in India: A Rapid Assessment*, FPA India, IPPF and UK Department for International Development, 2011.

PROCESS

1. Who managed and coordinated the assessment?

- The implementation of the Rapid Assessment Tool was coordinated by FPA India with technical support from IPPF South Asia Regional Office (SARO) and financial support from the UK Department for International Development (DFID).
- An assessment team was formed comprising representatives of NACO, NRHM, UNAIDS, key populations (men having sex with men, transgender and people who use drugs), PLHIV, young people, civil society organizations (CSOs) and service users to discuss the tools, methodology and findings.

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

The implementing team consisted of staff from FPA India headquarters and two consultants – one social scientist and one researcher – who trained 5 investigators for the interview process.

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

The literature review addressed both SRH and HIV, including the Indian Constitution, national policies and plans, project implementation plan, major studies on SRH–HIV linkages, donor policies, national laws and government circulars related to SRH and HIV linkages. Specific policies and plans included the Indian Planning Commission's Eleventh Five Year Plan (2007–2012); National Health Policy (2002); National Population Policy (2000); National AIDS Control Programmes (NACP) I, II, III and IV (draft) and Programme Implementation Plans (PIP) I, II and III; NRHM PIP; Reproductive and Child Health (RCH) Policy and PIP; and Technical Guidelines on RCH and HIV/AIDS.

4. Was the assessment process gender-balanced?

While the assessment process was not gender-balanced, both men and women were involved:

- in the assessment team overall (7 men and 9 woman);
- as consultants (1 + 1);
- as investigators (3 + 2);
- as interviewees: policy-makers (19 men and 7 women), service providers (6 + 12) and clients (7 + 17).

Transgender people were involved in the assessment team (1) and as client interviewees (3).

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

The assessment team designed a separate questionnaire based on the Rapid Assessment Tool for policy, systems and service delivery levels, keeping in mind the diversity and socio-cultural context of India. Additional questions were introduced to understand perceived barriers in implementing SRH and HIV integration. The adapted tools were translated into four languages: Hindi, Marathi, Kannada and Bengali. These were pre-tested and finalized after receiving approval from FPA India's Ethics Committee.

6. What was the scope of the assessment?

The scope of the assessment was to assess HIV and SRH bi-directional linkages at the policy, systems and service-delivery levels. It was also intended to identify gaps, and ultimately contribute to the development of country-specific action plans to forge and strengthen these linkages. Due to time and cost constraints, the study focused on five states: Karnataka, Maharashtra, New Delhi, Uttar Pradesh and West Bengal; 115 interviews were undertaken with selected policy-makers, programme managers, service providers and clients.

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

Yes. National and state SRH and HIV policy-makers and planners were interviewed. Informal in-depth interviews were conducted with 26 policy-makers and planners, including parliamentarians, MOHFW, NACO, state/district family welfare and mission directors, project directors and deputy directors of state AIDS prevention and control societies. In-depth interviews were also conducted with five donors and four international and national non-governmental organizations (NGOs) supporting SRH and HIV programmes, including UNAIDS, UNFPA, the United States Agency for International Development (USAID), HIV/AIDS Alliance, Family Health International (FHI), Hindustan Latex Family Planning Promotion Trust (HLFPPT), Transport Corporation of India (TCI), MAMTA (a national NGO committed to integrated health and development issues) and Naz Foundation.

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

Yes. Interviews were held with 42 service providers, including medical officers, auxiliary nurse midwives (ANMs), nurses, counsellors, paramedics, project coordinators, and community workers from government hospitals, state and district level health centres, private hospitals, NGO-run clinics and charitable hospitals providing HIV or SRH services or both.

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

Yes. Interviews were held with 27 clients from SRH and HIV facilities.

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

The assessment team included the following key populations:

- men having sex with men (3);
- transgender (1);
- people living with HIV (3), including one woman living with HIV.

The assessment process took special care to involve clients from key populations, including:

- men having sex with men;
- people who use drugs;
- sex workers;
- transgender people.

The assessment process also involved:

- people living with HIV, though it was difficult for people to reveal their status on the questionnaire due to issues of confidentiality;
- youth and women, to understand their perspectives;
- selected community clinics frequented by these populations.

FINDINGS

1. Policy level

International commitments

India's political commitments on SRH and HIV linkages are reflected in many international declarations, including International Conference on Population and Development (ICPD), UN Millennium Development Goals, Glion Call, New York Call and the Declaration of Commitment on HIV/AIDS at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, 2001.

Legal framework

The legislative framework to a great extent supports implementation of SRH and HIV linkages. India has laws on age at marriage, age of consent for sexual intercourse, age of consent for HIV testing and prevention of domestic violence, although the HIV and AIDS Bill (2005) has not been passed by Parliament and the HIV/AIDS Workplace Policy does not incorporate SRH. However, laws provide different ages for marriage, consent to sexual intercourse and HIV testing; and various aspects of sex work are criminalized.

Policies

National policy on HIV/AIDS and RCH support SRH and HIV linkages, and these have been initiated over the last five years. Implementation of both HIV and SRH policies is based on the principle of gender equality.

- **Level of linkages in the National HIV Policy:** Although the National HIV Policy mentions "to bring in horizontal integration at the implementation level with other national programmes like Reproductive and Child Health", integration was limited to a few components in the NACP-III Implementation Plan. For example, family planning (FP) was not included, and SRH for PLHIV remains neglected.

- **Level of linkages in National SRH Policy:**

Effective HIV links with the Reproductive and Child Health Programme (RCHP) include access to safe blood, integrated counselling and testing, treatment of sexually transmitted infections (STIs), and antenatal care (ANC) HIV screening for prevention of parent-to-child transmission (PPTCT), although voluntary HIV counselling is not part of national FP programmes. However, the SRH needs of PLHIV and sexual minorities have not been addressed in RCH and NRHM programmes, particularly fertility and reproductive choices.

Guidelines

The government has drafted SRH- and HIV-related clinical and programme guidelines, including condom promotion, reproductive tract infections (RTIs)/STIs, post-exposure prophylaxis for survivors of sexual assault, medical termination of pregnancy (MTP) and antiretroviral therapy (ART).

Challenges

- While the policy environment is generally favourable, the voice of clients and demand for linked services is missing in efforts to scale up SRH and HIV linkages.
- State governments lack evidence on what modes of HIV and SRH integration to adopt in different settings.
- There are no policies or guidelines on population size for laboratories and diagnostic facilities, which has resulted in fewer Integrated Counselling and Testing Centre (ICTC) and PPTCT sites.
- The government provides fewer care and support services compared to the private and NGO sectors.
- Underutilization of an estimated 21 million youth volunteers in National Service Scheme (NSS), National Cadet Corps (NCC), Scouts and Guides, Nehru Yuva Kendra Sangathan (NYKS), youth clubs, Youth Red Cross and Red Crescent for prevention and building an enabling environment.

- Although both the NRHM and NACP programmes are under the MOHFW, with regular meetings to discuss common agendas, programmes are implemented vertically; and at both the national and state levels there are significant gaps in exchanging information, organizational coordination, joint planning, monitoring and joint reporting.
- Lack of meaningful civil society involvement in NRHM and RCHP, including planning implementation and M&E.
- Participation of women (aged 15–49) through civil society in SRH and HIV planning is inadequate.
- There are gaps between policy and implementation at the grassroots level with a lack of coordination between ANMs, Accredited Social Health Activists (ASHAs), Multi-Purpose Workers (MPWs), Anganwadi (a government-sponsored centre for care of children and mothers in India) and link workers in providing SRH and HIV services, and most of the 24x7 (day and night centres) primary health centres are non-functional and ill equipped, providing poor service quality.

2. Systems level

Partnerships

- The partners for SRH and SRH linkages are the European Union (EU), IPPF, UNAIDS, UNFPA and WHO.

Coordination

- An NACP health and family welfare integration committee has been set up within the West Bengal Department of Health and Family Welfare to oversee integration between NACP and departmental programmes.
- Among the organizations reviewed, 50% of respondents have established a mechanism for joint SRH and HIV planning.

Training

- Although few organizations have training curricula and modules that integrate HIV into SRH and vice versa, those existing are revised and updated regularly.
- The identified training needs of the survey organizations are the Computerized Management Information System; evidence-based integration; M&E; technical themes related to integration and cross-cutting issues, including gender and human rights; communications; health system strengthening; and the role of Public-Private Partnerships (PPPs).

- SRH- and HIV-related education is not provided to late primary school students, but only to students in secondary schools.
- None of the organizations foresaw any challenges in relation to staffing, including staff retention, recruitment, task shifting, workload and quality.

Logistics and supplies

- Under the government system, MOHFW procures kits, drugs, contraceptive vaccines and commodities for NACP, NRHM and RCHPs, which manage the commodities separately.
- Most of the respondent organizations are not supporting logistics and laboratory services and are linking clients to existing government and private health service providers.
- Lack of laboratories, diagnostic facilities and trained personnel for integration and/or scaling up programmes.

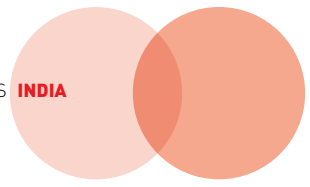
Monitoring and evaluation

- Although most respondent organizations generated data on SRH and HIV disaggregated by sex, age and HIV status, only FHI had introduced integrated M&E indicators.

3. Services level

HIV integration into SRH services

- HIV counselling and testing: 33% of ANC clinics provided voluntary counselling and testing services, 36% of FP clinics provided HIV counselling and referral for testing, and 61% of STI clinics provided HIV counselling, testing and referral. The study clearly indicates that STI services are the entry point for integrating HIV services within SRH clinics.
- Condom promotion/provision: 97% of ANC clinic and FP centres promoted condoms to prevent unintended pregnancies, 48% of SRH providers promoted dual protection, and 89% of STI clinics promoted condoms for STI and HIV prevention.
- PPTCT: 65% of SRH centres were referring clients to PPTCT programmes in government health centres.
- HIV information for key populations: All SRH service facilities were providing HIV information for the general population, with more than half providing information for key populations.



- HIV care and support/ART services: SRH service facilities are not providing care and support services, but are linking people to existing available care and support facilities run by government hospitals/NGOs where ART and community care services are provided free of cost.

SRH integration into HIV services

- Prevention and management of STIs: 86% of HIV centres were providing STI prevention and management services.
- FP services: 55% of HIV centres provided at least one FP service to SRH clients.
- Prevention/management of abortion, post-abortion care and gender-based violence (GBV): These services were not available at HIV centres, so clients were referred to services elsewhere.
- RCH: NACP, where it is linked with RCH/NRHM, provides ICTC and PPTCT services through government facilities. However, PPTCT and ICTC services are not available in all government facilities, so people are referred to major district hospitals.

SERVICE PROVIDER PERSPECTIVES

- Most of the service providers indicated that 'shortage of staff time' and 'lack of additional funds' were the major constraints in providing integrated services. Other issues identified were 'non-availability of space for providing private and confidential services' and 'lack of motivation among the staff to provide integrated services'.
- NGOs and CSOs have made significant contributions in reaching key populations with HIV prevention and care services.
- Respondents from youth groups, NGOs and community-based organizations (CBOs) felt that GBV is prevalent across all locations and across groups, particularly affecting women living with HIV.
- 68% of service providers are of the view that integrating HIV and SRH services would increase service efficiency, and decrease stigmatization of HIV (67%) and SRH (55%) clients.

SERVICE USER PERSPECTIVES

HIV integration into SRH services

- Access to SRH services is not dependent on marital status; however, societal pressure, taboos, gender inequality, and attitude of service providers prevent women from accessing SRH services.
- Of the clients, 30% had received at least one HIV service, including HIV counselling and testing (48%), referral to HIV services within SRH facilities (28%), and HIV monitoring and treatment (15%).
- 78% of clients preferred SRH and HIV services from the same facility because they felt that it would 'save time and maintain confidentiality' (44%), 'reduce overall expenses' (37%) and 'build rapport with the providers' (19%).

SRH integration into HIV services

- 26% of clients received at least one SRH service and 18% received referral for SRH services (FP, maternal, newborn and child health, abortion-related, and/or condom provision).
- 63% of the clients preferred SRH and HIV services from the same facility and from the same provider instead of any referral, because 'it will save money' and 'it will be more comfortable with the same provider'.
- Concerns about service integration included fear of increased waiting time (as providers may be too busy) and the possibility of reduced confidentiality and privacy (as different types of clients would come to the one facility).

Challenges

- Lack of comprehensive SRH and HIV integrated programmes addressing the specific needs of people living with HIV and key populations.
- Women's access to SRH/ICTC/PPTCT services remains a challenge in urban slum, rural and tribal areas.

LESSONS LEARNED AND NEXT STEPS

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

- **Time and resource constraints:** These resulted in a small sample, focused mostly on urban and semi-urban populations, leading to inadequate representation of service facilities and key populations.
- **Limitation of generic tool:**
 - Length of policy section: a separate questionnaire was developed for policy-makers.
 - Limited options in services section: this was modified by adding further options.
 - Limited scope for generating data on CBOs, schools, women's and youth groups: an additional questionnaire was developed.
 - English: FPA India translated the tool into four languages.
- **Respondent-related constraints:**
 - Conducting interviews with policy-makers due to their time commitment.
 - Recruiting key population respondents as they were not available at every facility.

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

- Increasing advocacy with the Country Coordinating Mechanism and MOHFW.
- Supporting CBOs to demonstrate and document good practices.
- Involving the private sector in the development of PPP models for SRH and HIV linkages.
- Complementing and supplementing the efforts of NACP IV and NRHM programmes.

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:

- Increasing advocacy around integration. Advocacy workshops are planned to promote SRH and HIV programme integration, legal and rights issues, medical curricula and national training modules.
- Initiating SRH and HIV integration in a staggered manner.
- Addressing structural issues from the grassroots to the policy level by assessing infrastructure before looking at the superstructure.
- Meaningfully involving civil society in the integration process.
- Establishing integration committees from policy to village levels.

Systems level:

- Facilitating joint working groups and task forces and including representatives from donors, CSOs, key populations and networks of PLHIV.
- Building strong grassroots workers.
- Demonstrating and documenting good practice SRH and HIV integrated programmes.
- Advocacy with HIV and SRH programmes to incorporate SRH and HIV integration indicators.

LESSONS LEARNED AND NEXT STEPS CONTINUED

Services level:

- By the end of 2012, PPTCT centres will include antenatal and postnatal care, FP, MTP, RTI/STI treatment, safe institutional delivery, voluntary and confidential HIV counselling and testing, information, education and communication on breast feeding and nutrition, ART and linkages with community care centres.
- Generating evidence to identify structural gaps and develop a plan of action.
- Building the capacity of service providers and programme managers on models of integration.
- Generating support for the national MOHFW HIV/AIDS and RCH plans on integration among service providers.

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

- MOHFW supports and promotes integration through NACO and NRHM. Key partners include IPPF, WHO, EU, USAID, Swedish International Development Cooperation Agency (SIDA), Canadian International Development Agency, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNAIDS, United Nations Development Programme, UNFPA, UNICEF, DFID and the Bill & Melinda Gates Foundation (BMGF).
- The country SRH programme is supported by the government through NRHM. UNFPA and UNICEF support various RCHPs; USAID is supporting the implementation of the State Innovations in Family Planning Services Project Agency in Uttar Pradesh and also supports FHI; BMGF is implementing the SRH project; SIDA is supporting SRH programmes for young people.
- The budget for NACP III (2006–2011) was US\$1,558 million, made up of US\$636 million through direct budgetary support and US\$922 million through external support from DFID, GFATM, USAID and the World Bank. NACP and RCH integration under NACP III received US\$3.6 million.

Abbreviations

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ANM	auxiliary nurse midwife
ART	antiretroviral therapy
ASHA	Accredited Social Health Activist
BMGF	Bill & Melinda Gates Foundation
CBO	community-based organization
CSO	civil society organization
DFID	UK Department for International Development
EU	European Union
FHI	Family Health International
FP	family planning
FPA India	Family Planning Association of India
GBV	gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+	Global Network of People Living with HIV
HIV	human immunodeficiency virus
HLFPPT	Hindustan Latex Family Planning Promotion Trust
ICPD	International Conference on Population and Development
ICTC	Integrated Counselling and Testing Centre
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
M&E	monitoring and evaluation
MOHFW	Ministry of Health and Family Welfare
MPWs	Multi-Purpose Workers
MTP	medical termination of pregnancy
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	non-governmental organization
NRHM	National Rural Health Mission, India
PIP	Program Implementation Plan
PLHIV	people living with HIV
PPP	Public-Private Partnership
PPTCT	prevention of parent-to-child transmission (of HIV)
RCH	reproductive and child health
RCHP	Reproductive and Child Health Programme
RTI	reproductive tract infection
SARO	IPPF South Asia Regional Office
SIDA	Swedish International Development Cooperation Agency
SRH	sexual and reproductive health
STI	sexually transmitted infection
TCI	Transport Corporation of India
UN	United Nations
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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