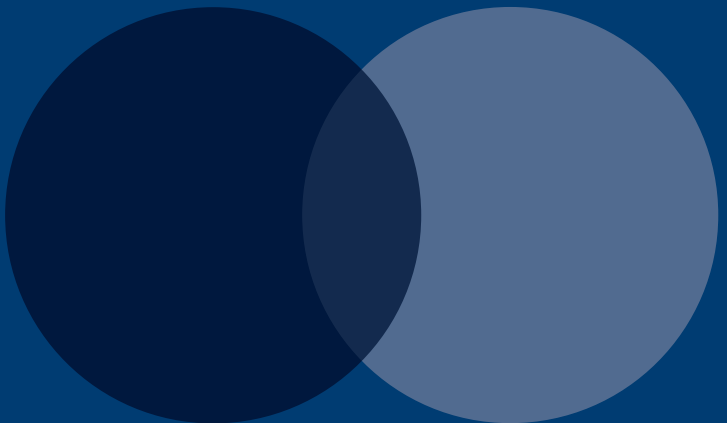




**RAPID ASSESSMENT
OF SEXUAL AND
REPRODUCTIVE HEALTH
AND HIV LINKAGES**



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 Uganda¹. 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?

- Establish or operationalize mechanisms for joint planning, supervision, monitoring and evaluation (M&E) of SRH, HIV and prevention of mother-to-child transmission (PMTCT) services at all levels.
- Advocate for an increased share of the national budget for health and SRH services, and lobby donors to increase support for SRH services.
- Establish mechanisms for increasing and sharing resources for SRH, HIV and PMTCT services.
- Ensure that adequate numbers of appropriately qualified and skilled service providers are in place at all levels of health facilities to offer integrated SRH and HIV services.
- Review training curricula for comprehensive nursing (Enrolled Comprehensive Nursing, Diploma in Comprehensive Nursing and Registered Comprehensive Nurse) with a view to increasing the duration of the midwifery component of this training, so shifting back from training of generalist nurse-midwives, to those competently and highly skilled in midwifery.
- Scale up adolescent-friendly SRH and HIV services.
- Develop and implement measures to increase utilization of high-quality integrated SRH, HIV and PMTCT services, including antenatal care (ANC), delivery care, post-partum care (PPC) and family planning (FP).
- Develop and implement measures to increase community, family support, and male participation in SRH, HIV and PMTCT services.
- Exploit other entry points for SRH and HIV other than PMTCT.
- Lobby for funds for infrastructure development. Meanwhile, rationalize use of space in existing infrastructure for SRH, HIV and PMTCT services.
- Improve dissemination of SRH, HIV and PMTCT policies, guidelines and protocols to health care workers.
- Sensitize the general population on the risks involved in the activities of key populations, including men who have sex with men, people who use drugs, and sex workers.

1. This summary is based upon: *Sexual Reproductive Health and Rights, HIV/AIDS Linkages and Integration in Uganda: Rapid Assessment Study*, Final Report, Ugandan Ministry of Health, Kampala, February 2010.

PROCESS

1. Who managed and coordinated the assessment?

The Ugandan Ministry of Health (MoH), with technical and financial support from UNFPA and WHO, and with the contributions of the following Rapid Assessment Technical Working Group members: Dr Collins Tusingwire, Dr Olive Sentumbwe, Rosemary Kindyomunda, Rita Nalwadda, Dr Godfrey Esiru, Dr Angela Akol, Dr Zainab Akol, Dr Apollo Kansiime and Dr Jennifer Wanyana.

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

The review was carried out by a team of consultants (Drs Godwin Turyasingura, Sebastian O. Baine and Andrew Baryeku) who undertook the document review, data collection and analysis, with assistance from Simon Kasasa, statistician.

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

Yes. A total of 86 documents were reviewed, including policy documents and guidelines on SRH (23) and HIV (14), as well as other policies impacting on reproductive health (RH) (4); and protocols, training manuals, and clinic cards (18). Other documents included international commitments (5), international treaties (7), national laws (5) and programme-related materials (10).

4. Was the assessment process gender-balanced?

It is not possible to form an opinion from the data in the report.

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

The Rapid Assessment Tool was adapted to the Ugandan context and field tested. The Rapid Assessment was undertaken in English.

6. What was the scope of the assessment?

The scope of the assessment was to review the current SRH and HIV integration efforts, in order to inform the development of a broader national strategic framework that would guide stakeholders engaged in policy- and decision-making, planning, and delivery of SRH and HIV services. Specific objectives were to:

- Review the current policy environment for comprehensive SRH and HIV linkages and integration.
- Identify current approaches, good practices and gaps in planning, programming and implementation of SRH and HIV linkages and integration.
- Use the findings and recommendations to develop national SRH and HIV linkages, and a national integration strategy and operational plan.

Interviews were undertaken with policy-makers and programme managers, as well as with service providers and clients from service delivery sites in 5 districts: Gulu, Hoima, Kampala, Mayuge and Soroti.

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

Yes.

- At national level, key informants and group discussion participants interviewed included representatives of donor, UN and other international agencies; international and national non-governmental organizations (NGOs); and national health and programme managers and administrators, working in SRH and HIV.

- At the district and sub-district levels, key informants interviewed included District Health Officers; focal persons for SRH and HIV prevention, care and support services; technical heads of NGOs/civil society organizations (CSOs) providing SRH and HIV services, heads of health sub-districts, and service providers.
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8. Did the assessment involve interviews with service providers from *both* SRH and HIV services?

Yes. Service providers were interviewed from a total of 90 health facilities providing SRH and/or HIV services in 5 districts: Gulu (24.4%), Hoima (6.7%), Kampala (25.6%), Mayuge (16.7%) and Soroti (26.7%).

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

Yes. Interviews were conducted with 167 clients from both SRH and HIV prevention, treatment and support services, mostly in hospitals and Health Centre III facilities (sub-county level, larger than parish health centres), in 5 districts: Gulu (5.4%), Hoima (13.2%), Kampala (33%), Mayuge (13.1%) and Soroti (35.3%).

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

Yes, as part of the client exit interviews and as participants in the stakeholder consultation and validation meetings.

FINDINGS

1. Policy level

National policies, plans and guidelines:

International commitments and treaties supporting SRH and HIV linkages have influenced the development of national policies, laws and programmes. Generally the policy environment is supportive of SRH and HIV services linkages and integration; however, they are poorly disseminated, especially at lower levels, and poorly implemented. Furthermore, there are no formal links between the MoH RH division and the AIDS Control Programme (ACP).

There is a National Strategic Plan for HIV/AIDS Activities (NSP) and a National Monitoring and Evaluation Framework for HIV/AIDS Activities (2007/8–2011/12). The NSP prioritizes HIV prevention with a target of a 40% reduction in incidence. HIV prevention strategies include SRH-related issues, e.g. dual protection, adolescent sexual and reproductive health, sexually transmitted infections (STIs), addressing structural factors, and for people living with HIV, FP, fertility and reproductive choices.

The national SRH strategy includes HIV prevention, treatment and care and support, as well as M&E, covering voluntary counselling and testing (VCT) within FP, HIV behaviour change communication (BCC) within SRH services, PMTCT within maternal health services, and HIV treatment for people living with HIV (PLHIV). There are National Policy Guidelines and Services Standards for Reproductive Health Services which detail the strategies and RH services to be offered at different levels, providing minimum standards for RH services and logistics management.

Laws:

National laws are largely supportive of SRH and HIV integration. The Constitution stresses the rights of women and obliges the state to protect women and their rights. However, sex work and homosexual acts are criminalized under the Penal Code Act (1950).

2. Systems level

Coordination:

- There is an absence of coordination in resource sharing, joint programming and planning, supervision and monitoring, especially at central (MoH) level, i.e. there are no formal links between the SRH programme and ACP.
- There is inequitable programme support (technical and financial) between the SRH programme and ACP.
- At the district level, joint planning for SRH and HIV programmes is undertaken, e.g. SRH and HIV services exist in the same district work plan, and some SRH and HIV items are funded from the same source.

Partnerships:

- Many partners exist at all levels for SRH and, in particular, HIV services, including systems support for effective linkages at the district level.
- There are many NGOs, faith-based organizations (FBOs) and CSOs involved in SRH and HIV activities, which can be engaged for integration.
- The involvement of the private sector and civil society in PMTCT activities is still low in most districts.

Human resources and capacity building:

- There are inadequate human resources. Recruitment and retention, especially in remote areas, are critical in ensuring appropriate numbers, skills mix and avoiding overworking available staff. Other issues include inadequate remuneration and poor motivation.
- While available staff are well trained, they are overworked, providing HIV services on top of other work, which could compromise quality. For example, midwives who ordinarily provide delivery services are called upon to provide PMTCT without any increase in staffing.

Strengths:

- Capacity building on SRH and HIV integration guiding principles and values includes stigma and discrimination eradication, male involvement, attitudes towards PLHIV and key populations, and

confidentiality, though gender sensitivity, youth-friendly services and reproductive rights and choices need to be addressed.

- Several medical training institutions regularly train different cadres of health workers.
- Some relevant pre-service and in-service training materials for health workers have been revised to incorporate SRH and HIV.

Weaknesses:

- The district level indicated that nurses, midwives, clinical officers, counsellors and nursing assistants should be trained in both SRH and HIV services.
- Poor dissemination of SRH and HIV policies, policy guidelines and protocols.
- Inadequate inclusion of SRH and HIV integration in some aspects of the Integrated Management of Pregnancy and Childbirth (IMPAC): Essential Care Pregnancy Guidelines for Pregnancy, Childbirth and Newborn Care.

Funding:

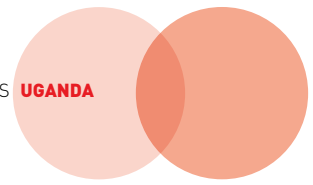
- The government is the main funder of the health sector and therefore of RH (excluding HIV activities). Other important sources of funding are FBOs. FBOs own most of the infrastructure for RH service delivery; pay staff; purchase RH drugs, medical equipment and supplies; and receive government subsidies.
- The main HIV funders and technical assistance providers have been international organizations and donor agencies. Some donors and agencies fund government activities either through budget support to the MoH or through project support directly to districts or implementing sites, while others support NGOs involved in HIV activities. Most development partners' funding is not aligned to support SRH and HIV linkages, and is provided through parallel programmes, with limited funding for staff recruitment.
- The 2008 PMTCT mapping of partners and districts revealed that each district now has donor support.
- Inadequate funding for health in general and for RH services in particular, is affecting the quality of services, including integrated services.
- Domestic HIV resources have been inadequate for implementing the NSP.
- Involvement of the private sector in SRH and HIV services integration is low.

Logistics, supply and laboratory support:

- Delinked supply chain management for the two programmes, with delays in SRH and HIV commodities supply, hinders service integration. For example, planning for and supply of SRH and HIV commodities, including contraceptives, condoms and antiretroviral therapy (ART), as well as commodity registration and monitoring, are undertaken separately. In addition, the supply of SRH and ART commodities uses the Pull System for inventory control, while supply of PMTCT commodities uses the Push System.
- Laboratory facilities serve the needs of SRH and HIV services both centrally and at the facility level.
- With scaling up of PMTCT (2008), HCT is available in all hospitals, in 91% of the Health Centre IV facilities (county-level, mini-hospital) and about 47% of Health Centre IIIs.

Monitoring and evaluation:

- There is a national HIV M&E framework, but none for RH, PMTCT or paediatric AIDS. SRH M&E is undertaken through the Health Management Information System (HMIS).
- The tools used for RH and HIV M&E in maternity services are fairly well integrated, containing both SRH and HIV indicators though not capturing integration of HIV services in FP and SRH services in HCT and ART.
- New areas of work such as cervical cancer are not integrated (lack of guidelines).
- M&E structures capture SRH programme integration results (service access reports), uptake of services (HMIS), quality (support supervision reports), and client satisfaction (client interviews and return visits).
- Most protocols and client cards, including the HMIS, contain checklists and indicators to monitor SRH and HIV services and integration, though not comprehensively.
- The number of HIV clients receiving SRH services is used as an SRH and HIV integration indicator, though the figure for SRH clients receiving HIV services is not used as an indicator.



3. Services level

Availability of integrated SRH and HIV services:

- Integrated service delivery exists, especially in lower facilities, but is unsystematic.
- PMTCT is integrated within SRH and ANC clinics, delivery care and PPC services.
- CSOs implement integrated SRH and HIV projects to a certain extent.
- PLHIV networks exist up to the district level.
- The adolescent health programme provides an opportunity for integration.

Weaknesses:

- No systematized linkages even when services exist in the same facility, particularly hospitals.
- Inadequate exploitation of entry points, other than PMTCT, for integrating SRH and HIV services, such as the integration of HIV and STI services with those offering FP and vice versa.
- There is a referral system for SRH and HIV services, but it needs to be revised as there is a lack of referral follow-up.
- There is a critical shortage of space in most health facilities which is particularly problematic for privacy and confidentiality, e.g. HIV counselling and testing (HCT).
- Poor utilization of maternity services (ANC, delivery care, and PPC).
- Difficult to engage men in addressing structural vulnerability. For example, men have been invited through home visits and invitation cards to accompany their wives to ANC services and to receive HCT, with little success.
- Inadequate community and family support.
- Limited availability of adolescent-friendly SRH and HCT services.
- Inadequate services for key populations, including men who have sex with men, people who use drugs, and sex workers.

SERVICE PROVIDER PERSPECTIVES:

- Approximately half of the 90 service providers interviewed cited shortage of equipment, space and staff time as constraints to linked SRH and HIV services.
- Over half of service providers interviewed cited the impact of linking SRH and HIV services as positive in terms of increased efficiency and time spent per client; and negative in terms of increased costs, workload and need for equipment, supplies and drugs.

SERVICE USER PERSPECTIVES:

- The majority of respondents were satisfied with services received. 78% of clients came for a specific service, and 75% received all requested services. The main reason for not receiving a service was its non-availability, with 26% being unaware of the reason.
- 134 out of 167 clients (80.2%) received one type of service, and 32 (19.2%) were referred on to further services.
- 80% of clients preferred receiving both SRH and HIV services at the same health facility. Advantages included: reduced transport costs (52.7%), reduced number of trips (44.5%), reduced waiting time (27%), increased efficiency (22.2%), and opportunities for additional services (22.2%). Disadvantages included: provider being too busy (40%) and increase in waiting time (27%).

LESSONS LEARNED AND NEXT STEPS

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

The rapid assessment (RA) tool was useful for collecting additional information from related ministries. It included an analysis of gender-based violence services, the findings of which will be useful for future planning. The findings will be very useful in assisting MoH and partners to develop the strategy and action plan to improve SRH and HIV programming. The RA tool can be adapted to address the specific RH and HIV needs of the country (e.g. adolescent and community health).

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

Opportunities for scaling up SRH and Rights and HIV/AIDS integration:

- Improved or integrated training materials and curricula, and M&E tools (integrated registers, client cards, reporting formats, supervision tools and HMIS) contribute to integrated data collection, M&E and supervision. Increased supplies and equipment, through integration of PMTCT in maternity services, improve staff motivation and quality of services.
- Despite inadequate human resources, those available could be given specific training in SRH and HIV service integration for the scaling up of SRH and HIV integration.
- Revision of guidelines and training protocols, including the IMPAC pregnancy care guidelines, could be used to fully incorporate guidelines for SRH and HIV service integration.

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?

Priority areas:

- advocacy for bi-directional linkages;
- advocacy for commitment of resources;
- strengthening linkages in SRH and ACP coordination, planning and supervision;
- SRH and HIV commodity programming;
- capacity building for integrated service delivery;
- quality improvement, technical supervision and monitoring; and
- service demand generation.

Priority services for integration:

- adolescent health services;
- condom promotion;
- focused ANC;
- FP in HCT and PMTCT;
- STIs;
- male partners' involvement;
- information, education and communication (IEC)/BCC;
- outreach programmes (key populations); and
- home-based care.

LESSONS LEARNED AND NEXT STEPS CONTINUED

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

- Increased international and donor community interest in supporting HIV activities. As a result, HIV programmes have been well funded compared to SRH programmes. The SRH programmes could take advantage of this and design interventions to tap resources.
- Previously donors focused their support separately on either SRH or HIV, according to their mandate. This is changing, especially for PMTCT, as these services are provided within maternity services so PMTCT can only function within functional RH services. In response, donors supporting PMTCT programme are now more flexible and willing to support maternity services, including infrastructural development.
- Major development partners for SRH and HIV programmes include:
 - UN organizations: UNDP, WHO, UNFPA, UNICEF, WFP and UNHCR;
 - Bilateral and multilateral agencies: USAID, GIZ, DFID, World Bank, SIDA, NORAD, DANIDA, Netherlands Development Cooperation, JICA, Italian Development Cooperation, Irish Aid, the French Development Agency, the European Union, the African Development Bank, Austrian Development Agency, CDC, GFATM, PEPFAR, GAVI Alliance.
 - International NGOs: AIDS International Model, Uganda Program for Holistic Development.
 - Other partners include national NGOs and FBOs, sectoral ministries, CSOs and CBOs, and networks or associations of key populations.
 - Some partners are donors and some are implementers of SRH or HIV programmes, or both.

Abbreviations

ACP	AIDS Control Programme
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
BCC	behaviour change communication
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CSO	civil society organization
DANIDA	Danish International Development Agency
DFID	UK Department for International Development
FBO	faith-based organization
FP	family planning
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	German Agency for International Cooperation
GNP+	Global Network of People Living with HIV/AIDS
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
HMIS	Health Management Information System
ICW	International Community of Women Living with HIV/AIDS
IMPAC	Integrated Management of Pregnancy and Childbirth
IPPF	International Planned Parenthood Federation
JICA	Japan International Cooperation Agency
M&E	monitoring and evaluation
MoH	Ugandan Ministry of Health
NGO	non-governmental organization
NORAD	Norwegian Agency for Development Cooperation
NSP	National Strategic Plan
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
PPC	post-partum care
RA	rapid assessment
RH	reproductive health
SIDA	Swedish International Development Agency
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	the UN Refugee Agency
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WFP	World Food Programme
WHO	World Health Organization

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