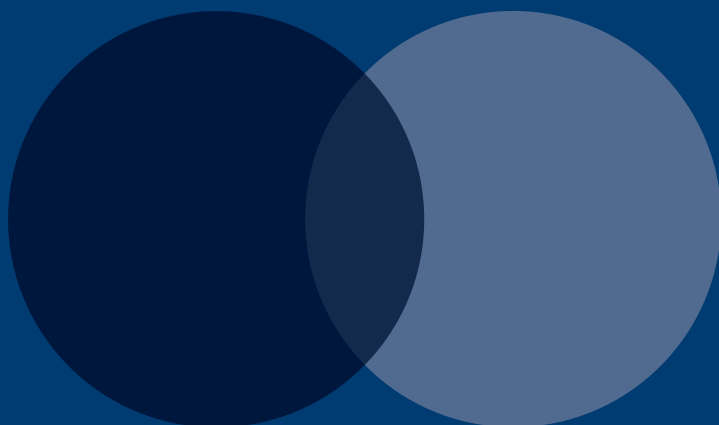




AFGHANISTAN



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 Afghanistan¹. 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?

Advocacy:

- Using the rapid assessment (RA) findings and recommendations as an advocacy tool by and with relevant stakeholders.
- Holding a national workshop based on the RA results to clarify the benefits of SRH and HIV linkages, identify key challenges and limitations, and identify supervision and monitoring mechanism for linkages.
- Conducting advocacy with policy-makers to support and strengthen existing SRH and HIV integration within health system delivery mechanisms (e.g. basic package of health services/BPHS and essential package of health services/EPHS).
- Documenting SRH and HIV integration best practices, and sharing these with all stakeholders to assist in supporting implementation of best practices and identify and remedy gaps in existing practices.

Coordination:

- Establishing a multidisciplinary working group with clear terms of reference to oversee, guide and advise on SRH and HIV linkages.
- Strengthening existing efforts to enhance UN and donor coordination of SRH and HIV linkages.
- Enhancing government and civil society SRH and HIV linkages and integration

coordination, through, for example, technical working groups, the Global Fund to Fight AIDS, Tuberculosis and Malaria's (GFATM) Country Coordinating Mechanism (CCM), and the HIV and AIDS Coordinating Committee of Afghanistan (HACCA). Note that the government has recently included a representative of people living with HIV (PLHIV) in the CCM.

Partnerships:

- Identifying and leveraging public-private partnerships to improve SRH and HIV linkages-related processes, including advocacy, capacity building, development of materials and monitoring and evaluation (M&E).

Human resources and capacity building:

- Strengthening the National AIDS Control Programme's (NACP) SRH and HIV linkages capacity by providing additional human resources for BPHS and EPHS implementation.
- Developing a standard SRH and HIV linkages training package and conducting training of a core group of trainers, with follow-up.

Monitoring and evaluation:

- Developing an overarching SRH and HIV linkages M&E plan.
- Strengthening the national M&E system to capture SRH and HIV linkages and sharing reports between the Reproductive Health (RH) Directorate, the NACP and the M&E Directorate.

1. This summary is based upon: *Rapid Assessment of Reproductive Health and HIV Linkages in Afghanistan*, European Commission, IPPF, UNFPA, WHO, Afghan Family Guidance Association and Ministry of Public Health of Afghanistan, 2011.

PROCESS

1. Who managed and coordinated the assessment?

The RA was undertaken jointly by the Afghan Family Guidance Association (AFGA) and the Ministry of Public Health (MoPH), with the financial support of a European Union (EU) funded project (2011–2013)² being implemented by AFGA.

The RA was supervised by a country team, comprising the MoPH (NACP, RH and M&E Directorates), UNFPA, WHO and other non-governmental organizations (NGOs) working in the HIV and RH sectors, civil society, Médecins du Monde (MDM) and CCM members. Note that due to prevailing stigma, it was not feasible to include key populations in the RA team.

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

The 13-person RA implementation team included an assessment coordinator, two consultants, nine field interviewers and one supervisor.

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

Yes. In total, 24 documents were reviewed, including policies, strategies and guidelines on SRH (5), HIV (6) and health systems strengthening (3), as well as the Constitution, laws (1), HIV-related reports (2) international guidelines (1), and national sector-wide strategies (3). Specific strategies, policies and plans included: Health and Nutrition Sector Strategy (2008–2013), Afghanistan National Development Strategy (2008–2013), National Reproductive Health Strategy (2003–2005), Draft National Reproductive Health Strategy (2010–2015), National AIDS Control Programme Strategic Plan Final Draft (2011–2015), National HIV Communication Strategy (2007), National Child and Adolescent Health Policy (2009–2013), and the Child and Adolescent Health Strategy (2009–2013). The guidelines reviewed covered family planning (FP) (2005), harm reduction (2008–2010), voluntary counselling and testing (VCT) (2008) and prevention of parent-to-child transmission (PPTCT) (undated), as well as the EPHS (2005) and the BPHS for Afghanistan (2009).

4. Was the assessment process gender-balanced?

In part, yes:

- The 13-person assessment team comprised eight men (61.5 per cent) and five women (38.5 per cent).
- Of the 43 people interviewed at the policy level, 39.5 per cent were female (n= 17) while 60.5 per cent were male (n=26).
- Of the 50 service providers, 35 were male and 15 female.
- Of the 50 clients interviewed, there were 37 females and 13 males.

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

The RA tool was adapted to the local context, including questionnaires for interviewees, and translated into Dari, with a leaflet developed for group interactions and meetings with stakeholders and policy-makers.

6. What was the scope of the assessment?

- The objectives of the RA included:
 - gaining an understanding of the current situation in terms of linking SRH and HIV at the at the policy, systems and service delivery levels;
 - identifying current critical gaps at the policy, systems and service delivery levels; and
 - developing a country-level action plan to address existing gaps.
- The RA focused on all types of health facilities under the BPHS and EPHS systems, including basic health centres (BHCs), health sub-centres, mobile health centres, comprehensive health centres (CHCs), and district, provincial, regional and specialized hospitals, as well as vertical programme health facilities (VCT, drop-in and prison health centres) located in Kabul, and Nangarhar and Parwan Provinces.

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

Yes, in total 43 people were interviewed from both the SRH and HIV sectors.

- Informal in-depth interviews were conducted with 10 key informants, including SRH and HIV experts, representatives of UNFPA, UNICEF, the United Nations Office on Drugs and Crime (UNODC) and WHO, and people living with HIV.
- Questionnaires were completed by:
 - 8 policy-makers (General Directorate of Policy and Planning, General Directorate of Health Service Delivery, Grant and Contract Management Unit, CCM and private and professional organizations);
 - 12 programme managers (NACP, RH Directorate, National TB Programme Manager);
 - 5 representative of donors and development partners, including GFATM, UNFPA, UNICEF, UNODC and WHO.
 - 11 civil society representatives, including an HIV-positive representative of AFGA.

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

Yes. In total, 50 service providers from both SRH and HIV services were interviewed, specifically in BPHS and EPHS health facilities, and through vertical services.

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

Yes. In total, 50 clients from both SRH and HIV services were interviewed when exiting BPHS and EPHS health facilities and vertical services.

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

In part. Due to prevailing stigma, it was not feasible to include key populations in the RA team. However, 11 members of the AFGA PLHIV network were interviewed.

FINDINGS

1. Policy level

Overview:

- Toth SRH and HIV national strategies and guidelines support SRH and HIV linkages; however there are no specific national SRH and HIV integration strategies and guidelines.
- BPHS and EPHS are the main service delivery systems and the best examples of bi-directional SRH and HIV linkages.
- Specialized services for HIV prevention and treatment, including harm reduction and antiretroviral therapy (ART), are implemented through vertical programmes with services available in key urban centres.
- Considering the socio-cultural context, disclosure of HIV status, contact tracing and sexual rights and orientations are controversial issues.

SRH-related:

- The National Reproductive Health Strategy Final Draft (2011–2015) provides for integrated approaches, emphasizing that comprehensive services should be available to all, especially to women and newborn children, integrating maternal and neonatal care, FP, nutrition, immunization, child survival, prevention and management of malaria, sexually transmitted infections (STIs) and HIV infections, and other aspects of primary health care.
- The operational plan mentions improving coverage and quality of STI services, as well as access for the general population, especially women.

HIV-related:

- The National HIV and AIDS Policy Final Draft (May 2011) reiterates the commitment to ensure that every person in the country has equitable access to HIV prevention, treatment, care and support services, and the right to live with dignity; however, there is no clear statement on SRH and HIV integration, though integration is supported through BPHS and EPHS.
- The goal of the Afghanistan National HIV and AIDS Strategic Framework-II (2011–2015) is to achieve universal access to HIV

prevention, treatment, care and support for key affected populations, vulnerable populations and people living with HIV. The Strategic Framework focuses on integrating HIV services into general health services, including RH, which is provided in BPHS and EPHS facilities.

- The National AIDS Control Programme Strategic Plan Final Draft (2011–2015) provides for improved linkages between HIV management of STIs, and Hepatitis B and C, including vaccination for people living with HIV.

Guidelines:

- Guidelines include: FP (2005), VCT (2008), HIV training manual (2009), harm reduction (2008–2010), TB, STI management, HIV Code of Ethics, PPTCT and post-exposure prophylaxis.

Legal framework:

- A number of issues arose during the RA, including:
 - While there is no policy or law regarding criminalization of HIV transmission, there are no anti-discrimination laws protecting PLHIV.
 - Based on the Afghanistan criminal and sharia laws, sex work, sex between people of the same sex, and drug use are criminalized and punishable.
 - FP services are available only to married couples.
 - Article 70 of the Civil Law contains different minimum ages for marriage for males and females – 18 and 16 years of age, respectively.
 - There is no HIV workplace policy (although NACP plans to develop one in the near future).
- According to the national HIV policy, all HIV testing should be voluntary, with no mandatory testing permissible.
- The NACP conducted training in 2012 of law enforcement and judicial agents (e.g. police and Ministry of Justice staff) on HIV and attitudes towards PLHIV.

2. Systems level

Partnerships:

- Major SRH partners include: MoPH (RH Directorate), UN agencies (UNFPA, UNICEF and WHO), donors (United States Agency for International Development/ USAID, EU, World Bank and Japan International Cooperation Agency/JICA) and national and international NGOs.
- Major HIV partners include: NACP, UN agencies (UNAIDS, UNICEF, World Bank and WHO), donors (GFATM and USAID), and national and international NGOs. Civil society organizations are members of HACCA.
- Major stakeholders support SRH and HIV integration, with champions including NACP, AFGA and UNICEF (through integration of the PPTCT programme into RH centres).
- There is no network of PLHIV; however, AFGA, MDM and NACP have begun to facilitate such a network and to build capacity.
- The MoPH has established the National Technical Coordination Committee (NTCC) for discussion and information sharing with donors and all national-level agencies.
- A lack of coordination is exacerbated by the absence of SRH and HIV integration guidelines and a multi-sectoral SRH and HIV integration working group.

Planning:

- There is no joint planning and insufficient collaboration in management and implementation between SRH and HIV programmes. However, HACCA has wide representation, including from the RH Directorate, which is involved in national HIV strategy development.
- Some SRH services (including STI prevention and management, and condoms to prevent unintended pregnancy) have been integrated into HIV planning; and some HIV services (e.g. VCT and PPTCT) have been integrated into SRH planning.

Human resources and capacity building:

- The greatest challenges for SRH and HIV service integration are quality and workload.
- BPHS and EPHS staff have received basic HIV information, although they need training and capacity building in

counselling, confidentiality and attitudes towards key populations.

- SRH and HIV linkages awareness raising and capacity building is needed at all levels. Linkages are a new concept, with low awareness of their value among many health workers, programme managers and institutions, and are not included in training materials and curricula.
- STI prevention and management are included in the SRH and HIV training materials for health service providers' in-service training and as part of pre-service training in medical universities and nursing schools.
- General information on HIV transmission modes is included in school curricula for grades four to twelve and in teacher training; however, there is no specific information on SRH issues in the school curricula.

Logistics, supply and laboratory support:

- The logistic and medical supply systems support effective SRH and HIV service delivery integration, though these need strengthening in remote areas.
- Laboratory facilities support SRH and HIV services in BPHS and EPHS.

Monitoring and evaluation:

- M&E structures do not collect data on SRH and HIV integration programmes and there is no specific M&E system for SRH and HIV linkages, including tools for integrated supervision.
- There are HIV-positive case report and referral forms which collect client-related information such as age, sex, marital status etc.

3. Services level

A. SERVICE PROVIDER PERSPECTIVES:

Overall:

- Generally policies and the health service delivery system, including BPHS and EPHS, support SRH and HIV integrated services.
- Shortage of staff training (88 per cent), space for offering private and confidential services (82 per cent), and lack of equipment (76 per cent) were identified as the greatest constraints to SRH and HIV integration.
- While 48 per cent of service providers considered that SRH and HIV integration will decrease service cost to clients and



86 per cent that it would reduce stigma against HIV-positive clients, 90 per cent or more considered that SRH and HIV linkage will increase service cost to facilities (90 per cent), time spent per client (94 per cent), providers' workload (96 per cent), and the need for additional supplies and equipment (96 per cent).

- Prevention and management of gender-based violence (GBV) is not fully integrated into the service delivery system, including in the BPHS and EPHS. Medical care is provided to survivors, but there are no proper screening and counselling services.

HIV integration into SRH services:

- CHCs, district, provincial and regional hospitals provide VCT in their facility, while health posts, health sub-centres and mobile health teams refer VCT clients to CHCs or hospitals.
- There are only two ART centres (Kabul and Herat) which provide management of opportunistic infections and HIV prophylaxis; home-based care; prevention for and by PLHIV; and HIV information services for key populations (people who use drugs, sex workers and men who have sex with men), and follow-up.
- PPTCT services have only been recently introduced in AFGA Family Welfare Centres in Kabul.
- BHCs, health sub-centres and mobile health centres provide syndromic STI management.
- Organizations working in HIV prevention coordinate their activities through national fora and meetings, and the NACP has memorandums of understanding with these NGOs.

SRH integration into HIV services:

- BPHS and EPHS facilities provide FP, STI prevention and management, and maternal and neonatal care.
- FP is a major component of post-abortion care at BHCs, CHCs and in district hospitals.
- Health posts, BHCs, health sub-centres and mobile health centres provide HIV prevention information and services to the general population, and condoms as part of FP services.
- CHCs, and district, provincial and regional hospitals provide VCT, HIV prevention information and services for the general population, and condoms.

- ART and VCT centre staff have been trained in FP in general, and specifically in STI management, however training and capacity building is needed in modern FP methods (e.g. use and management of side effects), counselling, GBV and post-abortion care.

B. SERVICE USER PERSPECTIVES:

- Most BPHS and EPHS clients came for maternal and child health services including FP, antenatal care, vaccination and child care.
- Drop-in-centre clients were referred to RH services in other health facilities.
- VCT services were not available in the BHCs and mobile health centres. Non-availability of services was the main reason for not receiving a service.
- Female condoms are not available, and talking about sexuality and relationships is taboo and difficult.
- 80 per cent of clients were mostly satisfied with the services they received.
- 80 per cent of clients preferred SRH and HIV services at the same facility, with only 10 per cent preferring services at different facilities. Advantages cited included reduced number of trips (90 per cent) and transportation costs (90 per cent), and opportunity to access additional services (40 per cent). The main disadvantages cited were that providers would be too busy (60 per cent), and increased waiting time (50 per cent).
- 80 per cent of respondents preferred to receive health services from the same provider, with only 10 per cent preferring different providers. The advantages and disadvantages were the same as those cited above.
- Suggestion for improving services included providing integrated services, preventing medical supply shortages, female health service providers and private counselling areas.

LESSONS LEARNED AND NEXT STEPS

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

- RA implementation provides an opportunity to undertake advocacy with all stakeholders about what SRH and HIV linkages mean, their importance, and how to support implementation.
- The RA found dramatically varying levels of understanding within different government bodies, while other stakeholders held fears that linkages would threaten jobs and reduce resources. Overall understanding of SRH and HIV linkages and integration was low.
- Of crucial importance are:
 - Partnership building, which takes time and coordination. Key to the process is bringing all key partners on board from the beginning, and investing time and energy in team building.
 - Encouraging the MoPH to lead the process of building ownership and leadership.
 - Allocating more time pre-RA to build understanding and commitment to SRH and HIV integration among policy-makers and programme managers.
- More partners could be mobilized to engage in SRH and HIV linkages, technical needs assessments and developing training materials, complemented by advocacy efforts at higher levels of the MoPH and CCM.

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

Next steps that have been taken:

- A joint monitoring visit from BPHS and EPHS to facilities in Perwan, Nangarhar, Balkh and Badakhshan Provinces, with the RA summary disseminated at the provincial level. A consolidated report of the visit and recommendations to NACP, MoPH, BPHS and EPHS implementer NGOs and AFGA has been shared with all relevant stakeholders. Coordination meetings for follow-up on recommendations are being held at the provincial level.
- A coordination meeting with MoPH policy level officials for validation of the RA.

Next steps planned:

- Organizing capacity-building workshops on SRH and HIV integration for health service providers from BPHS and EPHS implementer NGOs in the above four provinces (key recommendation from monitoring visit). First workshop was planned for Nangarhar Province, November 2012.
- Dissemination of RA report was planned for World AIDS Day 2012, depending on MoPH Independent Review Board validation.
- Coordination meeting with BPHS and EPHS implementer NGOs for orientation on proposal development for additional budget allocations (human resources, capacity building, commodities and infrastructure for VCT integration) in the next round of BPHS and EPHS contracts.

LESSONS LEARNED AND NEXT STEPS CONTINUED

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?**
- Advocacy with the MoPH's Grant and Contract Management Unit³ to accept comprehensive proposals from BPHS and EPHS implementing NGOs, including additional budgets for HIV activities (e.g. commodities, capacity building in HIV counselling and testing, and infrastructure such as separate counselling rooms). This is in response to the AFGA and MoPH joint monitoring visit, which found extensive gaps in the availability of HIV services, a lack of counselling space and lack of HIV awareness and knowledge among service providers. In response, BPHS and EPHS implementing NGOs were requested to include these in budgeted proposals for the next funding round of BPHS and EPHS projects.
- Advocacy with the M&E Directorate to revise the national M&E checklist to include HIV-related indicators for data collection in BPHS and EPHS service delivery facilities.
- Capacity building of BPHS and EPHS health service providers on SRH and HIV integration at the provincial level.
- Advocacy to promote SRH and HIV integration with provincial Public Health Directorates, BPHS and EPHS implementing organizations and other relevant stakeholders.

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

- There is no specific funding for SRH and HIV linkages, though UNICEF supports the PPTCT programme in selected provinces, i.e. technical and logistics support for VCT integration in RH centres.
- The main sources of SRH funding include USAID, EU and World Bank. In addition, JICA, UNFPA, UNICEF and WHO provide technical and financial support to the RH programme.
- The main sources of HIV funding include the World Bank (54 per cent), international NGOs (15 per cent), GFATM (14 per cent), United Nations (10 per cent), bilateral donors (6 per cent) and MoPH (less than 1 per cent).
- There are no donor restrictions on SRH components of HIV programmes, as HIV and SRH are included in the donor-funded BPHS. Both the HIV and SRH budgets have allocations for STI supplies and drugs, and the BPHS supplies HIV and SRH commodities and laboratory supplies to CHCs and district hospitals.
- All health services are free of charge, with data on out-of-pocket expenses unavailable.
- Acceptance of SRH and HIV integration at the policy level is an opportunity to improve systems and service delivery integration.
- Integrated health service delivery mechanisms at the national level (BPHS and EPHS) support and facilitate SRH and HIV integration.

3. The Grant and Contract Management Unit is the only body that accepts and analyses proposals from NGOs (BPHS and EPHS implementers) for the running of the health system.

Abbreviations

AFGA	Afghan Family Guidance Association
AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
BHC	basic health centre
BPHS	basic package of health services
CCM	Country Coordinating Mechanism
CHC	comprehensive health centre
EPHS	essential package of hospital services
EU	European Union
FP	family planning
GBV	gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+	Global Network of People Living with HIV/AIDS
HIV	human immunodeficiency virus
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
HACCA	HIV/AIDS Coordination Committee of Afghanistan
JICA	Japan International Cooperation Agency
M&E	monitoring and evaluation
MDM	Médecins du Monde
MoPH	Ministry of Public Health
NACP	National AIDS Control Programme
NGO	non-governmental organization
PLHIV	people living with HIV
PPTCT	prevention of parent-to-child transmission (of HIV)
RA	rapid assessment
RH	reproductive health
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nation Population Fund
UNICEF	United Nation Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WHO	World Health Organization

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