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 Sri Lanka\(^1\). 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 level:**
- Develop a national SRH and HIV integration policy and/or strategy with related guidelines which can be integrated at various stages of the life cycle, and identify the roles and responsibilities of stakeholders to assist service providers to implement interventions uniformly.
- Take steps to review and revise laws (e.g. Penal Code Section 365a, Vagrants Ordinance No. 4 (1841), the Contagious Diseases Ordinance No. 17 (1867), and the Brothels Ordinance No. 5 (1889)) to create an enabling environment for prevention and management of sexually transmitted infections (STIs) and HIV, for prevention of gender-based violence (GBV), and to prevent adverse pregnancy outcomes, including teenage pregnancies.
- Identify specific SRH and HIV integration and linkage indicators.

**Systems level:**
- Gradually scale up HIV service integration in SRH settings, taking into consideration HIV epidemiology, infrastructure, human resources and logistics. SRH service integration in HIV setting should be further strengthened.
- Develop the capacity of public and private sector SRH and HIV care providers.
- Develop a single SRH and HIV integration training curriculum.
- Establish a coordinated logistics system for commodities (including condoms and contraceptives), and distribute information and education material to all stakeholders regularly.
- Strengthen coordination of integrated SRH and HIV activities at the programmatic and service delivery levels (after discussions with provincial authorities about staffing and workload).

**Services level:**
- Plan periodic reviews with policy and programme managers, as well as service providers, to motivate service providers.
- Identify and fill SRH- and HIV-related services cadre positions.

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1. This summary is based upon: Rapid Assessment Review of Sri Lanka, Family Planning Association of Sri Lanka, 2012.
1. Who managed and coordinated the assessment?
The Family Planning Association of Sri Lanka (FPASL) managed and coordinated the rapid assessment (RA).

2. Who was in the team that implemented the assessment?
One consultant, Dr Sujatha Samarakoon, advised and supported by an assessment team consisting of 16 people: policy-makers (3), academics (3), a consultant venereologist, representatives of donor agencies (3), representatives of non-governmental organizations (5), and a person living with HIV.

3. Did the desk review cover documents relating to both SRH and HIV?
Yes. The desk review covered 38 documents addressing both SRH- and HIV-related issues, including the Constitution, a national charter, national policies (7), strategies (1), plans (2), guidelines (2), laws (6), national and international reports and studies (13), international declarations and frameworks (3), and a website.

4. Was the assessment process gender-balanced?
It is not possible to provide a definitive answer:
- The consultant was female.
- The 16-person assessment team consisted of 9 females and 7 males.
- 6 policy-makers and 10 programme managers, not disaggregated by gender.
- 32 service providers, not disaggregated by gender.
- 46 clients: 21 HIV service clients, not disaggregated by gender; and 25 female SRH service clients.

5. What parts of the Rapid Assessment Tool did the assessment use?
The Rapid Assessment Tool was used in its totality, with only minor adaptations to the local context.

6. What was the scope of the assessment?
To assess current SRH and HIV linkages at the policy, programme (systems) and service delivery levels.

7. Did the assessment involve interviews with policy-makers from both SRH and HIV sectors?
Yes. Six policy-makers and 10 programme managers from both the SRH and HIV sectors were interviewed. Due to their schedules it was not possible to conduct group interviews or focus group discussions.

8. Did the assessment involve interviews with service providers from both SRH and HIV services?
Yes. In total, 32 service providers were interviewed, including 18 SRH and 11 HIV service providers from the public sector, as well as 3 service providers from the private sector.

9. Did the assessment involve interviews with clients from both SRH and HIV services?
Yes. In total, 46 clients were interviewed, including:
- From HIV services: 21 clients from two HIV clinics randomly selected from 11 HIV clinics.
- From SRH services: 25 clients (all female and aged between 18 and 38) from all nine provinces.

10. Did the assessment involve people living with HIV and key populations?
A person living with HIV was included in the assessment team, and client interviews included people living with HIV and representatives of key populations.
FINDINGS

1. Policy level

Policies:
- The government is responsible for health-related policy development and programme planning, and provincial Ministries of Health (MoHs) are responsible for implementation.

Legal framework:
- Laws are comprehensive, but implementation is slow. For example, the Prevention of Domestic Violence Act (2005) is only slowly being enforced and used for redress.
- Laws in relation to key populations (including sex workers, men who have sex with men and injecting drug users) are barriers to effective HIV programmes. Specifically:
  - Regarding sex work, the Vagrants Ordinance No. 4 (1841), the Contagious Diseases Ordinance No. 17 (1867) and the Brothels Ordinance No. 5 (1889) are all inconsistent with the principle of non-discrimination. The National STD/AIDS Control Programme (NSACP) is initiating a review through the Legal and Ethical Issues Subcommittee.
  - Regarding same sex relations, the Penal Code Section 365a criminalizes homosexual activity by men or women, although this law is generally not enforced.

Policy-makers:
- Most policy-makers and programme managers interviewed were aware of health and legal policies and laws that support SRH and HIV integration, though some were unaware of the extent to which these address the rights and SRH needs of people living with HIV.
- Regarding HIV service integration into SRH, most policy-makers and programme managers were aware that prevention of parent-to-child transmission (PPTCT) Prong 1 (primary prevention of HIV among women of reproductive age) is integrated, although it needs a phased scale-up at national level.
- Almost all policy-makers stated that HIV is well integrated into STI services, with SRH-related services such as family planning (FP) and GBV being integrated into HIV care, creating opportunities for systematic referrals. There has been some HIV service reorientation to accommodate SRH (e.g. making FP available, and providing FP, HIV counselling and STI management training).

2. Systems level

In Sri Lanka, the health infrastructure model supporting delivery of SRH HIV integrated services is different to that seen in many South Asian (SA) countries which is aligned with that conceptualized in the IPPF SRH HIV framework. In Sri Lanka, STI and MCH/RH programs are standalone programs and not combined, as in other SA countries. In 1987, Sri Lanka integrated HIV into STI services, and the STI/HIV program and the MCH/RH programs initiated SRH HIV integrations before the 2011 UN High level Declaration. The MCH and STI/HIV systems were planned well and are functioning successfully, i.e. maintaining low HIV prevalence. SRH is well integrated into HIV services, while HIV integration into SRH services is progressing satisfactorily.
Partnerships:

• There is no Technical Working Group for SRH and HIV Integration [SRH and HIV are already linked].

• SRH and HIV linkages champions include programme managers, and Family Health Bureau (FHB) and NSACP PPTCT focal points.

• Major MCH programme partners include UNICEF, UNFPA and WHO. FHB closely coordinates with the Provincial Health Administration, with limited civil society organization (CSO) partnerships.

• Principal NSACP partners include the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNAIDS, UNFPA, WHO and World Bank. Other partners include:
  • Health sector entities, including FHB and National Blood Transfusion Service.
  • Other sectors, including Ministry of Labour, National Dangerous Drug Control Board, National Child Protection Authority, Department of Prisons, Sri Lanka Bureau of Foreign Employment, plantation sector, tri-forces (unified military comprising the national army, navy and air force) and police.
  • CSOs engaged in key population outreach, organizations of people living with HIV, the Business Coalition on HIV/AIDS, FPASL, academia and the private sector.
  • Networks of people living with HIV, young people and men who have sex with men have been involved in the development of the National HIV/AIDS Policy and the NSP. In addition:
    • People living with HIV have implemented HIV and positive prevention, treatment counselling and positive living; however, they have minimal involvement in SRH planning and programming.
    • Young people have been involved in awareness raising, skills building, advocacy, condom promotion, and prevention of HIV, unwanted pregnancy and GBV.
    • Networks of men who have sex with men have been involved in awareness raising, skills building, and condom distribution.
  • There are no networks of sex workers and injecting drug users.

Planning:

• FHB is responsible for MNC planning, implementation and monitoring, and developed the National MCH Policy and programmes with multisectoral involvement. FHB reports to the MCH Advisory Committee, which includes MoH senior officials and directorates, including NSACP.

• The National AIDS Committee is the highest HIV coordination body and has multisectoral representation, including corporate and non-governmental sectors. NSACP developed the National AIDS Policy and NSP.

Human resources and capacity building:

• NSACP focal points include PPTCT, STI care, HIV care and support, counselling and strategic information management.

• FHB focal points responsible for SRH and HIV interventions include PPTCT, FP, adolescent health and monitoring and evaluation (M&E).

• Peripheral STI clinics and health units have trained medical officers; however, the numbers of assisting staff are inadequate and unequally distributed, with frequent shortages.

• FHB regularly builds the capacity of primary health care (PHC) and labour room staff, including on PPTCT and STIs, with the MCH Programme delivering a comprehensive antenatal service package (syphilis screening, FP counselling, HIV-related information and promotion of voluntary counselling and testing/VCT). FHB is piloting an upgraded antenatal service package for national phased implementation from 2013, requiring strengthened human resources and capacity building.

• The private sector provides well integrated SRH and HIV services.

Logistics, supply and laboratory support:

• The National Reference Laboratory carries out STI and HIV investigations, including confirmatory HIV tests and CD4 counts, with viral load testing to be introduced shortly.

• Cervical cytology is available in about 50 per cent of STI clinics, and almost all provide syphilis and HIV testing.

• Antenatal clinics implement the antenatal package, and the syphilis tests are sent to STI clinics or hospital laboratories.
• Providing condoms, a principal task of SRH and HIV programmes, occurs in almost all centres. However, STI clinics are supplied by NSACP, while PHC services are supplied by FHB (which also provides contraceptives to PHC and STI services, the latter upon request).

Monitoring and evaluation:
• There are no SRH and HIV integration indicators.
• NSACP and MCH have separate M&E systems for gathering SRH- and HIV-related data, with both including some indicators for international reporting.

3. Services level

A. SERVICE PROVIDER PERSPECTIVES:

HIV services:
• STI prevention and management are provided by all HIV care providers, as are FP, condoms, information and services for the general population, information for key populations (female sex workers and men who have sex with men), and PPTCT Prong 1 interventions.
• HIV services (including laboratory investigations, STI treatment and antiretroviral therapy/ART) and SRH services are provided free of charge by trained personnel.

SRH services:
• All SRH facilities were providing condoms, FP and MCH care, with 44 per cent providing prevention of unsafe abortions, 33 per cent STI care, and 27 per cent GBV services.
• All public SRH centres routinely offered condoms, with 44 per cent offering HIV information and/or PPTCT Prong 1, and 22 per cent offering HIV counselling and testing (HCT). All private sector SRH centres offered HCT, condoms and HIV information.
• None of the SRH providers provide opportunistic infection prophylaxis or ART.
• Of all SRH services, only one private sector facility provided services to key populations.
• The main constraints on SRH and HIV service integration were staff shortages, time, low motivation and equipment shortages. In terms of SRH and HIV service integration impact, the perception is that the cost of services would increase, but the cost to the client and stigmatization would decrease.

B: SERVICE USER PERSPECTIVES:

HIV services:
• All clients who came for a particular service received it, with 57 per cent seeking STI care. All received condoms and HCT.
• 75 per cent preferred receiving SRH and HIV services from the same facility, citing reduced number of trips, transport costs and waiting time (75 per cent), reduced stigma (25 per cent) and improved efficiency (10 per cent). Of the 25 per cent who preferred different facilities, all cited embarrassment from discussing HIV with a provider from the same village, and thought the provider would be too busy.
• Suggestions to improve services included increased clinic space and more staff. Regarding integration, 75 per cent preferred having all services under one roof, though 75 per cent preferred to receive HIV services away from their village.
• Regarding client satisfaction, 48 per cent were either mostly satisfied or very satisfied.

SRH services:
• Of the 68 per cent of clients who had sought MCH services, 64 per cent had received the care they sought. Furthermore, 48 per cent had come for FP services, and all except one received the care they came for. Ten clients (40 per cent) were referred to other services.
• When questioned whether they received all the services they wanted during their visit, 14 (56 per cent) had; however, 20 per cent had not. Of these, most had arrived on the wrong date for the service.
• 85 per cent of clients preferred SRH and HIV services from the same facility because it is easier, saves time and travel costs.
• Suggestions to improve services included holding clinics on Sundays and public holidays, increasing the number of Public Health Midwife home visits, decreasing waiting time, increased staff numbers, and improved facilities.
• Regarding client satisfaction, the majority were mostly satisfied (56 per cent). A further 16 per cent were very satisfied, and 16 per cent were somewhat dissatisfied.
1. What lessons were learned about how the assessment could have been done differently or better?

- While the existing health infrastructure challenged the implementation of the RAT to some extent, the data showed that it has not limited integrated service delivery, thereby demonstrating that the strength of SRH HIV integration is its adaptability to different country contexts.
- More time for the RA would have been helpful.
- The tool was used as a ‘standalone’ activity, although it could be integrated into a larger review of the national response.

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

- The recommendations have been disseminated at different levels in order to prioritize and design programmes.
- The recommendations are also being shared with CSOs through workshops, and plans are in place to address the province level.

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?

At policy level, FHB’s MCH Programme has nominated two components to improve service quality: the life cycle approach and packaging interventions. FP is a cross-cutting theme with different components of the MCH Programme, including various HIV interventions.

At the systems and service delivery levels:

- Packaging of services permits multiple interventions as well as links with other programmes. For example, PPTCT and empowered community service activities are conducted collaboratively, with FHB identifying target populations and NSACP providing treatment and care.

- NSACP and FHB have jointly developed information, education and communications materials to target pregnant women with syphilis, and the antenatal care package has been upgraded to provide information on STIs and HIV, including risk factors, behaviours and testing.

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

- The government meets 93 per cent of health expenditure.
- The main source of funding for the MCH Programme is the government with international partners, including UNFPA and UNICEF supporting selected FHB activities, and WHO providing technical assistance when required.
- The main source of funding for NSACP is the government with donors, including GFATM, UNFPA, UNICEF and WHO contributing between 30 and 35 per cent. In 2010, a National Aids Spending Assessment was undertaken with UNAIDS support.
- It is possible that increased engagement with the private health and industrial spheres of the corporate sector may lead to identification of mutually beneficial funding partnerships. A project partners’ workshop held after the RA (April 2012) showed that opportunities exist for capacity building for integrated approaches in the private health sphere. In 2013, the European Union-funded IPPF South Asia Regional Office Advocacy Project on SRH and HIV Integration, implemented by FPASL in Sri Lanka, hopes to take forward the workshop’s recommendations to explore opportunities to engage with the private health and industrial spheres to further SRH and HIV integration.
### Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
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<td>ART</td>
<td>antiretroviral therapy</td>
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<td>CSO</td>
<td>civil society organization</td>
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<td>FHB</td>
<td>Family Health Bureau</td>
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<td>FPASL</td>
<td>Family Planning Association of Sri Lanka</td>
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<td>FP</td>
<td>family planning</td>
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<td>GBV</td>
<td>gender-based violence</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>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>NSACP</td>
<td>National STD/AIDS Control Programme</td>
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<td>NSP</td>
<td>National HIV/AIDS Strategic Plan</td>
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<td>PHC</td>
<td>primary health care</td>
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<tr>
<td>PPTCT</td>
<td>prevention of parent-to-child transmission (of HIV)</td>
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<td>RA</td>
<td>rapid assessment</td>
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<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
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<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VCT</td>
<td>voluntary counselling and testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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