Consultation to Discuss Country Implementation of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages

IPPF, UNAIDS, UNFPA and WHO

1-3 December 2010, Geneva
ACRONYMS

ART     Antiretroviral therapy
CDC     Centres for Disease Control
FHI     Family Health International
Global Fund  Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+    Global Network of People Living with HIV
HSS     Health systems strengthening
ICW     International Community of Women Living with HIV
IPPF    International Planned Parenthood Federation
MENA    Middle East and North Africa
MNH     Maternal and newborn health
MSM     Men who have sex with men
NGO     Nongovernmental organisation
SOGI    Sexual orientation and gender identities
SRH     Sexual and reproductive health
STI     Sexually transmitted infection
UNAIDS  Joint United Nations Programme on HIV/AIDS
USAID   United States Agency for International Development
UNFPA   United Nations Population Fund
WHO     World Health Organisation

DEFINITIONS\(^1\)

**Bi-directional**
Both linking SRH with HIV-related policies and programmes and linking HIV with
SRH-related policies and programmes.

**Integration**
The joining together of different kinds of SRH and HIV services or operational
programmes to ensure and, perhaps, maximize collective outcomes. This includes
referrals from one service to another and is based on the need to offer
comprehensive services.

**Linkages**
The bi-directional synergies in policy, programmes, services and advocacy between
SRH and HIV. This refers to a broad human rights-based approach, of which service
integration is a subset.

**Rapid Assessment Tool** *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A
Generic Guide*, IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives,
2009.

\(^1\) *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A
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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

During 1-3 December 2010, a Consultation to Discuss Country Implementation of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages was co-hosted by IPPF, UNAIDS, UNFPA and WHO, in collaboration with the other key partners that led the development of the tool (GNP+, ICW and Young Positives). The Consultation involved participants from: 16 countries that have implemented the tool; 9 countries that plan, or have started, to implement the tool; and regional and international partners. It focused on six themes:

Theme 1: SRH & HIV linkages and the rapid assessment tool

This addressed the rationale for SRH & HIV linkages – a critical approach to achieving Millennium Development Goals 5 and 6, with increasingly proven benefits (such as enhanced programme efficiency, reduction in stigma and discrimination and improved access to services, including for PLHIV and key populations). The Rapid Assessment Tool is based on key principles (such as attention to human rights and gender) and enables countries to gain a ‘snap shot’ of current national linkages, identify gaps and develop action plans. Its use should be coordinated by a multi-sectoral team, involve a wide range of stakeholders and focus on the three levels of policy, systems and service delivery. The tool is available in Arabic, English, French, Russian and Spanish, including from www.srhhivlinkages.org.

Theme 2: Getting the SRH & HIV linkages assessment process right

The participating countries shared their good practices and recommendations for coordinating and managing an SRH & HIV linkages assessment. Examples included the need to ‘prepare the soil’ - by securing the basics (political support from both the SRH and HIV programme, funding, technical expertise and engagement of national leadership) from the start. They also included the need to: invest in consensus building; get to know the tool and adapt it to the country context (while not ‘adapting out’ sensitive issues, such as key populations); and use the assessment to advocate on why linkages matter. Meanwhile, in terms of involvement in an assessment, the recommendations included: have an assessment team that involves all key stakeholders (not only the Ministry of Health and UN agencies); maximise the broker role of UN agencies to secure government involvement and build UN/donor coordination; and develop tailor made strategies to involve PLHIV and key populations (where possible, working directly with such communities, rather than NGOs that work with them).

Theme 3: Key findings of SRH & HIV linkages assessments to date

Countries that had implemented the Rapid Assessment Tool shared their key findings, confirming both similarities and differences across contexts. For example:

- **At the policy level**, while some countries found strong political will and strategies for SRH & HIV linkages, others found national strategies, legislation and policies to be unsupportive – due to being inadequate, neglectful of specific groups (such as key populations) and/or not rolled-out to district and provincial levels. Meanwhile funding for linkages is often inadequate, heavily dependent on external sources and/or affected by poor donor coordination.

- **At the systems level**, while some countries found strong partnership for linkages, many others found a lack of coordination mechanisms, with national responses to SRH and HIV managed vertically, with little joint planning. Meanwhile, countries had diverse findings in relation to capacity building, logistics and monitoring and evaluation – with some reporting progress on linkages, but others finding a lack of ‘joined up’ thinking and action.
• **At the service delivery level**, countries found that integration predominantly takes place among selected services and/or through specific entry points. In many countries, SRH & HIV integration is limited and tends to occur by default (due to shortages of human resources). Service providers often have different levels of understanding about linkages and are limited by unhelpful clinical standards. Service users often welcome the benefits of linkages (especially the ‘one stop shop’), but, in practice, still experience significant barriers to accessing SRH and/or HIV services.

**Theme 4: Overcoming challenges to linking SRH & HIV**

The participants identified concrete, practical solutions to five critical challenges to linkages:
1. **Coordination and accountability.** Solutions include having: a coordination strategy and guidelines; a multi-sectoral coordination body driven by the host country; coordination at the highest levels; and a formal, national SRH & HIV linkages policy.
2. **Policy and legal barriers to service delivery.** Solutions include: establishing a Technical Working Group to identify actions on the results of the linkages assessment; identifying existing, supportive laws and policies that can address barriers to linkages; exploring inconsistencies and loop holes in relevant legislation; gathering data and evidence relating to key populations; and involving lawyers and legal bodies in assessments and follow-up.
3. **Capacity building of health care providers.** Solutions include: carrying out an assessment of facilities’ needs and health workers’ capacity relating to linkages; developing training materials on linkages; and multiplying the impact of linkages training (such as through training of trainers).
4. **Stigma discrimination.** Solutions include: introducing protective legislation; translating human rights-based frameworks into national policies; actively involving PLHIV and key populations in the development of programmes and policies; and training health workers on relevant issues.
5. **Donor conditionality:** Solutions include: building country ownership of programmes; advocating to power brokers (to shape national strategies and donor relations); and aligning linkages efforts with national monitoring and evaluation systems.

**Theme 5: Donor support for SRH & HIV linkages**

Here, the key messages included that the Global Fund provides a critical opportunity for linkages – with the mechanism willing to fund a range of SRH initiatives (provided there are proven links to HIV outcomes). Specific opportunities include the: Gender Equality and Sexual Orientation and Gender Identities strategies; and new policy on CCM funding (which can, for example, provide funds for the implementation of the Rapid Assessment Tool and for CCM capacity building, including related to linkages). A WHO study on the inclusion of SRH components in HIV proposals to Rounds 1-9 found that, while the proportion of proposals encouraging linkages has progressively increased, the mechanism remains under-utilized. Meanwhile, other opportunities to engage donors on SRH & HIV linkages include USAID’s Global Health Initiative and WHO’s Global Health Sector Strategy for HIV 2011-15.

**Theme 6: Next steps – strengthening SRH & HIV linkages at the national level**

The Consultation concluded with the participating countries planning their next steps – in terms of follow-up actions to be taken. Examples of identified priorities included: strengthening national coordination and leadership of SRH & HIV linkages work; agreeing a national minimum package for linkages; developing training materials and capacity building on linkages; strengthening linkages among referral, logistics and commodities systems; positioning attention to linkages within dialogue on the broader national health systems; and using the involvement of key populations to advocate on SRH rights. The participants committed to confirming and expanding upon their plans on return to their country and to finalising their Linkages Country Summary – a synthesis of their assessment process, findings and recommendations to be used for advocacy among relevant stakeholders.
INTRODUCTION

Introduction to consultation

This report summarises the key issues and actions from a Consultation to Discuss Country Implementation of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages\(^2\). The Consultation took place on 1-3 December 2010 at the World Health Organisation (WHO), Geneva, and was co-hosted by the International Planned Parenthood Federation (IPPF), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA) and WHO. It was carried out in collaboration with the other key partners that led the development of the Rapid Assessment Tool - the Global Network of People Living with HIV (GNP+), International Community of Women Living with HIV (ICW) and Young Positives.

Consultation aim, participants and programme

The aim of the Consultation was for countries to: share their experiences and results from implementing the Rapid Assessment Tool; review good practice for linkages; and identify actions to improve health, human rights and gender equality related to sexual and reproductive health (SRH) and HIV. The outcomes would support countries to plan national follow-up to strengthen linkages, including activities for inclusion in proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund).

The Consultation involved participants [see Annex 1 for a full list] from:

- 16 countries that have already implemented the Rapid Assessment Tool, represented by national stakeholders from the National AIDS Control Programme, Ministry of Health/Reproductive Health Units and/or civil society organisations.
- 9 countries that plan to, or are at the early stages of, implementing the Rapid Assessment Tool, represented by a stakeholder involved in the process.
- Regional and international partner organisations involved in policy and/or programme development related to SRH & HIV linkages.

The Consultation was chaired by representatives of the key partners, as well as other international organisations, such as the Global Fund, GNP+, Family Health International (FHI) and United States Agency for International Development (USAID). The programme combined presentations, plenary sessions and regional group work [see Annex 2]. The sections of this report summarise the six main themes addressed.

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THEME 1: SRH & HIV LINKAGES AND THE RAPID ASSESSMENT TOOL

What are SRH & HIV linkages and why do they matter?

‘SRH & HIV linkages’ refers to the bi-directional synergies in policy, systems and services between SRH and HIV. The rationale includes that: most HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding; and sexual and reproductive ill health and HIV share common root causes, such as gender inequality, human rights violations and marginalisation of key populations. The approach has significant potential benefits [see Figure 2], some of which have been demonstrated through a systematic review3.

The most compelling argument for linkages is that it makes ‘people sense’4. Acknowledging that health systems need to reach people where they are, SRH services provide a platform upon which HIV interventions can be built. Examples include female and male condom provision for dual protection from unintended pregnancies and sexually transmitted infections (STIs), including HIV. Similarly, HIV services can strengthen SRH services, such as sexuality counselling, family planning and referral for maternal and newborn health (MNH) services.

Scaling up and integrating comprehensive SRH & HIV services provides a unique opportunity to improve coverage, quality of care and programme efficacy. Moreover, it requires strengthening and re-orientating systems, such as partnerships, coordination mechanisms, capacity building and commodities security. It also involves going beyond services and health systems strengthening (HSS) to address structural determinants through relevant laws and policies.

The global agenda on linkages formally began in 2004 with the Glion Call to Action5 and New York Call to Commitment6. The approach has secured increasing support and is now recognized as critical to the universal access goals of HIV and reproductive health – Millennium Development Goals (MDGs) 5 and 67.

[Note: For more information, please see the SRH and HIV Linkages Resource Pack. This has been developed by the Inter Agency Working Group on SRH & HIV Linkages and including information materials, policy commitments and tools: http://www.srhhivlinkages.org/en/index.html].

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5 Glion Call to Action, UNFPA and WHO (2004).
What is the Rapid Assessment Tool?

In 2009, IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives developed a tool to assess the bi-directional linkages between SRH and HIV. The objectives of the Rapid Assessment Tool are to enable countries to assess current national SRH & HIV linkages, identify gaps and contribute to the development of country-specific action plans. It is based on a set of principles, including: addressing structural determinants; focusing on human rights and gender; promoting a coordinated and coherent response; meaningfully involving people living with HIV (PLHIV); fostering community participation; reducing stigma and discrimination; and recognizing the centrality of sexuality.

The tool can be used as a stand-alone activity or as part of a larger review of national strategies and responses. It can be adapted to local contexts and translated into local languages. It is envisaged that the process takes approximately three months, with a budget of US$ 30-50,000. It should be coordinated by a multi-sectoral assessment team, including representatives of civil society organisations and PLHIV. Implementation involves outreach to and involvement of a wide range of relevant stakeholders in the SRH and HIV fields, including policy makers, civil society (including networks of people living with HIV and key populations), international partners, programme managers, service providers and clients.

The tool is structured in three parts:

1. **Policy:** This includes: political positions; national policies and guidelines; and funding and budgetary support.
2. **Systems:** This includes: partnerships; planning, management and administration; staffing, human resources and capacity; logistics and supplies; laboratory support; and monitoring and evaluation.
3. **Service delivery:** This is divided into service provider interviews and client exit interviews.

The implementation of the tool involves a series of steps and methods. These usually include: establishing an assessment team; selecting a coordinator; conducting a desk review; developing an outline of the assessment process; hosting group discussions with policy and programme stakeholders and programme managers; training and supervising field interviewers; analyzing data and compiling a report; and reviewing the findings and deciding on next steps.

The tool has been produced in five languages (Arabic, English, French, Russian and Spanish). It is available from all of the key partners that led its development and at www.srhhivlinkages.org.
THEME 2: GETTING IT RIGHT - THE SRH & HIV LINKAGES ASSESSMENT PROCESS

This theme explored the process of implementing an assessment of SRH & HIV linkages. As described, the Rapid Assessment Tool requires intensive activity within a limited timeframe and budget. The session started by asking those countries which have already used the tool to identify their key challenges, good practices and recommendations in relation to coordinating and managing the process.

Figure 5: Challenges, good practices and recommendations for coordinating SRH & HIV linkages assessments

<table>
<thead>
<tr>
<th>Challenges:</th>
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<tr>
<td>• The coordination of assessments is particularly challenging in contexts where SRH and HIV are managed by <strong>different, vertical units/programmes</strong> and/or where the sectors are not used to working together.</td>
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<td>• The donor conditionality of a <strong>short timeframe</strong> to implement the assessment can restrict the potential to involve a full range of stakeholders (such as PLHIV and key populations) and to have full consultation. This can contribute to the process being driven by the Ministry of Health, with little ownership among wider stakeholders. In some cases, assessments have actually needed 5-7 months.</td>
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<td>• At first glance, the <strong>tool</strong> can seem lengthy and complex. Without time to understand the tool, it is not immediately clear why issues and questions appear to be repeated and how to get started.</td>
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<td>• <strong>Funding</strong> can be a challenge. In some countries, the budget was inadequate to do the assessment in full. In others, there was a lack of resources for follow-up, such as action planning and implementation.</td>
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<th>Good practices and recommendations:</th>
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<tr>
<td>✓ Ensure that <strong>the basics</strong> – political support from both the SRH and HIV unit/programme, funding, technical expertise and engagement of SRH and HIV leaders – are in place before starting.</td>
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<tr>
<td>✓ In particular, ensure <strong>high-level endorsement</strong>. If SRH and HIV are different units/programmes, then go higher up, for example to the level of Directorate or Ministry of Health.</td>
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<tr>
<td>✓ Start the process by investing in <strong>consensus building and planning</strong>, including developing a working group and clear decision-making processes. For example, in Tunisia, it was important to reach agreement among key stakeholders about the selection of the 30 sites for the assessment (15 focused on SRH, 15 on HIV).</td>
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<tr>
<td>✓ Start by <strong>piloting the tool</strong> in 2-3 locations. Use the lessons learned to adapt it to meet local contexts.</td>
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<td>✓ Provide the data collectors with <strong>thorough training</strong> - to fully understand the process and feel ownership.</td>
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<tr>
<td>✓ <strong>Get to know the tool very well</strong> - dissecting its different sections (policy, systems and services) and understanding how they complement each other.</td>
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<tr>
<td>✓ Then adapt the tool to the <strong>local context and language</strong>. For example, in Lebanon, the team translated the tool into Arabic and adapted it, including through inputs from PLHIV and MSM. This led to changes, such as the replacement of the term ‘abortion’ with a legally acceptable alternative and the removal of attention to female condoms (which are not available in the country).</td>
</tr>
<tr>
<td>✓ Consider collaborating with <strong>research institutions</strong> to gain from their technical expertise (for example in data analysis) – while bearing in mind that the tool is not designed as a research instrument (but to give a ‘snapshot’ of linkages at a specific time and place). Carefully consider the type and skill set of consultants needed to carry out the assessment. For example, in Belize, having a local, but independent, consultant ensured that there was not only knowledge of the local context, but neutrality – enabling stakeholders to speak openly.</td>
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<tr>
<td>✓ View assessments as a critical opportunity to gather relevant stakeholders together, build momentum for linkages, provide <strong>evidence</strong> and identify critical links. Use these resources to inform action plans.</td>
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✔ Where available, access technical support to build understanding of and buy-in to the Rapid Assessment Tool. For example, for countries in the Middle East and North Africa (MENA), attending regional training meetings organised by UNFPA was crucial to understanding the background to and purpose of the tool.
✔ Where possible, link the implementation of an assessment to other critical national processes, such as the development of a National Health Strategy or review of a National AIDS Programme. Also coordinate with other research activities to avoid ‘consultation fatigue’, especially among service providers.

The Rapid Assessment Tool is designed to be coordinated by a multi-sectoral team, with minimum membership to include the national government’s SRH and HIV units, networks of PLHIV, key populations, civil society, UN organisations and donors. The second part of this session explored participants’ experiences of putting such a team into practice. Again, countries were asked to identify their key challenges, as well as their good practices and recommendations.

Figure 6: Challenges, good practices and recommendations for stakeholder involvement in SRH & HIV linkages assessments

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<tr>
<th>Challenges:</th>
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<tr>
<td>• PLHIV and key populations were particularly under-represented in the teams that planned and coordinated linkages assessments. For example, countries in the Middle East and North Africa noted particular under-representation by groups representing or supporting sex workers, people who use drugs and MSM.</td>
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<tr>
<td>• This lack of involvement was exacerbated by issues of stigma and oppressive legal environments. For example, sex between men is illegal in Malawi, Uganda and Zimbabwe – which made it difficult to involve MSM in the assessment process.</td>
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<td>• In some countries, areas of expertise were also under-represented within the teams. Examples included expertise in gender-based violence and legal matters.</td>
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<tr>
<td>• The teams, and the management of the assessment process, tended to be dominated by the Ministry of Health and UN agencies. Other stakeholder groups, such as civil society, were often not involved until later on in the process (for example, during data collection).</td>
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<td>• In many contexts, while agencies such as IPPF and UNFPA were typically the most engaged in the assessment process, other stakeholders could be under-represented. Examples cited by countries in Asia included: men; religious organisations; transgender people; and the private sector.</td>
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<td>• There were a number of barriers – from lack of engagement to bureaucratic processes – that slowed down or prevented stakeholder involvement. For example, in Kyrgyzstan, it was difficult to secure the time of high-level policy-makers, while local representatives of a UN agency had to seek approval from their international headquarters.</td>
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<td>• In some contexts, countries faced challenges about representation, such as which NGOs to involve in the management team for the assessment. In particular, it was important to differentiate between groups that support PLHIV and key populations and groups of PLHIV and key populations.</td>
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<td>• The assessment process identified different understandings and dynamics around SRH and HIV linkages. For example, in some countries, there were dramatically varied levels of understanding within different government bodies. In others, there were fears among some stakeholders that linkages would threaten jobs and reduce resources.</td>
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<th>Good practices and recommendations:</th>
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<tr>
<td>✔ Partnership takes time and coordination. So, bring all key partners on board from the beginning and invest time and energy in team building.</td>
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<tr>
<td>✔ Enable the Ministry of Health to lead the process – to build ownership and leadership.</td>
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✓ Ensure that the assessment team includes all key stakeholders – not only the Ministry of Health and UN agencies, but key donors (such as USAID), civil society (including PLHIV and key populations) and regulatory groups (such as nurses associations). For example, in Tunisia, the assessment was guided by a steering group including the Global Fund, MCH, PHC, UNAIDS, UNFPA and WHO, as well as NGOs, including an organisation of PLHIV.

✓ See a multi-sectoral assessment team as a means to not only ensure good planning, but ease the roll-out of the assessment (for example by ‘opening doors’ and enabling the tailoring of questions to specific stakeholder groups). For example, in Botswana, setting up a multi-sectoral reference group was vital to establishing good relations and getting buy-in.

✓ Develop working groups to respond to the national context and ensure access to appropriate technical expertise.

✓ Where necessary, UN agencies, such as UNFPA and WHO, can play an important broker role with the government and/or other key stakeholders that are reluctant to get involved – advocating to them about the importance of linkages and mobilising them to support an assessment.

✓ Find an entry point that provides a ‘hook’ to engage stakeholders that need convincing of the value of linkages. For example, in the Caribbean region, it has helped to present Ministries of Health with socio-economic studies that demonstrate the cost-benefit of integrated services.

✓ Build on existing work and develop tailor made strategies to involve PLHIV and key populations. For example, the Belize Family Life Association built on its sexual diversity project to reach sex workers through people that they trust (NGOs that work with them). They also recognised that, for this group, ‘time is money’ – so they used creative methods to encourage their involvement in the assessment.

✓ Seize the implementation of the assessment as an opportunity to advocate to all stakeholders about what linkages means and why it matters, and what they can do to support it.

The group work on issues relating to process and involvement was followed by a plenary discussion to focus on the most critical challenges and lessons learned. This concluded that it is vital to:

- ‘Prepare the soil’ before implementing a linkages assessment: It is vital to make upfront investment – dedicating time and resources to building understanding and commitment to SRH & HIV linkages. In countries that have already implemented the tool (such as Zimbabwe) and countries that plan to implement it (such as Nigeria), it has been important to build relationships and getting stakeholders (such as government departments and bilateral and multilateral donors) on board.

- Adapt the Rapid Assessment Tool to national contexts, but not ‘adapt out’ sensitive issues: In countries such as Morocco, it was important to adapt the tool to the national policy, systems and

Figure 7: Viewpoints on getting it right - the SRH & HIV linkages assessment process

“Before getting started on an assessment, you need to get consensus and involvement. You need to test your tools and make specific efforts to involve people living with HIV and key populations.”

Participant from Tunisia

“It’s really important to involve all of your key stakeholders from the beginning of your linkages assessment – to get to know the people you’re going to be working with.”

Participant from Malawi

“It’s critical to involve and address key populations in linkages assessments. The question is, if there are legal constraints, at what point do you drop key populations from the survey or find a way to assess that there are no services for such groups? Every effort should be made to identify a way to involve them.”

Chris Mallouris, GNP+
services context, as well as the local culture and language. However, in all countries, it is essential that this process does not involve removing areas of the assessment that are challenging or sensitive (such as questions relating to human rights or key populations).

- **Be bold and creative in involving key populations and PLHIV:** In practice, while many countries had involved PLHIV groups in their assessment, only one (Lebanon) had involved MSM, two (Pakistan and Tunisia) sex workers and three (Kyrgyzstan, Pakistan and Tunisia) people who use drugs. Even within oppressive legal environments, it is often possible to find creative ways to engage such groups – which are critical to understanding the challenges and potential of SRH & HIV linkages.

A distinction was made between involving PLHIV and key populations directly and involving NGOs that work with them. The former is preferable, but can be challenging in some contexts due to legal restrictions and/or stigma.

A specific recommendation was made to ring-fence a percentage of the budget for SRH & HIV linkages assessments for the involvement of key populations and PLHIV in coordination and implementation.

- **Build on existing harmonisation efforts to enhance UN and donor coordination of SRH & HIV linkages:** In all countries, it was important to build on, strengthen or establish a system for UN and donor coordination in relation to linkages. In Malawi, this involved working through the ‘one UN’ system, while, in Uganda, it involved using the government’s existing reproductive health focal point to bring stakeholders together.

### THEME 3: KEY FINDINGS OF SRH & HIV LINKAGES ASSESSMENTS TO DATE

This theme of the Consultation enabled the countries that have implemented the Rapid Assessment Tool to share their key findings at the three levels of policy, systems and service delivery.

The session also enabled all of the participants to identify the extent to which the situation, challenges and opportunities for SRH & HIV linkages are common or different across countries and regions.

**Figure 8: Viewpoints on key findings of SRH & HIV linkages assessments to date**

“In our country, when the departments of HIV and SRH came together to prepare the implementation of the assessment, it was the first time that they had ever had a joint meeting.”

Participant from Lebanon

“There’s a gap between the national level (where there’s awareness of linkages, but SRH and HIV stakeholders rarely work together) and the services level (where people use their common sense and link services, but maybe not systematically). And it’s clear that key populations aren’t accessing services – so something is not working.”

Raoul Fransen, Young Positives
1. Policy level

The policy-level findings of SRH & HIV linkages assessments include those relating to:

Political positions:

- **In some countries, the assessment confirmed that there is strong political will and national strategies to support SRH & HIV linkages.** In Uganda, for example, SRH policies, guidelines and standard operating procedures include HIV prevention, treatment and care, while the national HIV strategy and guidelines address SRH. Here, most protocols and manuals (for example for training and supervision) have been updated to address linkages. In countries in West Africa (such as Cote D’Ivoire), there are also strong bi-directional linkages in national strategies for SRH and HIV, supported by standard operating procedures and minimum packages of services that address both areas.

- **In other countries, however, national strategies on linkages are inadequate.** This can be due to:
  - **Lack of national strategies.** For example, Lebanon, Morocco and Tunisia report that, despite verbal commitment, there is no official national policy on linkages, with HIV and SRH programmes run vertically.
  - **Limited national strategies.** For example, Tanzania’s national strategy for HIV only mentions family planning as a core intervention in the context of PMTCT and does not cite any activities or indicators for this area. In Burkina Faso, the national health development framework addresses SRH more strongly than HIV. The latter is part of an intermediate objective, although it is not detailed further.
  - **Lack of implementation details.** For example, in Tanzania, while the national strategy for MCH mentions HIV, it does not explain how this will be implemented.

National policies and guidelines:

- **In many countries, national legislation does not support or facilitate SRH & HIV linkages.** This can be due to:
  - **Inadequate legislation:** For example, in Malawi, there is no legislation that specifically addresses SRH and HIV (either individually or together), apart from some references to SRH in the Public Health Act. Here, there is currently an HIV Bill in parliament, but it has little content on SRH linkages.
  - **Inconsistent legislation:** For example, in regions/countries such as the Caribbean, Kyrgyzstan and the Russian Federation, there are inconsistencies between the ages of consent for sex, access to SRH services and/or legal rights.
  - **Inactive legislation:** For example, in Benin, while there are laws on SRH that address HIV and vice versa, they are often not enforced. In the Russian Federation, the implementation of the Rapid Assessment Tool revitalised knowledge and dialogue about an existing law (passed in 1991) that, although now out-dated, contains many positive measures.

- **Similarly, national policies can provide inadequate support to SRH & HIV linkages.** This can be due to:
  - **Policies being impractical or unenforced:** For example, in Kyrgyzstan, although some policies are supportive of linkages, they are only declarative and cannot be implemented.
  - **Policies neglecting population groups:** For example, in Belize, there is a gap in policy provision for 13-17 year olds (who are not covered by either paediatric or adult measures), while, in Pakistan, SRH services are only provided for married couples. In Botswana and Swaziland, while national policies address some key populations (such as sex workers), they neglect others (in particular MSMs and people that use drugs).
• **Poor roll-out of policies from the national level.** For example, in Malawi, supportive national policies and guidelines on SRH and HIV are often poorly disseminated by district health management teams to service providers – resulting in a low level of awareness.

**Funding and budgetary support:**

• **Countries often experience an imbalance between national and external funding for SRH, HIV and/or linkages.** For example, in Kyrgyzstan, the national government only provides 7% of related funding – severely limiting the sustainability of the response if donors were to withdraw.

• **Often, there is poor donor coordination and little collaborative budgeting on SRH, HIV and linkages.** For example, countries in Southern Africa (such as Zimbabwe) found that funding is largely vertical, with resources allocated specifically to, for example, just SRH commodities, rather than being channelled to integrated interventions and providing a package of support.

• **Countries experience inadequate funding for SRH & HIV linkages.** For example, countries such as Morocco, Lebanon and Tunisia cited that there is a lack of financial support for the work involved in putting linkages into action, such as the training of service providers.

**2. Systems level**

Countries’ key findings at the systems level included those relating to:

**Partnerships:**

• **In some countries, there is strong support for SRH & HIV linkages among stakeholders.** For example, in Uganda, linkages benefits from interest by a range of development partners and NGOs.

• **Often, partners provide vertical responses to SRH and HIV and collaborate with a limited group of stakeholders.** For example, countries in the Middle East and North Africa found that partners focused on SRH predominantly work with government ministries, while those focused on HIV predominantly work with NGOs and the National AIDS Programme/Council.

• **Sometimes, countries lack coordination mechanisms to facilitate partnership on linkages.** For example, in Belize, there are no mechanisms to coordinate the involvement of the private sector and other stakeholders (such as civil society).

• **Civil society can be inconsistently involved in partnership work.** For example, in Pakistan, while key populations (such as sex workers and people who use drugs) are involved in the planning of HIV activities, they are not involved in SRH services.

**Planning, management and administration:**

• **In many countries, national responses to SRH and HIV are managed separately, with little joint planning.** For example, in Pakistan, SRH planning is led by the Ministry of Population and Welfare and HIV planning by the health department, with the two not coordinating. Similar findings were reported in countries such as Benin and Uganda. In Tanzania, the assessment’s finding of lack of coordination among the government’s Reproductive Health and HIV Units led to the formation of a Technical Working Group – which is co-chaired by the Units and brings them together.

• **In some countries, national SRH and HIV leaders are beginning to plan together.** For example, in Malawi, the Ministry of Health’s three coordination bodies – the SRH Unit, HIV Unit and National AIDS Commission – collaborate through an Integration Working Group.

• **SRH and HIV can receive inequitable investment and coordination.** For example, countries in Southern Africa report that Technical Working Groups are often dominated by HIV stakeholders (due to the availability of more funds for that area). Also, generally, responses to HIV benefit from stronger coordination, interest and planning.
Staffing, human resources and capacity:

- **In some countries, SRH & HIV linkages are being increasingly addressed.** For example, in Malawi, both SRH and HIV are now included in the pre-service training curricula for health workers.
- **In other countries, awareness raising and capacity building is needed at all levels.** For example, in countries in the Middle East and North Africa, linkages are seen as a new concept. As such, basic awareness of the value of the approach is still low among many health workers, programme managers and institutions and linkages are not included in training materials and relevant curricula, for example within universities. Similarly, in West African countries such as Côte D’Ivoire, there is no integrated capacity building (such as training modules) that addresses SRH and HIV together.

Logistics, supplies and laboratory support:

- **In some countries, logistics and supply systems support the implementation of SRH & HIV linkages.** For example, countries in the Middle East and North Africa reported that there is one source of supplies for all services being implemented by the Ministry of Public Health.
- **In other countries, such systems are vertical.** For example, in Uganda, logistical support for SRH and HIV services are managed vertically, with those for HIV mainly supported by donors and those for SRH by the government. Similarly, in Morocco, the Ministry follows two separate procedures for the supply of condoms for SRH and HIV, while, in Burkina Faso, there is no joint planning for SRH and HIV commodities, for example in terms of procurement or distribution.

Monitoring and evaluation:

- **In some countries, national collaborative efforts facilitate monitoring and evaluation of SRH & HIV linkages.** For example, the ‘Three Ones’ approach can help to harmonise the collection of data at the local and provincial levels and its analysis at the national level.
- **In other countries, monitoring and evaluation remains largely vertical.** For example, in Botswana and countries in West Africa, there is a lack of harmonisation in SRH and HIV indicators and tools. In Uganda, the monitoring of SRH and HIV interventions is carried out by different government units.

3. Service delivery level

Countries’ key findings at the service delivery level included those relating to:

**Provision of integrated services:**

- **In many countries, integration predominantly takes place among selected services and/or through specific entry points.** For example, in Uganda, most integrated services relate to PMTCT, while other entry points remain under-exploited.
- **In many countries, there is limited SRH & HIV integration within services.** In West Africa, the minimum package of integrated services (outlined in standard operating protocols) is often not being implemented uniformly across facilities. In Tanzania, after the assessment found very few examples of integrated services, pilot projects were set up to create specific opportunities (such as expanding family planning beyond PMTCT to also include the provision of ART and HIV testing and counselling).
- **Where integration does take place, it is often by default.** For example, in countries and Southern Africa, integration is often a consequence of acute shortages of human resources.
- **Sometimes, specific types of service providers do not implement linkages.** For example, in Malawi, few faith-based facilities provide family planning, despite providing 37% of the country’s HIV services.
• **Lack of integration within facilities can be mirrored at the community level.** For example, in Uganda, while Village Health Teams are trained to provide SRH (but not HIV) services at the community level, PLHIV community health support providers are trained to provide HIV (but not SRH) services.

**Service providers’ views on linkages:**

• **In many contexts, service providers have different types and levels of understanding about SRH & HIV linkages.** For example, in Tanzania, the assessment found that service providers feared that linkages would increase their workload and the need for supplies and drugs, but would also decrease stigma related to HIV, the amount of time spent per client and costs.

• **In some countries, lack of, or unclear, clinical standards hamper linkages.** In Belize, there is little standardization of services (for example, in terms of delivery by Ministry of Health clinics in the North and South of the county). This is also experienced in the Russian Federation – where service delivery is influenced by donor support to each region. Here, linkages are also restricted by clinical standards that, for example, allocate a specific amount of time to examine each patient.

**Clients’ views on linkages:**

• **In many countries, clients welcome the benefits that linkages can bring.** For example, countries in Southern Africa found that service users welcome having a ‘one stop shop’ for SRH and HIV. In Tanzania and Malawi, most clients (48% and 77% respectively) preferred to be served by the same provider for SRH and HIV and to be served within the same facility (79% and 95% respectively).

• **In practice, there remain significant barriers to accessing SRH and HIV services.** For example, in Pakistan, it is difficult for key populations, such as pregnant HIV positive women, to access services within mainstream SRH facilities. In countries in the Middle East and North Africa, stigma and discrimination remain a significant barrier to the uptake of SRH and HIV services and better linkages.

**THEME 4: OVERCOMING CHALLENGES TO LINKING SRH & HIV**

This theme of the Consultation focused on five areas that, based upon their experiences, the participants identified as particularly challenging within the implementation (design, management and roll-out) of SRH & HIV linkages at the country level:

1. **Coordination and accountability** – with, for example, a lack of ‘joined up thinking’ and collaborative working among key national policy makers and programme planners.
2. **Policy and legal barriers to service delivery** that, for example, criminalise key populations or affect what type and age of people can access SRH & HIV services.
3. **Capacity building of health care providers** to, for example, provide high quality and accessible integrated SRH & HIV services within their facilities.
4. **Stigma and discrimination** that, for example, continues to present a major barrier to access to SRH & HIV services for groups such as PLHIV, MSM, sex workers and people that use drugs.
5. **Donor conditionality** that, for example, requires separate application and reporting processes for SRH and HIV or that favours linkages between specific types of services.
**Figure 9: Viewpoints on overcoming challenges to linking SRH & HIV**

“In our country, there have been vertical SRH and HIV services and no coordination. As it goes beyond a health problem, we’re now reaching out to involve all relevant bodies, not only the Ministry of Health, but civil society and international organisations.”

Participant from Kyrgyzstan

“Linkages is a really important opportunity for people living with HIV. We need to look at what’s needed – changes in laws, training of service providers, etc – to make it happen.”

Beri Hull, ICW

“The question is: what is enough? Our communities want a ‘one stop shop’, so why not move beyond SRH and HIV towards truly integrated health services?”

Participant from Zimbabwe

“We’ve held linkages consultations with MSM and sex workers to assess what package of services are needed, how to provide them and how to train service providers to ensure there is no discrimination. All this was necessary to ensure that the space is safe as well as appropriate.”

Participant from Belize

Within group work, the participants were asked to identify solutions to the five areas of challenges – in terms of concrete actions that could be taken to make efforts within their country easier and/or better.

<table>
<thead>
<tr>
<th>Key challenges to SRH &amp; HIV linkages</th>
<th>Solutions</th>
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</table>
| **Challenge 1: Coordination and accountability** | • Have a coordination strategy and guidelines – to outline key areas (such as decision-making processes and roles and responsibilities) and serve as a constitution for a national coordinating body.  
• Have a coordination body that is driven by the host country, while involving different stakeholders, such as UN agencies, Global Fund Country Coordinating Mechanism (CCM) and civil society.  
• Have regular meetings of the coordination body or a sub-committee (management group). For example, in Nepal, the monthly meetings of the Safe Motherhood Sub-Committee involve stakeholders and donors from SRH, HIV and other sectors.  
• Ensure coordination between SRH and HIV efforts at the highest level (for example, the Principal Director) – to provide political backing. For example, in Tanzania, it has been critical to convince and engage the Directorate of Preventive Services – the level within the Ministry of Health where the SRH and HIV units join.  
• If necessary, have a UN agency play the role of facilitator and matchmaker between SRH and HIV stakeholders. For example, in Lebanon – where the Ministry of Health’s SRH and HIV programmes were working vertically – UNFPA brought the groups together to plan for the future.  
• Carry out institutional capacity building of the coordinating body – to ensure strong infrastructure and human resources.  
• As required, develop Technical Working Groups to coordinate different thematic areas of SRH & HIV linkages work. |
- Ensure that a formal, national SRH & HIV linkages policy is in place – to provide foundations and justification for coordination efforts. For example, for Benin – where the HIV programme is vertical and SRH is integrated into broader health services – a national strategy would indicate political commitment to linkages and help ‘make it happen’.
- Replicate national coordination efforts at other levels of the health system. For example, in Botswana, mechanisms have also been established at provincial and district levels.
- Build accountability through: involving civil society organizations as ‘whistle blowers’; having effective monitoring and evaluation systems; providing regular reporting and feedback to stakeholders; and having transparent systems for financial management.

### Challenge 2: Policy and legal barriers to service delivery

- Establish a Technical Working Group to review the results of the SRH & HIV linkages assessment and identify policy and legal-related areas for advocacy and action.
- Identify and engage key policy and legal individuals and groups in the discourse on linkages. Examples include parliamentarians, policy-makers, civil society, legal bodies, faith-based organisations, human rights groups and members of key populations.
- Review and document past experiences and strategies that have been used successfully to achieve policy and legal changes in the SRH, HIV or related fields.
- Start by identifying existing, supportive laws and policies that can address some of the barriers to linkages and allow for the provision of services. For example, in Malawi, although sex work is criminalised, the Public Health Act calls for the provision of services – providing an opportunity to advocate for universal access.
- Explore inconsistencies and loop holes in legislation of relevance to linkages. For example, in Zambia, within efforts to promote male circumcision, attention is being drawn to the fact that the age of consent for surgery is higher than that for sex.
- Acquire and implement the WHO tool (available in 2011) for assessing the human rights and legal environment in which SRH & HIV services are provided.
- Carry out research and gather data relating to key populations – to provide evidence to policy and legal stakeholders and convince them of the magnitude of the issues.
- Involve lawyers and legal bodies in the implementation of SRH & HIV linkages assessments and the planning of follow-up actions.
- Do not work on policy and legal issues in isolation. Complement these actions with programmes that address socio-cultural factors - such as stigma and discrimination – at the community level.

### Challenge 3: Capacity building of health care providers

- Carry out an assessment of facilities’ needs and health workers’ capacity – to know what resources already exist and/or are needed (such as training materials, modules and standard operating procedures). Ensure that these efforts:
  - Address the curricula of educational systems that provide pre-service training - to identify changes required.
  - Respond to a common understanding of the components of a minimum package of SRH & HIV linkages, based on the priorities of the country, the type of facility (such as hospital versus primary health care clinic) and the packages promoted by WHO and other international bodies.
- Develop **training materials and modules** on SRH & HIV linkages to build the capacity of existing SRH providers in HIV (and vice versa) and train new service providers in both SRH and HIV. Within these efforts:
  - Use WHO’s Integrated Management of Adolescent and Adult Illness (IMAI) and Integrated Management of Pregnancy and Childbirth (IMPAC) training packages.
  - Tailor the resources to the needs of specific health care providers, such as midwives.
  - Ensure that, within adapting existing resources, they not only cover clinical aspects of SRH & HIV, but issues such as confidentiality, stigma and human rights.
  - Support health care providers to be sensitive to the needs and issues of key populations.
  - Consider who to involve in training (not just clinical staff, but others, such as counsellors and outreach workers).
  - Ensure that training efforts are monitored and evaluated – for both their quality and impact (in terms of making a difference to the work and attitudes of health care providers).

- **Multiply the impact** of training for health care workers, for example by:
  - identifying trainers that can work in multiple local languages; carrying out training-of-trainers; and exploring areas of linkages that can be addressed through task shifting.

### Challenge 4: Stigma and discrimination

<table>
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<tr>
<th>Policy level:</th>
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<tr>
<td>- Introduce <strong>protective legislation</strong> for young people, sex workers, drug users, MSM, women and PLHIV to guarantee equal rights, prevent discrimination and enable access to services.</td>
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<tr>
<td>- Introduce legislation to ensure services can be provided at the <strong>most relevant and suitable settings</strong> for the population in question, for example with those for young people provided at youth-friendly facilities.</td>
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<tr>
<td>- Translate human rights-based frameworks into <strong>national level policies</strong>.</td>
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<tr>
<td>- Carry out <strong>education and advocacy efforts</strong> on relevant legislation and equality of rights and access.</td>
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<tr>
<td>- Carry out <strong>operational research</strong> on SRH &amp; HIV linkages to provide evidence to advocate for effective, protective legislation.</td>
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<tr>
<td>- <strong>Involve PLHIV and key populations</strong> in the design and all other phases of relevant legislative processes.</td>
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<tr>
<th>Systems level:</th>
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<tr>
<td>- <strong>Involve PLHIV and key populations</strong> in the development and all other phases of programmes to ensure that efforts are non-stigmatizing and non-discriminatory.</td>
</tr>
<tr>
<td>- Ensure that the <strong>training curricula of health workers</strong> include information and education on: human rights; the rights of key populations; existing protective legislation; and the complexities and impact of stigma and discrimination.</td>
</tr>
<tr>
<td>- Include <strong>information on protective legislation</strong> in the training curricula for service providers.</td>
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</table>
**Services level:**
- Strengthen the **provision of knowledge and information** to service providers about issues related to stigma and discrimination.
- Introduce **customer care programming and training** to improve the skills and attitudes of service providers towards clients, especially key populations. Include attention to the dynamics of cultural norms and attitudes and the impact of stigma and moral judgments.
- **Involve PLHIV and key populations** in customer care programming and training.
- Promote **peer groups** at the service and community level, such as mothers-to-mothers support groups for PLHIV.

**Challenge 5: Donor conditionality**
- **Build country ownership of programmes**, for example by developing national strategies that can be presented to international donors to identify how best to support the country. For example, Rwanda has developed a strong national strategy and now places conditions on donors that they work within that strategy.
- Identify and advocate to the ‘**power brokers**’ within a country who shape and take decisions about national strategies and lead on donor relations.
- Encourage donors to **align with national monitoring, evaluation and reporting systems**.
- **Build accurate understanding** about what type of conditionalities donors do or do not have and why. For example, some donor priorities are based on WHO recommendations.

**THEME 5: DONOR SUPPORT FOR SRH & HIV LINKAGES**

This theme of the Consultation – which involved presentations, a panel and plenary discussion – focused on opportunities and challenges relating to support and collaboration with donors on SRH & HIV linkages.

**The Global Fund and SRH & HIV linkages**

The session started with a presentation on opportunities and issues for resourcing SRH & HIV linkages through the Global Fund. This provided contextual information, including that the Global Fund: promotes national ownership (with decisions taken by Country Coordinating Mechanisms (CCMs) and proposals and indicators developed by countries); and works as a ‘development partner’ (moving beyond the traditional donor/recipient model).

For Round 10, the Global Fund approved 79 proposals, at a cost of $1.73 billion over the first two years and $4.72 billion over five years. Out of 78 HIV proposals, 34 were approved, including 12 for the newly-created funding stream for most-at-risk-populations. This represented a success rate of 44%. In 2010, the Global Fund also underwent replenishment, resulting in US$11.7 billion being pledged for 2011-13. This fell short of the lowest estimate of likely demand and will bring challenges in prioritization in the years to come. Meanwhile, other strategic issues facing the Global Fund include: timing of Round 11; grant consolidation; and issues of equity and value for money.

*Figure 10: Viewpoint on donor support for SRH & HIV linkages*

> "The Global Fund is potentially crucial for funding SRH & HIV linkages. But the reality is that it remains an under-utilised mechanism. The CCM is the critical interface for linkages – where you need to have champions and experts to ensure it gets on the table and gets in proposals."

Manjula Lusti-Narasimhan, WHO
Of particular relevance to SRH & HIV linkages, the Global Fund Board has approved strategies on Gender Equality (November 2008) and Sexual Orientation and Gender Identities (SOGI) (May 2009). These seek to strengthen the model to ensure that normative attitudes, assumptions and power dynamics that marginalize issues and key populations are minimized and addressed within Global Fund processes at all levels. The Strategies aim to ensure that involvement and partnership principles work effectively for women and girls, MSM, sex workers and other groups most affected and at risk. Similarly, the new CCM Funding Policy – which has two options (basic and expanded) – is of particular relevance to linkages. It presents an important opportunity to enhance CCMs’ capacities in relation to areas such as: constituency engagement (including relating to SRH and key populations); harmonization and alignment; CCM performance measurement and capacity building (including in relation to linkages); and addressing gender and sexual orientation issues.

The Global Fund presentation was followed by one on a WHO study analyzing the inclusion of SRH components in HIV proposals to Rounds 1-9 of the Global Fund. The research compared the content of proposals against key WHO policies, including its strategy on global reproductive health (which focuses on strengthening a comprehensive range of SRH services as the basis of HIV prevention and treatment). The WHO study confirmed that the Global Fund is a potentially critical funding mechanism for SRH and rights. In Rounds 1-9, the proportion of proposals encouraging linkages increased progressively, peaking in Round 8 [see Figure 11]. Yet, overall, the mechanism remains under-utilized in many contexts.

**Figure 11: Percentage of proposals to the Global Fund encouraging SRH & HIV linkages**

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The other findings of the WHO study included that [see Annex 3 for graphs]:

- When assessed against the WHO’s comprehensive strategy for PMTCT\(^{10}\), there have been two general trends. The inclusion of interventions from Prongs 1 and, particularly, Prong 2, has increased - reaching highs of 70% and 52% respectively in Round 9. The inclusion of Prongs 3 and 4 has always been above 80%, with the exception of Prong 3 in Round 5 and Prong 4 in Round 3.
- When assessed against the WHO public health care package for the prevention and care of STIs\(^{11}\), it was found that, in relation to the general population\(^{12}\):
  - The proportion of proposals including STI case management was usually under 40%, reaching a high of 58% in Round 8.
  - The proportion of proposals including syndromic management was 40-50% in Rounds 1-7. It then increased to over 61% in Round 8, but dropped to 41% in Round 9.
  - The proportion of proposals including partner follow-up was 20% or less in all Rounds.
- When assessed against the same WHO STI package, but in relation to key populations\(^{13}\):
  - Proposals most often targeted sex workers (male and female), followed by young people (both in and out of school), orphans and young children. These were the only two populations consistently included in over 50% of proposals.
  - MSM were mainly targeted in Asian, Eastern European and Latin American countries and were largely omitted from proposals by African countries. Although the total number of proposals that included interventions for MSM men was initially low, it rose to 58% and 67% in Rounds 8 and 9 respectively\(^{14}\).
  - The percentage of proposals targeting people who use drugs fell to 35% in Round 9 from levels of 45-50% in Rounds 6-8.
  - The percentage of proposals targeting prisoners rose to approximately 45% in Rounds 7-9.

**Opportunities and challenges with donor support for SRH & HIV linkages**

This session benefitted from a panel of donors, comprised of representatives of: the Centres for Disease Control (CDC); the Global Fund; UNAIDS; and USAID. The panel’s inputs, combined with contributions by the participants in the plenary, highlighted a number of important issues, including relating to:

**The Global Fund:**

- The mechanism is willing to fund a range of SRH initiatives (for example, relating to STIs and the SRH of PLHIV). However, a country must present a robust and evidence-based application that clearly demonstrates the link with HIV outcomes and indicators.
- The success rate of HIV proposals remains disappointingly low. This is due to a number of reasons, often including the poor targeting of, and technical support for, interventions.

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\(^{13}\) *Importance of Sexually Transmitted Infections in Funding for HIV within Proposals to the Global Fund*, Lusti-Narasimhan M, Ndowa F and Pires S, Department of Reproductive Health and Research, WHO, 2009.

\(^{14}\) Note: Transgender people were not addressed as a separate group in this analysis.
• Active involvement in CCMs is critical to including issues relating to linkages within Global Fund processes. For example, if the CCM lacks anyone with expertise relating to gender-based violence, it may be difficult to get that issue included in a country’s proposal.
• The re-programming of PMTCT within African countries (resulting from a previous periodic review of the Global Fund) presents an important opportunity to re-assess the allocation of resources and linkages between SRH and HIV.
• Gender-based violence, a key issue in relation to linkages, is noted in the Global Fund’s Gender Equality Strategy and can be funded - with impact on human rights, SRH and HIV.
• The Global Fund is willing to resource the implementation and follow-up to the Rapid Assessment Tool within its funding for CCMs.

USAID:

• USAID’s Global Health Initiative presents a broad and comprehensive response to health and outlines clear priorities for the United States Government, including support to MCH. CDC and USAID representatives can help countries and institutions to ‘locate’ their work within the Initiative and identify opportunities to secure support for SRH & HIV linkages.
• In addition to its direct provision of funding, USAID continues to support the Global Fund - as a critical, complementary mechanism that promotes evidence-based and country-centric responses.
• At the country level, USAID can play a critical role in complementing the support of other donors. For example, while many African countries depend on the Global Fund to roll out WHO’s revised guidelines on antiretroviral therapy and PMTCT, they look to USAID for support on areas such as logistics and procurement.

WHO:

• The new WHO Global Health Sector Strategy for HIV 2011-15 is going to the WHO Executive Board and World Health Assembly. One of its four strategic directions focuses on finding better to work between SRH and HIV to strengthen responses and be more efficient in providing needed services.

THEME 6: NEXT STEPS - STRENGTHENING SRH & HIV LINKAGES AT THE NATIONAL LEVEL

The final session of the Consultation to Discuss Country Implementation of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages provided the participants with an opportunity to plan their next steps – in terms of priority follow-up actions to be taken within their countries. The following are three examples, from countries with different types of epidemics, of how to take linkages work forward.

Lebanon’s comprehensive action plan [see Annex 4] included attention to: advocacy (such as mobilising public and private sector stakeholders, carrying out a national workshop to agree on a minimum package for linkages and identifying national inter-sectoral planning processes within which linkages can be included); and awareness raising (such as developing a marketing plan for linkages that targets service users and providers). The action plan also includes attention to: capacity development (such as carrying out training of trainers, reviewing protocols and developing training modules for different health workers); health management (such as developing a strong and efficient referral system); logistics and commodities (such as ensuring that equipment and commodities are provided to both SRH and HIV service delivery points); and monitoring and evaluation (such as ensuring the availability of linkages-related data and the development of relevant indicators).
Belize’s follow-up work will include reviewing the composition and terms of reference of the existing National SRH Committee to ensure its readiness to guide linkages and integration. It will also include: convening a meeting of the National SRH Committee and National AIDS Committee Executive to discuss the findings of the linkages assessment; encouraging the National SRH Committee to take ownership of implementing the assessment’s recommendations; and developing immediate, short and medium term action plans to put in place the policies and systems needed to ensure effective linkages.

In Tanzania, the follow-up actions to the assessment will continue to include: monthly meetings of the Technical Working Group (involving the National AIDS Control Programme, RCHS Unit and other partners); mobilising more partners to engage in linkages; technical needs assessments in selected regions; and developing training materials (for example on the integration of family planning/care and treatment clinics and on community based distribution/home based care). The actions have also included the training of master trainers in linkages and the piloting of interventions in several regions (including the capacity building of HIV services providers on family planning, and vice versa). These initiatives have been complemented with advocacy to senior management within the Ministry of Health and Social Welfare.

Examples of specific planned follow-up actions by other countries participating in the Consultation included: positioning attention to linkages within dialogue and policies for the country’s broader health system and more proactively addressing the SRH needs of men (Zambia); using the involvement of key populations as an opportunity to carry out advocacy on the SRH rights of marginalised groups, such as MSM (Lesotho); speeding up national action on linkages, including by consolidating the existing coalition that includes NGOs working with populations such as women and young people (Morocco); and replicating the Consultation at the country level and developing a national action plan with particular attention to issues of sexuality education, rights and the needs of vulnerable populations (Cote D’Ivoire).

As the Consultation came to a close, the participants committed, on return to their countries, to continue to develop and expand upon their action plans. The countries that have already implemented the Rapid Assessment Tool were also asked to finalise their Linkages Country Summary – a resource that synthesises their assessment process, findings and recommendations and can used to raise awareness about SRH & HIV linkages and advocate for action by relevant stakeholders.
ANNEX 1: INVITED PARTICIPANTS

Note: The following lists the invited stakeholders. Some were unable to attend part or all of the Consultation due to adverse weather conditions.

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ANNEX 2: CONSULTATION PROGRAMME

Consultation to discuss country implementation of the Rapid Assessment Tool for sexual & reproductive health and HIV linkages

Executive Board Room, World Health Organisation, Geneva, 1 and 3 December 2010
Salle B, World Health Organisation, Geneva, 2 December 2010

AGENDA

Wednesday, 1 December 2010

Chairperson: Mike Mbizvo, WHO and Karl Dehne, UNAIDS

13:00 - 13:10 Opening                  Michael Mbizvo,WHO/RHR
13:10 - 13:20 Objectives of the meeting     Manjula Lusti-Narasimhan, WHO
13:20 - 13:30 Rationale and opportunities for strengthening SRH & HIV linkages Kevin Osborne, IPPF
13:40 - 13:50 SRH and HIV Rapid Assessment Tool Lynn Collins, UNFPA
13:50 - 14:00 Process and findings – introduction to group work sessions
14:00 – 15:30 Group work discussion on process undertaken at country level in implementing the Tool
15:30 -16:00 Coffee break
16:00 -17:30 Reporting back in plenary of the implementation process and findings
Thursday, 2 December 2010

Chairperson: Chris Mallouris, GNP+

09:00 - 09:30  Highlights from Day 1  Sarah Middleton-Lee

09:30 - 09:45  Introduction to Round-Robin group work:
Participants work in groups around the following questions:

1. What are the main steps to be taken between now and World AIDS Day in 2011?
2. What support do you need in order to make these next steps happen?

09:45 – 10:45  Round-Robin (part 1)

10:45 - 11:15  Coffee break

11:15 - 12:30  Round-Robin (part 2)

12:30 - 14:00  Lunch

Chairperson: Rose Wilcher, FHI

14:00 - 14:45  Feedback from the the Round-Robin session

14:30 - 15:30  Comments and questions from countries about to implement the Tool

15:30 - 16:00  Coffee break

16:00 - 17:30  Celebrating successes and addressing challenges

18:00  Reception

Friday, 3 December 2010

Chairperson: Mary Ann Abeyta-Behnke, USAID

09:00 - 09:30  Highlights from Day 2  Karusa Kiragu, UNAIDS

09:30 - 09:45  Global Fund mechanisms and support  Andy Seale, Global Fund

09:45 - 10:00  SRH components in HIV proposals approved by the Global Fund  Manjula Lusti-Narasimhan, WHO

10:00 - 11:00  Stakeholder Panel: Supporting Global Fund, USAID, UNAIDS, UNFPA

11:00 - 11:30  Action planning

11:30 -12:00  Summary of key action items and next steps

12:00 - 12:30  Concluding remarks and closing  IPPF/UNFPA/WHO/UNAIDS
ANNEX 3: KEY FINDINGS OF STUDY ON INCLUSION OF SRH COMPONENTS IN GLOBAL FUND PROPOSALS

Percentage of Round 1-9 proposals including comprehensive four-pronged approach to PMTCT

Percentage of Round 1-9 proposals including STI case management, syndromic approach or partner follow-up for the general population
Percentage of Round 1-9 proposals including STI prevention or early diagnosis for key populations

Percentage

Global Fund Round

- Other
- Unif. Man
- Young People
- Prisoners
- Mig. Workers
- IDU
- MSM
- Truckers
- Sex Workers
### ANNEX 4: EXAMPLE OF A FOLLOW-UP ACTION PLAN (LEBANON)

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Specific activities</th>
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| **Advocacy (partnership, roles, funding)** | • Identify partners from the public and private sector for areas related to the SRH & HIV linkages process (such as advocacy, capacity building, development of materials and monitoring and evaluation).  
• Form a multi-disciplinary Steering Committee with clear terms of reference to oversee, guide and advise on linkages.  
• Carry out a national workshop based on the results of the assessment to: 1. Reaffirm the concept of linkages; 2. Agree on the minimum package/general framework for linkages; 3. Identify key challenges and limitations; and 4. Agree on selected pilot service delivery points to introduce linkages.  
• Develop and disseminate advocacy materials using evidence-based indicators - for decision makers and stakeholders, as well as relevant target populations.  
• Identify opportunities with existing inter-sectoral and inter-agency coordination processes for joint policy development and funding. For example, introduce linkages within the development of national strategies (such as by the National AIDS Programme or SRH project).  
• Follow up on the recommendations of the national workshop.  
• Advocate on introducing changes to the health system concerning the job description and roles of relevant service providers.  
• Provide ‘certification’ to service delivery points/champions introducing linkages.  |
| **Awareness creation**               | • Develop a marketing plan to increase the use of relevant services by communities, including by developing and disseminating materials on: availability of such services in service delivery points; and users’ rights to quality services.  
• Implement the same in relation to service providers.  |
| **Capacity development**            | • Identify a core group of multidisciplinary trainers of trainers.  
• Review available materials, training modules, references, protocols and guidelines (by WHO and other international organisations).  
• Adapt and finalise comprehensive training modules (for doctors, nurses, counsellors, midwives, health and social workers, etc), preferably in Arabic.  
• Agree on the monitoring and evaluation indicators to assess the impact of training on trainees and their work performance.  
• Carry out training of trainers.  
• Carry out a series of training workshops to cover the pilot service delivery points.  
• Carry out follow up and monitoring.  |
| **Health management**               | • Develop and operationalise a referral - and follow-up - referral system that is strong and efficient.  |
| **Logistics and commodities**       | • Ensure equipment and all related reproductive health commodities are provided to both service delivery points.  |
| **Developing monitoring and evaluation systems** | • Develop a monitoring and evaluation plan for linkages, including reporting and ensuring the availability of data on people served, with a focus on developing robust indicators.  
• Document best practices.  
• Share with all stakeholders - as a feedback to maintain and sustain good practices and identify gaps for improving practice.  |