BURKINA FASO

RAPID ASSESSMENT
OF SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES

IPPF International Planned Parenthood Federation

UNFPA

World Health Organization

UNAIDS
UNHCR UNODC
UNICEF ILO
WFP UNESCO
UNDP WHO
UNFPA WORLD BANK
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

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 Burkina Faso[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?

- Developing guidelines and plans to further the process of SRH and HIV integration.
- Training stakeholders at different levels of the health system on how to integrate activities.
- Establishing mechanisms for collaboration/coordination on SRH and HIV at different levels.
- Developing plans for SRH and HIV integration that include: situation analysis; feasibility studies; assessment of needs for reorganizing and reorienting services towards better integration; necessary tools (e.g. job descriptions, work plans); and tools to evaluate service quality and user satisfaction in relation to integration.

1. This sumary is based upon: *Evaluation de l'Intégration des Activités de Lutte contre le VIH et les Services de Santé Sexuelle et de la Reproduction*, Burkina Faso, Ministère de la Santé, Burkina Faso, and UNFPA, March 2010.

PROCESS

1. Who managed and coordinated the assessment?

- The Family Health Authority was the main leader of all activities related to the assessment. The process was carried out by a consultant, guided by a committee for government HIV personnel and the Family Health Authority. UNFPA provided technical and financial support for the assessment.
- A first draft was published in March 2010 and the final version in May 2010.

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

- The assessment was implemented by a committee composed of key stakeholders, namely the Family Health Authority, National AIDS Committee (NAC), UNICEF, UNFPA, WHO, community-based organizations and the consultant.

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

- The desk review covered the main national strategy and policy documents – 19 in total, including ones focused on SRH, HIV, integration and wider areas of health and development.

4. Was the assessment process gender-balanced?

- Both men and women were involved in the assessment.
- The health care facilities targeted for the assessment are more widely visited by women than men, although open to both.
- The assessment addressed issues relating to both women/girls and men/boys.

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

- The assessment gave equal attention to SRH and HIV.
- The assessment followed the tool's headings for each level. Many of the questions were adapted to the national context so that they could be understood.

6. What was the scope of the assessment?

- The service-level data was collected from two health facilities per district, with all of the country's district and regional referral sites included approximately 60 sites. Faith-based/private health facilities were also included.

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

- Interviews were carried out at both: policy level, primarily with health-related government agencies (seven) and UN agencies (three); and at systems level, with health-related government agencies (nine).
- For both SRH and HIV, the assessment involved the highest level of policy makers (from NAC and the Family Health Authority respectively).

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

- There were 381 interviews with service providers working in a range of roles (over 40 per cent in maternity-related posts and 75 per cent working in urban facilities). The facilities provide both SRH and HIV services, although usually within different wards.

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

- There were 452 interviews with service users. 60 per cent of these were in urban facilities, and 36 per cent of the participants were housewives.
- The interviewees were from both SRH and HIV services.

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

- There was no involvement of organizations of people living with HIV (PLHIV) in the coordination of the assessment. It can be assumed, however, that PLHIV were among those interviewed.

FINDINGS

1. Policy level

National policies, laws, plans and guidelines:

- The national policy is to address HIV in a way that is integrated with health in general.
- In the national health development plan, HIV falls within reproductive health (RH).
- SRH is a priority in the national strategy on HIV. But the operational plans do not indicate much focus on the promotion of SRH.
- The national roadmap for fighting maternal and child mortality states that SRH, HIV, sexually transmitted infections (STIs) and malaria are integral to primary health care. The minimum package for RH includes maternal, newborn and child health (MNCH), family planning, malaria, STIs and HIV, as well as the training of health workers on STIs, prevention of mother to child transmission (PMTCT) and contraception, and the provision of equipment and commodities, especially for family planning and MNCH. It does not have operational plans or indicators relating to HIV.
- The national contraception plan was developed by the Ministry of Health (MOH) and NAC, and covers male and female condoms, other contraceptives, STI kits and PMTCT supplies.
- The national HIV strategy addresses the promotion of SRH. However, few activities in the different plans address SRH issues.
- The national strategy on HIV communication does not fully address linkages with SRH.
- An action plan to improve SRH and HIV integration was developed for 2009–2010.
- At the national level, the most visible examples of integration are the roll-out of PMTCT and youth centres. Also, the MOH has developed a contractual approach to funding non-governmental organizations (NGOs), covering five health areas including SRH and HIV.
- The main barrier to integration is the lack of operational guidelines. Service providers do not have the tools to do needs assessments or integration.
- The barriers also include that there is split national leadership on SRH and HIV and that the implementation of programmes in each area is vertical and project-based.

Funding and budgetary support:

- There is a holistic funding mechanism (for rapid results initiatives), with a broad mandate. This presents an opportunity for better SRH and HIV integration. But, in general, the extent of integration is largely determined by technical and financial partners.
- Non-eligibility for funds hampers functional integration.

2. Systems level

Partnerships:

- There are 24 partners working on SRH and 24 on HIV. Of these, 13 support work on linkages, including UN agencies, donors and NGOs. Coordination between actors and sectors is weak.
- There are multi-sectoral technical groups working on SRH and HIV integration.
- The involvement of civil society in the design, implementation and monitoring and evaluation (M&E) of SRH and HIV programmes is poor (due to weak individual and organizational capacity). However, PLHIV groups are increasingly involved in operational coordination at the local level.

Planning:

- Joint planning of SRH and HIV programmes is carried out annually at the intermediary level.
- At the systems level, the main functional integration is through supervision and monitoring.
- Integrated services are mainly provided by public facilities. They are less common in those by private, civil society and faith-based organization (FBO) providers.

Human resources and capacity building:

- Capacity building needs are wide ranging – including HIV, family planning, integrated management of childhood illnesses (IMCI), PMTCT, gender and rights, prevention of stigma and male participation.

- In-service training programmes for SRH include content on HIV prevention and treatment.
- The major challenges to effective integration include the insufficient levels of health care staffing and the attrition/departure of workers.

Logistics, supply and laboratory support:

- A wide range of the interviewees (61 per cent) felt that integrating logistics and supply for SRH and HIV commodities would make services more efficient. The challenge remains how to integrate the multiple monitoring tools that exist for both SRH and HIV.

Monitoring and evaluation:

- The usage of integrated services by users is well monitored, supported by appropriate indicators. The majority of the interviewees (74.6 per cent) felt that the data that is collected is disaggregated by gender, age and HIV status.

---

3. Services level

A. SERVICE PROVIDER PERSPECTIVES

HIV integration into SRH services:

- Service providers indicated that the SRH services that are least often provided are those related to gender-based violence and youth. On the other hand, over 90 per cent of SRH providers provide HIV testing, treatment, delivery, neonatal care and family planning services.
- In SRH settings, the most commonly provided HIV services are testing (in 96 per cent), antiretrovirals (ARVs) and treatment for opportunistic infections (74 per cent), HIV prevention information (88 per cent) and PMTCT (92 per cent). Across SRH services, 60–70 per cent provide support to HIV positive mothers, nutritional advice, psychosocial support and HIV treatment and care. The levels fluctuate according to services. For instance, antenatal care (ANC) and maternity services are more likely to provide PMTCT, support for HIV-positive mothers and nutritional support.
- Condom provision is not systematic in SRH services. Fewer than 30 per cent of delivery and postnatal services and 60 per cent of ANC services make them available. Availability in the behavioural change programmes and STI treatment services is much higher, although still not systematic (70–80 per cent).
- Services for key populations are very scarce. Fewer than 10 per cent of providers provide tailored services for men who have sex with men (MSM) or people that use drugs, and 20 per cent serve other key populations. But it is not essential that every provider serves every key population.
- Almost every service is involved in counselling and information provision. But the report does not give details about the nature of the information.
- Around 40 per cent of SRH services actively involve PLHIV.
- Where SRH services provide HIV services: in more than 70 per cent of cases, the HIV services are by the same provider; in 84 per cent of cases, they are available the same day in the facility (but not from the same provider); and in approximately 30 per cent of cases, they are provided by referral to another facility.

SRH integration into HIV services:

- The SRH services most common in HIV services are STI treatment, counselling/information, education and communication (IEC) on SRH (nearly 100 per cent) and family planning (92 per cent). Around 90 per cent provide maternity services and approximately 60 per cent child services. Only 40 per cent provide prevention and care related to gender-based violence.
- Some types of HIV services are more likely to integrate specific SRH services than others. For example almost all HIV counselling and testing services provide counselling on other SRH topics, particularly STIs. 75 per cent of such services also provide family planning, but less than 50 per cent provide services tailored for young people.
- Similarly, PMTCT services were more likely to provide directly related SRH services – such as ANC consultations (provided by 94 per cent) or family planning and maternity services (75–85 per cent). On the other hand, far fewer PMTCT providers (36 per cent) tackled issues such as gender-based violence. Similarly, the great majority of ARV service providers (97 per cent) also provide STI treatment, but far fewer provide maternity and family planning services (60 per cent and 64 per cent).

- Tuberculosis (TB) treatment services had fairly low integration of SRH services, with the exception of information and counselling (90 per cent). 66 per cent of such services provided STI treatment. But no other SRH service was provided by more than 40 per cent of TB providers.
- Community-based services for HIV are less likely to integrate SRH, with the exception of information provision. 28 per cent of providers said that community-based HIV services addressed gender-based violence, for instance. But these responses may not be comprehensive, as it appears that no community-based service providers were interviewed in the assessment.

Overall perspectives on linkages in SRH and HIV services:

- In general, SRH services seem to neglect certain key issues such as post-abortion care, prevention of dangerous abortion, gender-based violence and needs of young people.
- 83 per cent of providers said that, where other services were available, they were available the same day in the same unit. In 65 per cent of these cases, the same provider provided the secondary services. Referrals to another establishment were made in fewer than 50 per cent of cases.
- The report says nothing about follow-up or monitoring of cases that are referred out.
- 51 per cent of providers said they had formal agreements with other establishments for referrals.
- Guidelines (e.g. for IMCI and PMTCT) are essentially vertical – so they hamper an integrated approach. High workload, lack of facilities and equipment, and limited training and staff, were also cited as barriers to integration of SRH and HIV.
- Integration is facilitated by: guidelines that provide integrated care/treatment algorithms; youth centres; VCT centres; guidelines for IMCI and PMTCT (even though these were cited as barriers as well); and increased resources.
- Providers consider that integration increases the cost to the facility, but reduces the cost to the user. Most believe it increases efficiency and the quality of interventions. They also believe it would positively impact on stigma and confidentiality.

B. SERVICE USER PERSPECTIVES

- Respondents to the service user questionnaire had a broad range of complaints. The highest proportion related to outpatient care, but it was not clear if this related to SRH and HIV or other issues.
- 289 of the clients received HIV-related services, in many cases for HIV testing. 92 per cent were not referred to any other service. 90 per cent said they got what they came for. For those who did not, this was because of a lack of stocks of the needed supplies or medicines.
- 78 per cent of respondents said that they would rather get SRH and HIV services from the same place, as this would be convenient and less costly. But some were concerned that an integrated approach might create confidentiality issues and longer waiting times.
- Over 50 per cent of respondents said they would prefer SRH and HIV services to be provided by the same provider – to improve quality and confidentiality and reduce time and cost to them.
- 80 per cent said, in respect of the visit they had just made, that they had discussed something other than the primary purpose. 32 per cent said they had also discussed family planning, 26 per cent vaccinations and 24 per cent HIV prevention.
- The main improvements that clients required were: increased availability of information and advice; more friendly services; reduced waiting time; and greater availability of medicines and commodities. Many also said the service would be improved if more health care staff were available and the infrastructure was improved.

LESSONS LEARNED AND NEXT STEPS

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

- Some of the questions in the *Rapid Assessment Tool* appear to have been misunderstood. For example, under Systems, some questions generated statistics when they should have generated a yes/no answer or qualitative data. Also, in the SRH-to-HIV questions, researchers added subcategories that were sometimes unclear – breaking down SRH and HIV services into further levels of detail that were not always clearly related to either area.
- Service providers appear to have been asked about what services were provided *in their facility* (rather than by them *as individual providers*). This may have skewed some of the data, as several providers were interviewed for each facility.
- Some aspects of the data collection lacked clarity. For example, clients were asked to give a single reason why they prefer SRH and HIV services to be provided by one provider, whereas, originally, the tool gave the option to 'tick all that apply'.
- The assessment could have provided a more comprehensive view by involving a wider group of stakeholders, especially PLHIV and civil society.

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

The next steps involve the existing key stakeholders (Family Health Authority, National AIDS Committee – NAC, UNICEF, UNFPA, community-based organizations, the consultant and health care providers) and potentially new partners. They include:

- Conducting a one-day meeting to disseminate the findings of the assessment and plan future steps.
- Conducting promotional activities on the benefits of linking SRH and HIV services.
- Conducting training sessions for health care providers to enhance their knowledge.
- Following-up/monitoring the project activities.

3. What are the priority actions that are being taken forward as a result of the assessment, at the:
- **policy level?**
- **systems level?**
- **services level?**

Policy level:

- Scale up the integration of SRH and HIV services nationwide.
- Ensure that all relevant strategic documents take into account both SRH and HIV issues.

Systems level:

- Establish a mechanism for effective coordination of SRH and HIV activities at all levels.

Services level:

- Train health care providers to provide SRH and HIV services at the same time and place.
- Develop promotional activities that show the benefits of integrating SRH and HIV services.

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

- To ensure good partnership and networking, a pilot committee has been established, with the Family Health Authority (including the departments for PMTCT and family planning), the NAC, community-based organizations, UNICEF, WHO and UNFPA. This committee will strive to find funding to scale up SRH and HIV integration initiatives.
- Advocacy will be carried out with the government to increase its financial contribution to SRH and HIV integration.

Abbreviations

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ARV	antiretroviral
FBO	faith-based organization
GNP+	Global Network of People Living with HIV
HIV	human immunodeficiency virus
ICPD	International Conference for Population and Development
ICW	International Community of Women Living with HIV/AIDS
IEC	information, education and communication
IMCI	integrated management of childhood illnesses
IPPF	International Planned Parenthood Federation
M&E	monitoring and evaluation
MNCH	maternal, newborn and child health
MOH	Ministry of Health
MSM	men who have sex with men
NAC	National AIDS Committee (Comité National de Lutte contre le Sida et les Infections sexuellement transmissibles)
NGO	non-governmental organization
PLHIV	people living with HIV
PMTCT	prevention of mother to child transmission
RH	reproductive health
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	voluntary counselling and testing
WHO	World Health Organization

FOR FURTHER INFORMATION, PLEASE CONTACT:
Dr Olga Sankara, sankara@unfpa.org