Baseline Study

Quality of Care in SRH and HIV Integrated Services

Submitted to:
Family Planning Association of Pakistan (FPAP)

Submitted by:

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May 2015

Disclaimer:

The study is conducted to assess the quality of care provided to the patients accessing SRH and HIV integrated services at government and NGO institutions. The purpose of the study is to compare the quality and level of service provision at government and NGO facilities. The sample of the study is not representative at any level and as such the findings could be used mainly for understanding the issue but not be quoted or generalized.

Acknowledgement

The assessment of Quality of Care in SRH HIV Integrated services is the first ever initiative in Pakistan. The Consultant's team is highly obliged to FPAP management and project team for providing this opportunity to conduct the study for them. We are thankful to all the stakeholders for their valuable support towards the completion of this study. We are also grateful to the following individuals for their support, cooperation and inputs, which have enriched this study:

- Ms. Nabila Malik, Director, Advocacy and Resource Mobilization, Family Planning Association of Pakistan, Lahore
- Mr. Shabeeb Hussain, Project Coordinator, Project "Building Momentum for SRH / HIV Integration"
- Dr. Ghaffar Khan, DG Population Wing, Ministry of Health Services Regulation and Coordination (NHSRC), Islamabad
- Dr. Sabeen Afzal, Deputy Director Programs (Health), Ministry of National Health Services, Regulation & Coordination (NHSRC), Islamabad
- Mr. Malik Shahzad, DG, Chief Population, P & D, Islamabad
- Dr. Baseer Achakzai, National Program Manager, AIDS Control Program, Islamabad
- Dr. Salman Shahid, Program Manager, PACP, Lahore
- Dr. Tayyaba Rashid, Punjab AIDS Control Program, Lahore

  Mr. Sarfarz Kazmi, Regional Director and his team at Rahnuma-FPAP Punjab Regional Office, Lahore.
- The doctors, paramedical staff, lab technicians, VCT staff at Family Health Hospital (NGO), Services Hospital (Government), Lahore
- Management and Staff of Rahnuma-FPAP Karim Park Family Health Clinic, Lahore
- The Management and Staff of SHEED (NGO), Lahore

Our special thanks to the community groups including the Transgender, MSM, FSWs and Persons Living with HIV for their cooperation, insights and feedback without which a fair analysis would have been impossible.

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Acronyms

ANC	**Ante Natal Care**
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BC	Being considered
CIDA	Canadian International Development Agency
DFID	Department for International Development
DG	Director General
DHQ	District Head Quarter
FGD	Focus Group Discussion
FP	Family Planning
FPAP	Family Planning Association of Pakistan (FPAP)
FSW	Female Sex Worker
GBV	Gender Based Violence
GNP+	Global Network of People living with HIV+
GoP	**Government of Pakistan**
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Users
IPES	Integrated Package of Essential Services
IPPF	International Plan Parenthood Foundation
LHW	Lady Health Worker
LSHTM	London School of Hygiene & Tropical Medicine
M&E	Monitoring and Evaluation
MAQ	Maximizing Access and Quality
MDG	Millennium Development Goal
MNCH	Maternal Neonatal and Child Health
MNHSRC	Ministry of National Health Services Regulation and Coordination (MNHSRC)
MoH	Ministry of Health

MOPW	**Ministry of Population Welfare(MOPW)**
MOU	Memorandum of Understanding
MSM	Male Sex with Male
NACP	National AIDS Control Program
NACP	National AIDS Control Program (NACP),
NGO	Non Government Organization
OI	Opportunistic Infections
P & D	**Planning & Development**
PACP	Punjab AIDS Control Program
PEP	Post Exposure Prophylaxis
PHC	Primary health care (PHC)
PLHIV	People living with HIV
PNC	Post Natal Care
PPTCT	Prevention of Parent to Child Transmission
QAP	Quality Assurance Project
QoC	Quality of Care
SDP	Service Delivery Points
SRH	**Sexual and Reproductive Health**
STI	Sexually Transmittable Infection
SW	Sex Workers
TG	Trans Gender
UN	United Nation
UNFPA	United Nation Fund for Population
UNICEF	United Nations Children's Fund
USAID	United States Agency International Development
VCT	Voluntary Counseling and Testing
VCTC	Voluntary Counseling and Testing Center
WHR	Western Hemisphere Region

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Foreword

This document provides decision-makers and managers at country level with a systematic process which will allow them to design and implement effective interventions to promote quality in health systems. Conceived as a capacity-building tool in health-care quality, this guide focuses particular attention on people who have a strategic responsibility for quality. The reason for this approach is the understanding that in most countries there is an enormous amount of local readiness and action for quality improvement but frequently this action is carried out in an insufficient policy and strategic environment.

Furthermore, the process suggested here will help managers and decision-makers decide on which components of quality they wish to focus. In some countries, there may be more leverage for quality in reorganizing the delivery of care across settings, while in others it may be more appropriate to start with patient safety activities. The intention, therefore, has been to keep the process simple and to avoid suggesting that 'one size fits all' and that there are 'magic bullets' for quality.

The guide also assumes that a common process of decision-making for policy makers has relevance for the vast majority of countries, regardless of their particular circumstances. This assumption is made on the grounds that a robust process of decision-making will take into account country-specific factors – such as current resourcing, cultural sensitivity, affordability, and sustainability – in determining which combination of quality interventions will deliver the best outcomes and benefits for a country. The principles of quality management are largely identical across all countries, as they build on optimal use of scarce resources, client orientation, and sound planning, as well as evidence for improved quality of services.

Despite these commonalities across all countries, capacity-building in low and middle income countries has some specificities since it operates in a highly dynamic development context. During past decades, support to low and middle income countries has been driven by a supplier mentality. The focus was on the transfer of financial and physical resources and technology, with the assumption that this would trigger improvement. In many ways this supply led logic continues to dominate in quality improvement with a wide array of ready-made methods and brands being recommended to receptive health systems in low and middle income nations. Although many of these quality brands are very useful improvement approaches, this document is conceived to support countries in developing their own comprehensive strategies for quality before deciding to use specific branded approaches developed in other regions.

Recognizing the need to build capacity within countries, this guide has been designed to assist self-assessment and serve as a discussion guide so that decision-makers and interested parties in the quality arena can work together on finding answers for their own setting. The role of donors, development agencies, and/or consultant groups will be to support the implementation of these country-specific designs and not to substitute them.

This guide will enable project managers, trainers, supervisors, and others involved in the health management field to collect detailed information on the range and quality of integrated services available at a given facility service delivery program. In addition to providing essential baseline information, the assessment process facilitates the creation of a quality improvement action plan that helps health facilities to address a broad range of program areas, including policy, operations, and training. Used at regular intervals, program planners will be increasingly able to assess changes and determine the impact of their interventions. By helping facilities to assess their needs and the current state of their operations, this guide ultimately encourages the design of interventions aimed at improving the quality of a facility's overall service delivery.

Structure of the Document

This report is divided into the following seven sections.

Section	Title	Detail
0	**Executive Summary**	A summary and brief overview of the entire report including rationale, process, findings and recommendations.
1	**Introduction**	All about SRH HIV Integration and the concept of QoC, its philosophy, best practices, process and procedures, etc.
2	**Background**	Rationale and need of the study, the objectives of the projects and expected outcome.
3	**About the Study**	The purposes, process and methodology of the study.
4	**Findings of Assessment**	The findings and outcome of the study
5	**Assessment & Observation of Facilities** **a) VCT** **b) PPTCT** **c) Clinic services**	The physical assessment of the facilities providing SRH HIV integrated services with a comparison to international standards.
6	**Recommendations, Conclusions, Suggestions and Way Forward**	The suggestions and recommendation for the improvement of Quality of care, for SRH HIV integrated services in both government and private facilities.
7	**Annexes**	The reference documents and tools used for the conduct of base line study.

Session 0 - Executive Summary

Introduction: The importance of developing links between sexual and reproductive health and HIV services is widely recognized. Four priority areas for linkages – learning HIV status, promoting safer sex, optimizing links between HIV and sexually transmitted infection services and integrating HIV with maternal and infant health – could lead to significant public health benefits and improve efficient use of resources. Moreover, there is agreement within the international community that the Millennium Development Goals 4, 5, 6 will not be achieved without ensuring access to SRH services and an effective global response to HIV. Together they will contribute to and cannot be achieved without attaining MDG 3 – gender equality and empowerment of women.

SRH HIV Integration: Majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. HIV and SRH ill-health share common root causes e.g. poverty, gender inequality, GBV, human rights violation, stigma & discrimination and marginalization of key populations**.** Thus SRH HIV integration, by joining together different kinds of SRH and HIV services or programs enhances accessibility, affordability and improves quality of care.

Background: The quality of care and best practices for strengthening SRH and HIV linkages are poorly researched in Pakistan, where limited integrated services provision has existed for over five years in the obstetrical care departments of selected Government tertiary care hospitals (PPTCT integrated into SRH), about 50% of STI clinics provide HIV information and referrals for ARVs (HIV integrated into SRH) and all VCT and ARV centers provide STI prevention and management (SRH integrated into HIV). The *Integra project* was implemented in countries, with a generalized HIV epidemic whereas Pakistan has a concentrated epidemic type among two high risk groups-Intravenous drug users and MSM mainly Hijra (Transgender) sex workers. No assessment of public or private sector integrated services has been carried out to date.

Study Objectives: To identify critical QoC concerns/issues that adversely impact service delivery/denial of SRH rights and also reflect significant gap in the health system.

- To measure the coverage and quality of integrated SRH and HIV services in two Government and two NGO Service Delivery Points.
- To provide suggestions for future initiatives on advocacy with policy makers and capacity building support to integrated service implementers.

Methodology: The 3P Approach: This technique was used, which included a) Paper Assessment or document review for QoC commitment at policy and program level of Federal and Provincial departments of health, population and planning, b) Perception assessment or staff perception of policies and strategies with regard to their practicability, c) Practice assessment results from evidence-based, in-depth review of the degree to which QoC commitments as contained in the policies have been understood and put in practice by the service providers at various levels in the health facilities.

The QoC assessment of SRH HIV integrated services and facilities at two public and two NGO facilities was conducted and included in depth interviews with managers and service providers, exit interviews with clients and focus group discussions with the beneficiaries of services –key populations as TGs, FSW, MSM and PLHIV**.**

Key Informant Interviews were also conducted with policy makers of Health, Population and Planning Departments at Federal and Provincial levels.

SRH HIV integration is of a varying degree in the facilities selected. Hence, it is important to mention that the two VCTCs (Govt. and NGO) assessed fell into the partial–integration type whereas the Govt. hospital PPTCT services and the NGO Karim Park clinic providing community based services are examples of full-integration.

I. SRH Services Integrated in HIV	II. HIV Services integrated into SRH
STI Services in VCT Center (Services Hospital, Government Facility)	PPTCT in MNCH (Services Hospital, Government Facility)
STI Services in VCT Center (Rahnuma Family Health Hospital, NGO Facility)	HIV counseling, condom promotion and referral for testing and FP, STI and Abortion Services (Karim Park Clinic, NGO Facility)

The methodology of the assessment included both physical assessment and service statistics. A detailed comparison of the physical facilities focused mainly on quality of care criteria.

For the assessment of VCT Centers, an adapted self assessment tool (The NGO HIV/AIDS Code of Practice Project, Geneva, 2004)was applied in both government and private facilities to assess the various components including, the policies and strategies available for the implementation and service delivery to specific groups, the availability of systems and procedures for a quality delivery of the services, the capacities and competencies of staff to provide services to specific groups, the data and information collection system, capacities to conduct analysis from the data gathered and developing findings to share with the staff and other stakeholders and the organization and basic facilities for patients when they are waiting in the facility or being examined by the service provider.

For the PPTCT –MNCH Integration (Govt.) and HIV services integration in SRH (NGO clinic) an adapted IPPF QoC monitoring checklist was used to review the overall service provision set up, the skills and attitude of providers and the type of services provided from within the listed Integrated Package of Essential Services (IPES) prescribed for SRH Static Clinics.
For comparison between Government and NGO facility, determining minimum requirements for a health facility is a difficult task. Given the disparity in contexts and resource availability, no simple mechanism exists with which to evaluate each component that affects the quality of care and services. However, the self-assessment tools and QoC checklists being used measure the readiness of facilities to deliver services according to quality standards of care.

Findings:
The study has highlighted certain concerns/issues, some of which are encouraging while some are challenges that need to be overcome for provision of quality SRH HIV integrated services. We are encouraged:

- That national policies, laws, plans and guidelines for both SRH and HIV support linkages both at Federal and Provincial levels and consider it as a cost effective measure. HIV AIDS policy also recognizes the rights and SRH needs of PLHIV.
- By the policy trend that integrating services is beneficial to service provision and for the people.
- That at the systems level major stakeholders for SRH and HIV programs (Government and Non-Governmental Organizations) support integration and guidelines have been developed by a Technical Working Group.
- That at services level there is some level of HIV integration into SRH services such as HIV counseling and testing, condom promotion and provision, PPTCT (at selected tertiary care hospitals) HIV care and support and ARV treatment and prophylaxis for opportunistic infections for PLHIV and specific information /services for key populations.
- That with regard to SRH integration into HIV services: the prevention and management of STIs has been integrated to a large extent.
- By the presence in all related policies of the need to provide quality services whether integrated or not and to develop guidelines on QoC and institutionalize them.
- Both at Federal and Provincial levels there is some thinking with regard to joint purchasing of commodities and supplies for Health and Population departments.

Challenges

The issues/challenges mentioned below are constraints to the successful implementation of quality SRH HIV Integrated services.

Policy level

- Having two separate departments of health and population with some integration at the lowest level of service delivery, has split SRH elements with FP falling in the purview of Population and the other elements being under Health Department.
- No progress on laws to support integration and no legislative action to protect SRH rights, particularly of women, PLHIV and key populations except for the passing of two bills on domestic violence and sexual harassment of women at workplace.
- There is no focus on human rights and gender, there being no mention in any policy of the rights of persons of different sexual orientations such as TGs/MSM who would also benefit from integrated services.

At systems level

- Lack of frameworks for implementation of SRH HIV integrated services could prove a major obstacle to institutionalizing the initiative.
- The existence of two separate budgetary streams for SRH and HIV does not facilitate integration.
- Also there being no multi-sectoral working group for coordinated action on integration and collaboration

between sectors is a major issue.

- Regarding sustainability of SRH HIV integrated services currently the provinces have good level of donor funding for HIV and if it is withdrawn integrating HIV services into existing healthcare system will be a challenge.
- There is no involvement of PLHIV and key populations in SRH programs and with HIV programs their participation is limited to planning.
- Also there is neither a joint planning of SRH and HIV programs nor any collaboration for management/implementation.
- Logistics, supplies and laboratory support appear equally challenging though the latter could serve the needs of both SRH and HIV services.
- There is no Monitoring and Evaluation system for integrated services.

At service delivery level:

- Ownership of the program and provision of integrated services is more of an issue with NGOs rather than the Government. Fears that provision of HIV services especially to key populations will discourage the regular patients/clients need to be allayed for quality implementation of integrated services.
- Poor infrastructure, inadequate privacy, unclean environment are observed more with Government facilities and pose a threat to quality services. Inadequately trained staff providing services has been noted at both government and NGO facilities.
- Capacity building of staff with reference to both SRH HIV as well as QoC is a critical issue, more with the Government staff being unfamiliar with even the basics of quality of care. Attitudinal reconstruction of service providers enabling them to provide stigma and discrimination free services is a major concern. Removing provider's fears of handling HIV positive cases due to inadequate infection prevention at facilities is also important.
- Lack of visibility of available services for PLHIV and key populations and very limited HIV outreach services. Government because of the Special HIV Centers with a good coverage of HIV services including supplying ARVs is able to attract more PLHIV and other key populations to its facilities. Hardly any PLHIV access the NGO facility for services-there is only one case of a HIV discordant couple whose baby was delivered in the hospital 5 years ago.
- One of the principles of building quality SRH HIV integrated services is to recognize the centrality of sexuality, which being a taboo issue, is missing from the discourse on service delivery. It could prove to be an obstacle to increasing access to services for key populations.
- Apart from the above it is equally important to address root causes of HIV and sexual and reproductive ill-health. This includes action to reduce poverty, ensure equity of access to key health services and improve access to information and education opportunities.

C. Suggestions and Way Forward

Despite the many challenges to provide quality SRH HIV Integrated services, there is still some potential to make it work. The initiatives, which could make a difference, can be categorized into Advocacy Related, Capacity Building and Implementation of SRH HIV Integrated Services

Advocacy for:

1. Legislation ensuring rights of PLHIV and other key populations in accessing SRH HIV Integrated services
2. Setting up a multi-sectoral task force to develop:
    a. Framework for institutionalizing SRH HIV Integration.
    b. Guidelines and protocols for service delivery.
    c. Relevant training curriculum for all the different cadres of staff to provide stigma and discrimination free quality integrated services.
    d. M&E framework for SRH HIV Integrated services
    e. Special funding allocation for SRH HIV Integrated services
3. All Family Planning clinics of Population Department and NGOs to provide Syndromic Management for STIs and HIV counseling, condom promotion and distribution
4. Inclusion of HIV Counseling and condom promotion and distribution in the Primary Healthcare package

ii. Capacity Building on

1. All aspects of SRH HIV Integrated services
2. Quality of Care
3. Attitudinal reconstruction on provision of stigma and discrimination free integrated services to PLHIV and other key populations
4. Infection Prevention and Universal Precautions
5. Rights based and Gender sensitive SRH HIV service delivery for PLHIV and other key populations

iii. Implementation of SRH HIV Integrated Services

1. Improving visibility of services by making information and educational material (in local language) available at places of congregation of key populations
2. Strengthening outreach services for increasing VCT access of key populations and families
3. Reorganizing VCT Centers as per quality of care standards (Government)
4. Reenergizing VCT by integration with FP and Youth Friendly Services (NGO)
5. Focusing on Infection Prevention, perhaps supplying sterilized kits for C-Section delivery of HIV positive pregnant women, to allay the fears/reluctance of staff to provide them services.
6. Making appropriately trained staff available for SRH HIV integrated services (Govt.-VCT, NGO- Karim Park Clinic)
7. Increase range of SRH and HIV integrated services by including safe abortion and screening and management SGBV in the package to be delivered by appropriately trained staff.
8. Linking PLHIV and other key populations to income generation and socio-economic support programs to address barriers to access services such as poverty and illiteracy
9. Review of services of the NGOs implementing Care and Support programs for PLHIV (Govt.-ref. FGDs)

Section 1 – Introduction

The importance of developing links between sexual and reproductive health and HIV services is widely recognized. Four priority areas for linkages-learning HIV status, promoting safer sex, optimizing links between HIV and sexually transmitted infection services and integrating HIV with maternal and infant health could lead to significant public health benefits and improve efficient use of resources. Despite growing evidence that links between sexual and productive health and HIV services are feasible and beneficial, few countries have achieved significant scale-up of integrated services. However, there is agreement within the international community that the Millennium Development Goals 4, 5, 6 will not be achieved without ensuring access to SRH services and an effective global response to HIV. Together they will contribute to and cannot be achieved without attaining MDG-3 gender equality and empowerment of women.

A. Key international commitments and developments supporting sexual and reproductive health and HIV linkages since 2001

Timeline	Commitment	Detail
2001	United Nation General Assembly Special Session on HIV/AIDS Declaration of Commitment on HIV/AIDS,	Linked achievement of HIV prevention targets to delivery of an integrated set of interventions, including antenatal care, HIV testing and counseling, HIV related care, treatment and support services, and appropriate sexual and reproductive health services across the wider health sector.
2004	Glion Call to action on family planning and HIV/AIDS in women and children	Focuses on linkages between family planning and prevention of mother-to-child transmission; and the New York Call to commitment: linking HIV/AIDS and sexual reproductive health, which highlighted the public health rational for infection.
2005-2008	G8 commitment to reaching as close as possible universal access to HIV prevention, care and treatment services by 2010	Support for integration of HIV interventions with wider health services including maternal and child health, sexual and reproductive health and tuberculosis, reinforced by the June 2006 United Nations General Assembly high-level meeting on AIDS, 2007 & 2008 G8 Summits.
2006	Political Declaration on HIV/AIDS	Challenged the global health community to force closer linkages between sexual reproductive health and HIV through better policy and program coordination.
2007	Reproductive Health Matters	Ensuring sexual and reproductive health for PLHIV

2007	Global Partners' Forum Consensus Statement	Achieving Universal Access to Comprehensive Prevention of Mother-to-Child Transmission Services.
2007	GNP+ Global Consultation	Sexual and Reproductive Health and Rights of PLHIV
2008	World Association for Sexual Health	Sexual Health for the Millennium
2011	UN Political Declaration on HIV	"By 2015…. working with partners to direct resources to and strengthen the advocacy, policy and programmatic links between HIV and … sexual and reproductive health."
		"Redouble efforts to strengthen healthy systems, including primary health care, particularly in developing countries, through measures.

B. Principle Governing SRH HIV Linkages

The following are 6 key principles upon which linkages policies and programs must be built to make them work:

Sr.	Principle	Detail
1	Address Structural determinants	Root cause of HIV and sexual and reproductive ill-health need to be addressed. This includes action to reduce poverty, ensure equity of access to key health services and improve access to information and education opportunities.
2	Focus on Human Rights and Gender	Sexual and reproductive and human rights of all people including women and men living with HIV need to be emphasized, as well as the rights of marginalized populations such as Injecting Drug Users (IDU), Men having Sex with Men (MSM), and Sex Workers (SW). Gender sensitive policies to established gender equality and eliminate gender-based violence are additional requirements.
3	Promote a coordinated and coherent response	Promote attention to SRH priorities within a coordinated and coherent response to HIV that builds upon the principles of one national HIV framework, one broad-based multi-sectoral HIV coordinating body, and one agreed country level monitoring and evaluation system (Three Ones Principles)
4	Meaningfully involve people living with HIV	Women and men living with HIV need to be fully involved in designing, implementing and evaluating policies and programs and research that affect their lives.
5	Foster community participation	Young people, key vulnerable populations, and the community at large are essential partners for an adequate response to the described challenges and for meeting the needs of affected people and communities.

	Reduce stigma and discrimination	More vigorous legal and policy measures are urgently required to protect people living with HIV and vulnerable populations from discrimination.
6	Recognize the centrality of sexuality	Sexuality is an essential element in human life and in individual, family and community well-being.

C. SRH & HIV Integration

i. What is SRH & HIV Integration?

- Joining together different kinds of SRH and HIV services or program
- Ensuring, perhaps maximizing, their combined results, and
- Includes referral, with aim of comprehensive services.

ii. Why does SRH HIV Make Sense?

- Majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding.
- HIV and SRH ill-health share common root causes e.g. Poverty, Gender inequality, GBV, Human rights violation, Stigma & discrimination and Marginalization of key populations

iii. What are the key elements of SRH HIV integration?

SRH	HIV	Key Linkages
Family Planning, Maternal and Neonatal Care, Management of Sexually Transmitted Infections, Management of other SRH Problems	Prevention, Treatment, Care and Support	Learn HIV Status, promote safer sex, optimize connection between HIV/AIDS and STIs, and integrate HIV/AIDS with maternal and neonatal health

iv. What are the benefits of SRH HIV Integration?

For People	• Better quality and range of SRH and HIV services • One Stop Shop • Save clients time and Money • Increase clients' use of key health interventions
For Population	For People living with HIV, SRH/HIV Integration could: • Allow them to access both SRH and HIV services under the

	same roof or in the same facility. • Expand the range of clinical services • Reduce the frequency and costs of health related appointments • Help to reduce HIV related stigma and discrimination • Provide increased coverage for marginalized and under-served populations and • Promote an increased culture of rights-based responses
For Services	• Cost less than individual services • Encourage good uptake of full range of services • Enable staff to provide better and more comprehensive support • Help services support 'hard to reach' communities
For Systems	• Save money • Increase coverage or SRH/HIV interventions for vulnerable populations, and • Improve efficiency of health system
For Policies	• Encourage 'joined up' policies on SRH and HIV-resulting in a more complementary and strategic national response • Help governments to fulfill key interventional commitments on both SRH and HIV, such as the MDGs 5 & 6.

D. Overview of Quality of Care in Reproductive Health

i. Definitions and Measurements of Quality

Quality of care, a client-centered approach to providing high-quality health care as a basic human right, has emerged as a critical element of family planning and reproductive health programs. It has been promoted by local stakeholders, such as women's health and primary health care organizations, and affirmed at international conferences, such as the 1994 International Conference on Population and Development.

High-quality services ensure that clients receive the care that they deserve. Furthermore, providing better services at reasonable prices attracts more clients, increases the use of family planning methods, and reduces the number of unintended pregnancies. Several impact studies have shown that improving the quality of reproductive health services increases contraceptive use. Studies in Bangladesh, Senegal, and Tanzania showed that women's contraceptive use was higher in areas where clients felt that they were receiving good care than it was in areas with lower-quality health facilities (Koenig et al. 1997; Mroz et al. 1999; Speizer and Bollen 2000).

Providing high-quality care also makes sense for service providers, since improving basic standards of care attracts more clients, reducing per capita costs of services and ensuring sustainability. For example, the Bangladesh Women's Health Coalition attracts clients by providing a mix of services, so that clients can use a visit for more than one purpose, and by having well-trained paramedical personnel, rather than physicians, perform pelvic exams, IUD insertions, and menstrual regulation services. The high volume of clients has enabled the

program to distribute its fixed costs over a larger number of clients, allowing the coalition to serve more people at a lower cost (Kay et al. 1991, as cited in Kols and Sherman 1998).

Improving the quality of reproductive health care programs benefits other health services, in part by encouraging users to seek higher-quality services for all of their health care needs. In addition, improvements to health care facilities can enhance the quality of care for a wide range of adult and child health care needs.

Maximizing Access and Quality (MAQ) Initiative: The U.S. Agency for International Development's Office of Population and its partner agencies designed the MAQ Initiative to serve clients and programs by developing cost-effective ways to improve both access to and quality of reproductive health services. It is important to understand how the MAQ principles evolved, since various frameworks may be appropriate for different situations and practice settings.

ii. Defining Quality of Care

While most people feel that improving quality of services is important, health specialists do not always agree about which components should be included in the definition of quality.

Historically, quality has been defined at a clinical level, and involves offering technically competent, effective, safe care that contributes to the client's well-being. But quality of care is a multidimensional issue that may be defined and measured differently, according to stakeholders' priorities:

- Clients, whose perception of quality may be influenced by social and cultural concerns, place significant emphasis on the human aspects of care;
- Providers usually stress the need for technical competency, as well as infrastructure and logistical support from their institution;
- Program managers may focus on support systems, such as logistics and record keeping; and
- Policymakers and donors are concerned with cost, efficiency, and outcomes for health investment as a whole.

The complexity of defining quality of care makes it difficult to identify and measure improvements in service delivery.

Effective delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;	***Efficient*** delivering health care in a manner which maximizes resource use and avoids waste;	***Accessible*** delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
Acceptable/patient-centered delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;	***Equitable*** delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;	***Safe & Secure*** delivering health care which minimizes risks and harm to service users.

iii. The Basic Definition of Quality of Care: The Bruce-Jain Framework

The Bruce-Jain framework, developed in 1990, is often considered the central paradigm for quality in international

family planning. Judith Bruce and Anrudh Jain, researchers for the Population Council, have defined quality as "the way individuals and clients are treated by the system providing services" (Bruce 1990; Jain 1989). The framework identifies six elements, which apply mainly to clinical services, relevant to improving the quality of care in family planning programs: choice of contraceptive methods, information given to patients, technical competence, interpersonal relationships, continuity and follow-up, and the appropriate constellation of services.

Client's Rights: The Client and Provider Bill of Rights, created by the International Planned Parenthood Foundation (IPPF), outlines 10 rights of family planning clients, and extends the definition of a client to everyone in the community who needs services, not merely those who approach the system (Huezo and Díaz 1993).

According to the IPPF, the client's perspective of the quality of care emphasizes method choice and availability, respectful and friendly treatment, privacy and confidentiality, service providers' professional competence, information and counseling, convenient hours and acceptable waiting times, and affordability. Three elements can help clients feel well- treated: face-to-face communication; skillful providers who show clients that they care about their work; and consideration of how women's needs, fears, and reactions may be perceived differently by male and female providers (Díaz 1994).

Provider's Needs: The IPPF's bill of rights also addresses 10 needs of providers, including training and updated technical guidance; adequate supplies and strong infrastructure; and feedback and support from clients, other providers, managers, and supervisors.

Gender: The IPPF/Western Hemisphere Region (IPPF/WHR) further refines the definition of quality of care by considering the gender aspects of relationships between clients and providers. Gender refers to the roles, attitudes, values, and relationships affecting women and men throughout the world. The IPPF, in conjunction with three regional family planning associations and the Latin American and Caribbean Women's Health Network, has developed a manual for evaluating quality of care from a gender perspective, with an eye toward improving gender equity and sexual rights; assessing how well gender concepts have been incorporated into the institution; and strengthening staff members' ability to analyze how well they have integrated gender concepts into their delivery of reproductive health services.

The IPPF/WHR methodology, which has been tested in Colombia, the Dominican Republic, and Peru, indicates that while senior management and staff are generally committed to resolving gender and reproductive health issues, more work needs to be done to provide gender-sensitive services, such as counseling for women who have experienced gender-based violence, and to develop gender-supportive institutions, including antidiscrimination policies. (IPPF/WHR 2000).

Improved Program Standards: The Quality Assurance Project (QAP), a U.S. consortium led by the University Research Corporation's Center for Human Services describes quality as a comprehensive and multifaceted concept that measures how well clients' expectations, as well as providers' technical standards, are met. QAP's tools and methods, which are based on quality management principles derived from industry, are applied to the accreditation of facilities, supervision of health workers, and other efforts to improve health workers' performance and the quality of health services in less developed countries (Reerink and Sauerborn 1995).

Quality in health care can be broken down to three mutually reinforcing components: quality design, quality

control, and quality improvement.

- Quality design uses planning tools first to define an organization's mission, including identifying its clients and services, and then to allocate resources and set standards for service delivery;
- Quality control applies monitoring, supervision, and evaluation methods to ensure that every employee meets the established standards and delivers high-quality services; and
- Quality improvement involves solving problems and improving processes (Kols and Sherman 1998).

Family planning and other health care programs in less developed countries began adopting various components of quality assurance nearly two decades ago. For instance, QAP used quality design concepts to develop the Latin American Maternal Mortality Initiative, a regional effort to strengthen the delivery of essential obstetric care at the health facility and community levels (Quality Assurance Project 2002).

Section 2 - Background

The flagship *Integra Initiative* is supported by the Bill & Melinda Gates Foundation and managed by the IPPF in partnership with the London School of Hygiene & Tropical Medicine (LSHTM) and the Population Council. The five year research project was embedded within the day-to-day activities of 42 government and IPPF health facilities being studied in Kenya, Malawi and Swaziland and has looked into the cost, quality, health benefits and stigma reduction with integrated HIV and SRH service delivery in Africa. This largest ever evaluation of different models of HIV and SRH integration shows that there are benefits to integration such as improving health outcomes as well as service delivery, having the potential to lead to efficiencies (VCT within FP and PNC) and is the preferred individual choice and for women living with HIV (save time and money, continuity of care, stigma reduction). However, SRH HIV integration needs substantial and sustained investment to be scaled up. The evaluation also specifically demonstrated that:

- Integrating HIV services into family planning and postnatal care services can improve the use of HIV counseling and testing.
- Integration does not reduce the overall quality of care as is often perceived, but can increase the quality of family planning and postnatal care.
- There is potential for integrated delivery of services to improve cost efficiencies but this is often unrealized at the facility level.

In Pakistan, **the national assessment of bi-directional linkages between SRH and HIV** at policy, systems and services levels took place in 2009. It was led by the Ministry of Health, National AIDS Control Program (NACP) and received technical and financial support from UNFPA.

The assessment recommended action on the following:

1. **Non-existence of national multi-sectoral working group on SRH and HIV linkages.** A collaborative group is needed, involving people living with HIV (PLHIV) and key populations, to support the development of policies and laws, advocate for integration, mobilize resources, etc.
2. **Weak coordination on SRH and HIV between the Ministries of Health and Population Welfare.** Strong coordination is needed between the main government agencies working at all levels relating to policy, planning, programs and service delivery.
3. **Absence of national laws to facilitate implementation of SRH and HIV policies.** The members of the national and provincial assemblies already involved in HIV prevention could play an important role in preparing and approving relevant laws.
4. **Allocation of funds for SRH and HIV linkages.** Funds are required for materials, training of service providers, procurement of equipment and monitoring and evaluation (M&E) activities. Donors and the Ministries of Health and population Welfare could pool their resources for integration.
5. **Single national curriculum for integrated services.** The Ministries of Health and population Welfare should develop one curriculum to train SRH and HIV service providers on integration.
6. **Phased integration of SRH and HIV services.** This should start from the program level, with the services that can be more easily integrated and a focus on high prevalence areas and groups most at risk.

Post the 18th amendment to the Constitution of Pakistan in 2010 the Health and Population Ministries have ceased to exist at Federal level with most of the program and responsibility being transferred to the Provincial Departments (policy and oversight) and the actual implementation being devolved to the Districts. At the Federal level the Ministry of National Health Services Regulation and Coordination is a government agency responsible for Pakistan's health system. The National AIDS Control Program (NACP) is also placed under this Ministry, with Health and Population being represented by Director General (DG) level officials.

Section 3 - About the Study

The quality of care and best practices for strengthening SRH and HIV linkages are poorly researched in Pakistan, where limited integrated services provision has existed for over five years in the obstetrical care departments of selected Government tertiary care hospitals (PPTCT integrated into SRH), about 50% of STI clinics provide HIV information and referrals for ARVs (HIV integrated into SRH) and all VCT and ARV centers provide STI prevention and management (SRH integrated into HIV). The *Integra project* was implemented in countries; with a generalized HIV epidemic whereas Pakistan has a concentrated epidemic type among two high-risk groups-Intravenous drug users and MSM mainly Hijra sex workers. No assessment of public or private sector integrated services has been carried out so far, therefore, a study is proposed with the following objectives:

Objective	• To identify critical QoC concerns/issues that adversely impact service delivery/denial of SRH rights and also reflect significant gap in the health system. • To measure the coverage and quality of integrated SRH and HIV services in two Government and two NGO Service Delivery Points. • To provide suggestions for future initiatives on advocacy with policy makers and capacity building support to integrated service implementers.

A Methodology – The 3P Approach

The following "3P" assessment technique was adopted to conduct the baseline assessment.

Paper	Paper assessment" essentially refers to the document review, where the purpose is to find out how QoC commitment is enshrined in various policy and program documents of different departments including health, population and planning at Federal and Provincial level.
Perception	Perception assessment is about finding staff's perception of how these policies and strategies play out for them, how they perceive them and how it is translated into practice.
Practice	Practice assessment" results from evidence-based, in-depth review of the degree to which QoC commitments as contained in the policies have been put in practice. How it is understood by the head of the department, how it is practiced by the practitioners and how it is demonstrated at various levels in the health facilities

To achieve the above results the following activities were conduced:

i. Policy Review:

The existing policies and strategies at Federal and Provincial levels were reviewed. The Health, Population Planning and HIV AIDS Policies were reviewed with a special focus on QoC.

ii. Key Informants Interviews

To obtain the policy makers and implementers' perspective a range of key informant interviews were conducted both at Federal and Provincial levels. The following officials visited for In Depth Interviews:

Federal Level	Provincial Level
• National Program Manager, National AIDS Control Program (NACP), Islamabad • Senior Program Officer, National AIDS Control Program (NACP), Islamabad • Joint Secretary, Population Welfare, Islamabad • Director General, Population Wing, Ministry of National Health Services Regulation and Coordination (NHSRC) • Director, Population Wing, Ministry of National Health Services Regulation and Coordination (NHSRC) • Deputy Director Programs (Health), Ministry of National Health Services, Regulation & Coordination (NHSRC)	• Additional Secretary Health and Program Manager, Punjab AIDS Control Program (PACP) • Regional Director, Family Planning Association of Pakistan (FPAP) • In charge Diagnosis and Treatment, Punjab AIDS Control Program (PACP)

iii. Visit to Facilities Providing SRH HIV Integrated Services in Lahore

Both government and private facilities were assessed for the quality of care and services being provided. The following facilities were visited and staff was consulted for the above stated purpose.

Sr.	Facility	Staff at VCT Center	Facility Managers
1	**Services Hospital, Lahore** VCT Centre providing STI services (SRH integration in HIV)	Lab Technician Counselor	HIV Coordinator
2	**Rahnuma- FPAP Family Health Hospital, Lahore** VCT Centre providing STI services (SRH integration in HIV)	Counselor VCT Medical Officer, HIV Program	Medical Superintendent
3	**Karim Park Family Health Clinic-FPAP**	Counselor	Regional Manager

	SRH Clinic (STI, Abortion and FP services) providing HIV services(HIV integrated into SRH)		
4	**Services Hospital, Lahore** PPTCT services in MNCH Program (HIV Integrated in SRH).	PPTCT Coordinator	HIV Coordinator

iv. Exit Interview

The clients having availed of services at these facilities were also interviewed to collect their feedback with respect to the quality of services provided.

- FPAP Family Hospital – 3
- Services Hospital – 3

v. Focus Group Discussion (FGDs)

It was also planned to conduct focus group discussion with all the beneficiaries groups to collect a general perception of services they received from various outlets. The following four FGDs were conducted:

Sr.	Category	No. of FGDs	Participants
1	Transgender	**1**	6
2	Female Sex Workers	**1**	**6**
3	MSMs	**1**	**6**
4	PLHIV	**1**	**7**

vi. Application of Facility based QoC Checklist

At Service Delivery Points (SDP) there will be application of a facility-based checklist; and a patient record review to assess the availability of resources, training, access, quality and integration. The checklists will respond to the essential Quality of Care Standards and Criteria which are based on the IPPF QoC Framework for SRH services and ensure the principles of client's rights and provider needs. The foregoing will be adapted to assess QoC in SRH HIV integrated services.

vii. Data Analysis

The document below will provide the analysis of the data collected from all the above stakeholders. The data will have both the qualitative and quantitative information for the reader.

Section 4 - Findings of Assessment

A. Relevant Policy Reviews

The following points were evident on review of the relevant policies.

i. Health Policy

- Emphasis will be to re-vitalize Primary health care (PHC) system with a focus on reproductive health and family planning services, integration of services, improving quality of care and ownership of interventions at the local level.
- Improving QoC- Provision of quality health care and ensuring gender sensitive and patient-centered services;
- Emphasizing more on quality of care and services at all levels.

ii. Population Policy

- Quality of care is mentioned as a strategy to increase access to Family Planning Services.
- Ensure service standards and protocols are adhered to and client satisfaction monitored.
- Quality of Service and Client Centered Trainings will become core activities.

iii. HIV AIDS Policy and HIV AIDS Strategic Framework

- Standards of treatment and care will be set and monitored and the active participation of people with HIV and AIDS will be encouraged as a way of improving the quality of health services.
- To ensure the availability of easily accessible, affordable and acceptable quality STI services

iv. Draft Strategy 2012–2020 Health Sector of Punjab

- Strategic Directions include improving quality of care **–** through adoption of service standards and making investments in strategic health infrastructure as well as key areas of human resource development.
- One of the objectives is to institutionalize quality of care in the health services delivery system in order to achieve the outcome of improved access and quality of healthcare
- Develop guidelines on quality measures at provincial level and institute clinical audits and clinical assessments through Punjab Healthcare Commission.
- Development of patient rights statements with mandatory display and communication to patients
- Develop and apply of codes of behavior for health workers which should include gender sensitive standards for work place behavior with legal instruments for institutional accountability.

v. Country Context on SRH HIV Linkages

At Policy Level: National policies, laws, plans and guidelines for both SRH and HIV support linkages and the

Ministries of Health(MoH) and Population Welfare(MOPW) acknowledge the need to integrate STI services into facilities for MNCH and HIV but the method and extent of integration is not defined. Also the final draft of the National AIDS Policy (2007) addresses integrating HIV with services for Maternal Neonatal and Child Health (MNCH), STIs, Family Planning and TB. It also recognizes the rights and SRH needs of PLHIV. The NACP has developed STI management guidelines to pilot integration of HIV with SRH, family planning and MNCH. However, there has been no progress on laws to support integration. There has been no legislative action to protect SRH rights, particularly of women, PLHIV and key populations except for the passing of two bills on domestic violence and sexual harassment of women at workplace. Moreover, there exist two separate budgetary streams for SRH and HIV. For the former funding support is from Ministries of Health and Population Welfare (FP only), district governments and donors as UNFPA, UNICEF and DFID. For the latter, the main source of funding is National/ Punjab AIDS Control Program (MoH) and donors as UN agencies, World Bank, USAID, GTATM and CIDA. The MOH and MoPW do not specifically fund linkages only UNFPA and Packard Foundation have provided some support.

At Systems Level: Major stakeholders for SRH and HIV programs (Government and Non-Governmental Organizations) support integration and guidelines have been developed by a Technical Working Group. But there is no multi-sectoral working group for coordinated action on integration. Also there is no involvement of PLHIV and key populations in SRH programs and with HIV programs their participation is limited to planning. Also there is neither a joint planning of SRH and HIV programs nor any collaboration for management/implementation. Challenges also exist with regards to human resources and capacity building. Logistics, supplies and laboratory support appear equally challenging though the latter could serve the needs of both SRH and HIV services. There is no Monitoring and Evaluation system for integration.

At Services Level: To some extent HIV Integration into SRH services exists at this level such as HIV counseling and testing, condom promotion and provision, PPTCT (at selected tertiary care hospitals) HIV care and support and ARV treatment and prophylaxis for opportunistic infections for PLHIV and specific information /services for key populations. With regard to SRH integration into HIV services: the prevention and management of STIs has been integrated to a large extent, but, hardly any FP services are being provided at HIV facilities. However, prevention/management of abortion, post abortion and GBV are not integrated. Also no MNCH services are available at HIV facilities.

The DRAFT Strategy 2012–2020 Health Sector of Punjab: strategizes the integration of preventive healthcare (vertical) programs to optimize healthcare service delivery arrangements through adopting integrated models, like SRH-HIV and family planning service for reproductive health. However, there is no mention of the mechanism for integration at the systems and services levels. Neither are quality assessment, monitoring and evaluation of integrated programs clearly specified.

B. Key Informant Interviews

i. Federal Level Officials

Post 18th Amendment to the Constitution of Pakistan (2010) the role of National AIDS Control Program (NACP) and Health and Population wings of the Ministry of Health Services Regulation and Coordination (NHSRC) is to

provide Policy Guidelines and technical assistance on relevant matters to the Provincial Programs. The existing policies and strategic frameworks on HIV AIDS, health and population are in the process of being reviewed and new documents as Pakistan AIDS Strategy, National Policy Framework for population welfare are being developed.

With regard to provision of SRH HIV Integrated services the Reproductive Health centers of Population Welfare Departments provide comprehensive Family Planning services and limited STI services and HIV counseling. The manuals of Reproductive Health and Family Planning used for training staff have incorporated these issues also. A major constraint in full integration is funding and staff training.

According to NACP: Both in countries with concentrated HIV epidemics and in low prevalence countries SRH HIV integration is cost effective as more positive cases can be identified through SRH clinics providing STI services. All over the country there are 11 PPTCT centers being controlled by the provincial governments. These centers integrate HIV in MNCH services and are being supported by donor funding including staff salaries and consumables. Currently, there is no joint policy for purchasing of lab kits/ condoms/ commodities/ supplies for the integrated services. All ARVs and lab kits are available through Global Fund for the PPTCT centers and the other Special Clinics providing HIV treatment, care and support. However, the Ministry of NHRSC is working on joint procurement policies. Major constraints in functionalizing SRH HIV Integration are at systems level, which include collaboration between sectors and capacity building of staff. Regarding sustainability of SRH HIV integrated services currently the provinces have good level of donor funding for HIV and if it is withdrawn integrating HIV services into existing healthcare system will be a major issue.

ii. Provincial level Officials

Post 18th Amendment to the Constitution of Pakistan, Punjab government has prepared the Punjab AIDS Strategy, which has been approved for implementation and is currently in the process of dissemination. In Pakistan, the HIV AIDS epidemic is in a concentrated epidemic phase but SRH HIV integration is still a cost effective initiative as SRH centers providing STI services help in identification of HIV positive cases and hence this initiative should be implemented.

The implementation of SRH HIV integrated services through tertiary care hospitals in Punjab, mainly as a PPTCT initiative (2007-2010) was not as successful as was anticipated (3 HIV positive in 10,000 cases tested). After 2010, the Government adopted the District Model strategy for its implementation. The model emphasizes coordination of three sections-MNCH, PACP, LHW program, of the Health Department at district level. LHWs identify high risk individuals and their families, especially pregnant wives, through their regular community level preventive health activities. The Case Manager at the DHQ hospital then contacts the PACP (VCT) and MNCH (ANC, Natal, PNC) section for providing related services to them. Specialized HIV Center then registers patients and provides ART free of cost as well as treatment for opportunistic infections including Hepatitis B and C and TB. Compliance for ART and follow up is the responsibility of HIV Care and Support NGOs working with PLHIV. This program is being implemented through 2 hospitals in Lahore District (Services Hospital and Rahnuma Family Health Hospital) and one each through DHQ hospitals in Gujrat, Sargodha, DG Khan and Allied Hospital in Faisalabad. There are also VCT Centers at Services Hospitals and Rahnuma Family Health Hospital where STI services are also provided.

There is no special budgetary allocation for SRH HIV Integration but enough funds are available, only initiative is lacking. The department is flexible enough to make allocation for such activities if a good proposal is received. Government of Punjab has a joint purchasing policy for acquiring condoms to meet the requirements of the Health Department, PACP and Population Welfare Department.

SRH HIV Integrated services have increased access of PLHIV to these services. The quality of care of these services is satisfactory. Initially there were issues between staff of the integrating units but this has been resolved. Major constraint is service provider's stigma and reluctance to provide services to PLHIV. However, QOC has improved through increased capacity building of staff including attitudinal reconstruction. If infection control procedures are properly and consistently implemented it would further help to allay the fears of the service providers Sustainability is no longer an issue as funds are available. While UNICEF trained doctors at the beginning of the program but now their support is very nominal mainly for celebrating events as Family Heath Day.
For QOC of integrated services at the policy level no framework has been developed and at the systems level there is no capacity building of staff and no system for QOC monitoring and assessment. However there has been no stock out of related medicines and commodities including testing kits and condoms.

C. Service Implementers

i. Facility Managers: Services Hospital, Lahore:

The PPTCT Center has been functional since 2007. Between 2007 and 2009 three thousand HIV tests were performed as part of Antenatal Care at Services Hospital, but no positive cases were identified. After 2009 eight risk factors were defined for HIV testing of pregnant women and the number of test performed decreased to 1000 tests with still no positive results. It was then decided to move the PPTCT Centers to the districts where high risk cases had been identified through annual surveillance by National AIDS Control Program. In 2011 PPTCT Centers were established in Gujrat and Dera Ghazi Khan and in 2012 in Sargodha and Faisalabad. The first three Centers are set up in the DHQ hospitals of the districts and the fourth at Allied hospital in Faisalabad. Capacity building trainings on provision of HIV services were provided to staff of the hospitals and to Lady Health Workers, who provide community based primary health care and family planning services in the same Districts. LHWs identified HIV high risk cases based on three criteria: history of blood transfusion in past 5 years, husband living abroad or returning after tenure abroad and husband being an intravenous drug user. The team of doctor, counselor and laboratory technician are responsible for follow up of identified pregnant women with HIV testing and CD 4 counts being done at DHQ hospital.

Services Hospital has three gynecology units with 50 doctors and 30 trainee doctors. Full HIV services are provided through Specialized HIV Center comprising PPTCT, VCT and treatment facilities including treatment of Opportunistic Infections (OI) and Post Exposure Prophylaxis (PEP). Some staff has been provided PPTCT training by UNICEF while others have learnt on the job. No staff has been trained on SRH HIV integrated service delivery. Clients access services as walk in clients or through referral and appointments. PLHIV access services at the treatment center of hospital where staff advise them to send the pregnant wife for PPTCT services. Hospital staff has learnt on the job to provide stigma free services, however district staff have undergone regular trainings on the issue.

There is no quality assessment system for the services and staff has not been trained on quality of care. HIV positive pregnant woman is a pampered client with free and specialized care. Follow up visits are an indication of client satisfaction. Quality of services can be improved through capacity building and ownership of the services by the staff. Performance report of PPTCT Center is sent on monthly basis to Punjab AIDS Control Program.

ii. Facility Managers: Rahnuma-Family Planning Association of Pakistan (NGO)

The Family Health Hospital Lahore has been functional since 2001. Staff strength is 42 including 3 gynecologists, 7 medical officers, paramedical and support staff. No staff has been trained on SRH HIV Integration. Full range of SRH services are provided including HIV Counseling and condom distribution. VCT is available and for confirmation of test result patients are referred to Government Jinnah or Services Hospitals. Through a MOU with Punjab AIDS Control Program, a medical doctor and staff nurse have been seconded to the hospital to provide OPD services to PLHIV. Furthermore, after a year full PPTCT services will also be made available to them.

The system of clinical access to services is walk in, by appointment and referral. Hardly any PLHIV access facility for services-there is only one case of a HIV discordant couple whose baby was delivered in the hospital 5 years ago. There is no advertising of the services for PLHIV and key populations and very limited HIV outreach services currently exist. It is felt that if these groups start visiting the hospital general SRH client numbers will decrease. Initially staff stigma and reluctance was an issue but, after 2 HIV training workshops on attitudinal reconstruction and on service delivery including universal precautions, the situation has improved.

QOC of integrated services is satisfactory given the available resources. IPPF system for maintaining quality of care standards is followed. A Quality Assurance Doctor is in place and closely assesses QOC at the facility. There is a complaint redress system at the facility as per IPPF requirements.

D. Service Beneficiaries

i. General

TG/MSM	FSW	PLHIV
• The transgender and MSM usually face diseases like STIs, Hemorrhoids, genital ulcers, most commonly an anal skin condition characterized by pearl like papules (aptly called 'Moti-dana' in the vernacular) weakness, muscle pain. • There is no preference regarding the health facility: they only visit the one that is	• Female sex workers usually face typical health issues of women. The tendency of certain issues is bit higher due to the nature of their work. The minor illnesses include the fever, influenza, excessive vaginal discharge while the major illness or health issues relate to SRH include, abortion, maternal health issues, and	• The persons living with HIV reported that they mainly face the health issues as body itching, rashes, increased bleeding from wounds, cough, laziness and lethargy. • For minor illnesses they visit the nearby doctors while for serious illnesses they visit Government and private

near due to poverty and lack of money to go to specific clinic and hospitals. However, experiences at Government Hospitals as Shalimar and Ganga Ram have not been satisfactory. Moreover, Private Practitioners are very expensive • Peer suggestion • We only know about the DOSTANA (An NGO working on male sex workers issues in Lahore)	menstruation related problems. • The FSWs frequently visit local clinics and hospitals as the situation demands. The most frequently visited clinic is of NGO SHEED and hospitals attended include Mayo Hospital, Chitta Hospital, Lady Wellington Hospital. The selection of facility is based on the seriousness of the illness, e.g. for minor illness SHEED is the closest to the community, Mayo Hospital is the next choice due to it being a government facility where charges are affordable. The free Chitta Hospital is most popular with regard to expenses incurred while the Lady Willington Hospital is the rated as one of the best facility for its technically competent service delivery. Lady Willington has experienced doctors, polite staff and latest equipment to deal with any difficult situation.	facilities. As a practice they inform the doctor that they are HIV positive.

Case Study:

- *A daughter of one of the FSW had a serious maternity issue of fetal death at 6 months gestation. None of the facility/hospitals were willing to provide treatment. Finally the staff of Lady Willington hospital operated to deliver the fetus providing the patient full treatment till complete recovery.*

- *A similar case was repeated by another FSW where the fetus had died in utero 5 days back and staff of Lady Willington successfully provided necessary treatment.*

ii. Information

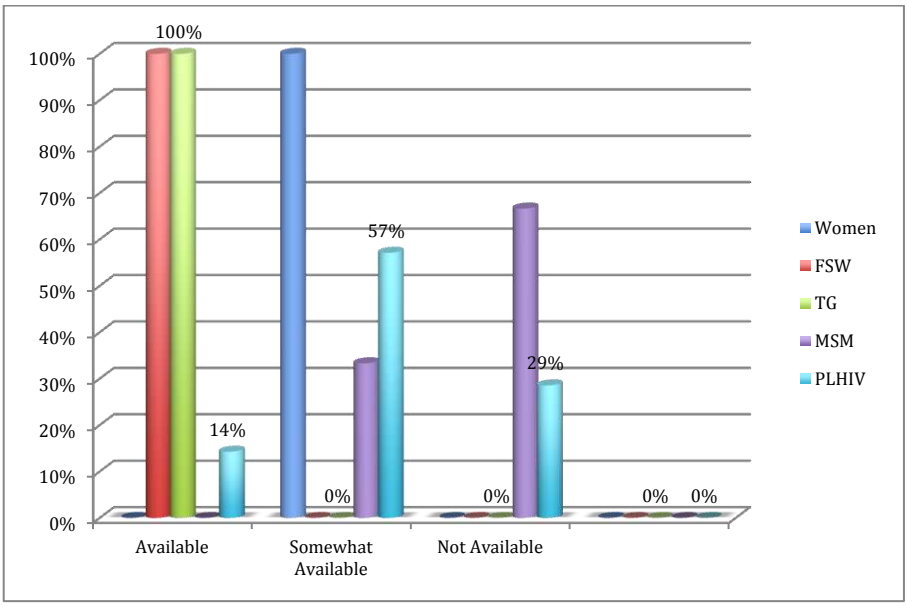
TG/MSM	FSW	PLHIV
• They are unaware of a SRH and HIV and AIDS facilitation center, which they, being part of the target community, can access to obtain relevant information. • The information about the disease and its cure is provided by the NGOs. The government institution does provide some information but it is insufficient • The information from both Govt. and NGOs is usually on HIV AIDS, its virus and infection. They also advise about condoms, its use and how to protect oneself from HIV AIDS by condom use and safe sex. No information is provided on SRH. • A major issue is dealing with customers or clients who insist on unprotected sex and also with police harassment if caught with condoms. However, they are aware of consequences of unsafe sex through information received from NGO outreach workers and peer educators who conduct sessions within the communities on proper condom use and negotiating safe sex.	• No specific information is required about these facilities. These health institutions are generally known for such services. • SHEED has its own outreach staff to provide information about the safe sex, HIV and AIDS and other STIs, its related risk and preventive measurements. They also distribute posters, flyers and condoms as part of the preventive activities. • SHEED also provides condoms for safe sex to FSWs at their door step.	• No information about the SRH and HIV AIDS facilitation center is provided to these groups. The information is not conveyed to the target community nor is it visibly displayed at any point for help and facilitation. • All information about HIV AIDS is provided by the Care and Support NGOs as Pak-Plus but the PLHIV are not satisfied with their services. • Government institutions do provide information on HIV AIDS but it is not sufficient. • They are not aware of any VCT Centers.

Case Study:

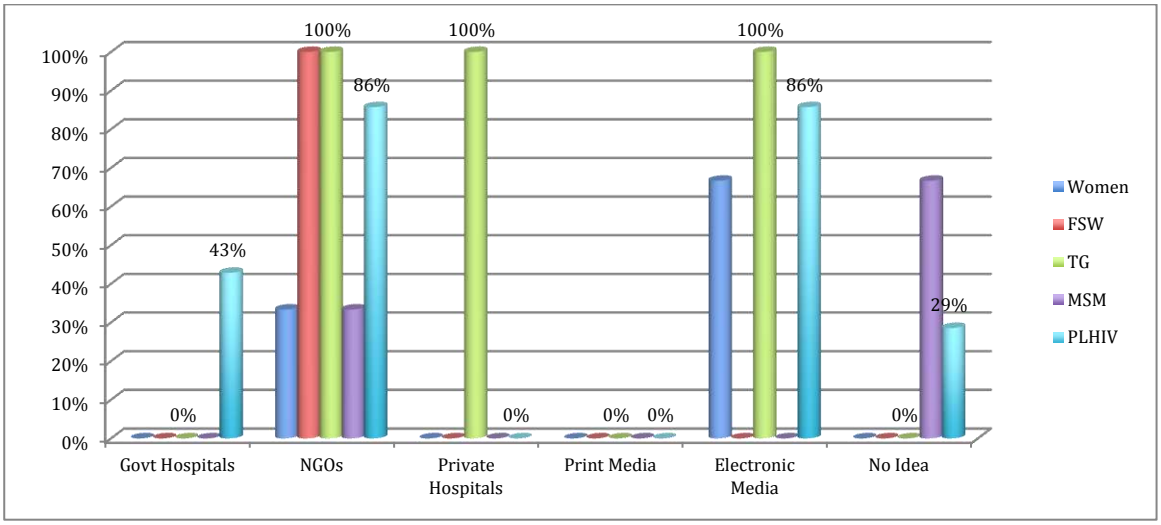
In Pakistan, a quick orientation on HIV is provided at Office of the Protectorate of Emigrants, Bureau of Emigration and Overseas Employment, Government of Pakistan but the orientation is only focused on

consequences of carrying "Drugs" in other countries. The information regarding HIV and AIDS is not provided at any level.

Availability of Information regarding HIV



Sources of Information



iii. Behavior/Care

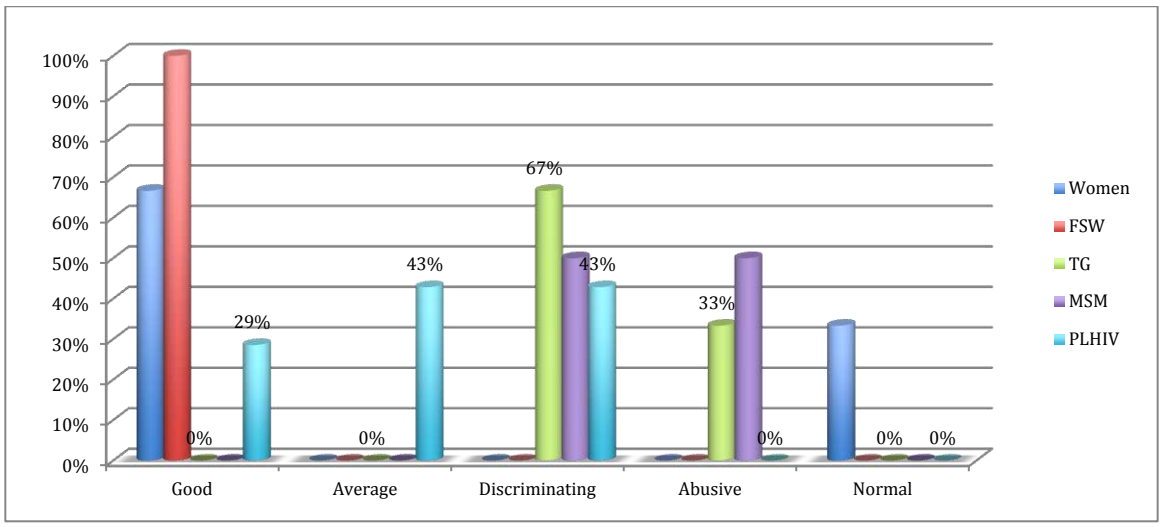
TG/MSM	FSW	PLHIV
• Both TGs and MSM complain that the doctors in health facilities behave strangely do not treat them as they do other patients and this attitude is also demonstrated with female sex workers. The doctors	• SHEED (NGO) clinic and its staff are rated by FSWs as being the most cooperative to provide solutions to their health related problems. • Since there is no stigma attached to these groups only	• The doctors in rural areas are not very sympathetic or caring while in Lahore (urban) they are more accepting and do not hesitate in providing treatment The only NGO working with PLHIV is rated

usually avoid examining these patients. • They NGO doctors are good in service provision but they are mostly in a hurry to close the clinic, especially in the evenings, which is the time when TGs and MSM can visit the clinic. • There are two categories of service providers that the group encounters, those with a non caring attitude and demonstrating clear discrimination by treating them badly, and the other who try to take advantage and abuse them due to their orientation. They ask for physical examination and try to touch their body and ask for some undue favors (in some cases).	(until they expose themselves), they are treated as normal patients in all the facilities. They also reported that the staff of the facilities which they visit frequently, have a fair idea about their work, still they treat them as they would the regular patients. • There is no discrimination in verbal and non-verbal communication of doctors and staff at any facility, but they sometime (while knowing their profession) warn them about the health risks attached to their work	low in service, behavior and even in supplies.

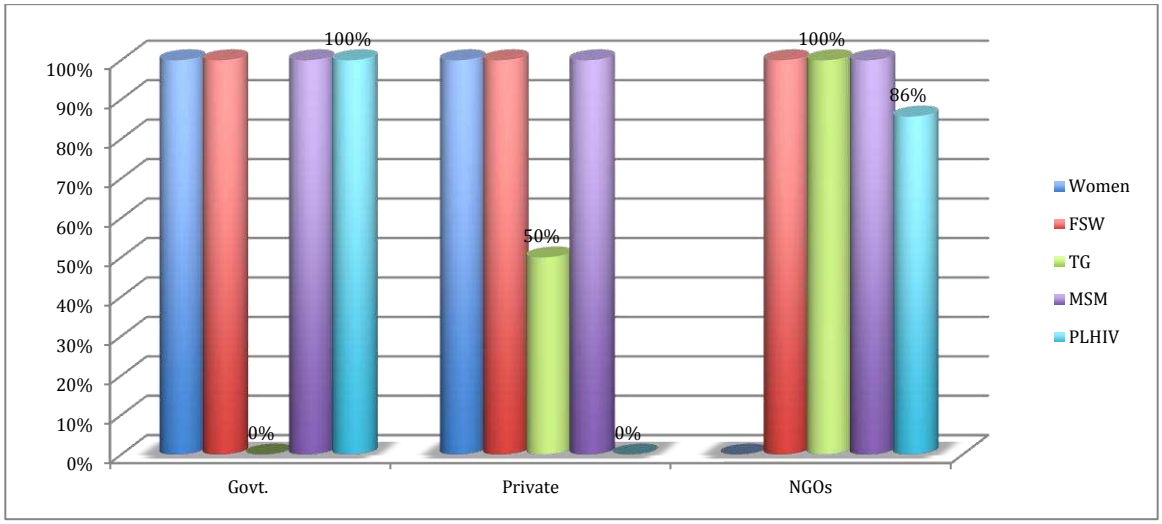
Case Study:

- *One TG mentioned that the community doctor asked him to come in the evening for the treatment and when she was unable to pay his fee the doctor asked for anal sex. To this the TG complied and since the doctor refused to use a condom, it was a case of unprotected sex. On probing the TG admitted to a certain level of willingness for the act because of being unable to pay for the treatment.*
- *Verbal and non verbal discrimination from doctors is faced by both TGs and MSM.*
- *One MSM had a similar experience like TG (mentioned above) but he took few of his friends, caught the doctor red handed and had him thrown out of the community with the help of other community members.*

Behavior of Service Provider



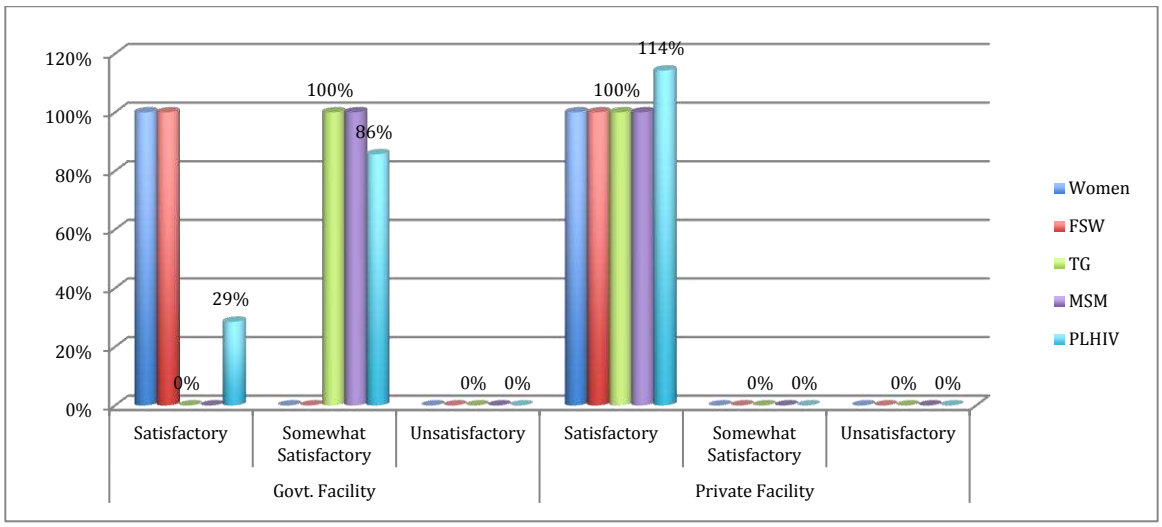
Preference of Facility for Treatment



iv. Safety/Privacy

TG/MSM	FSW	PLHIV
• Since counseling is one on one, privacy is maintained without interruption by others.	• No safety and privacy issues were reported by this group. • All treatment and test are conducted in private with full privacy.	• None of the participants mentioned any privacy or safety issues. They feel they themselves are responsible for safety. If they reveal the fact they are HIV+ they face discrimination, if they do not, the community treats them as normal human being.

Privacy during Checkup



v. Patient Care:

TG/MSM	FSW	PLHIV
• Being professional doctors they should examine the patient irrespective of their sexual orientation. Doctor's record a brief history of the patient and prescribe medicines without a proper physical examination. According to the TGs doctors usually are reluctant to even touch them with a stethoscope. They treat us like "Choot[1]" (Pariahs).	• No discriminating behavior was reported by any of the FSW. • They are treated as regular patients and there was no claim, demand, or sexual harassment by the staff or health facilities that they frequented.	• PLHIV visit both general doctors and HIV centers, and are treated as other patients, except the doctors in rural areas, who do not even allow them to come close to them or touch any of the equipment in the hospital (reported by a PHLIV). • Shaukat Khanum Hospital is rated one of the best facility in-terms of service and behavior.

Case Study:

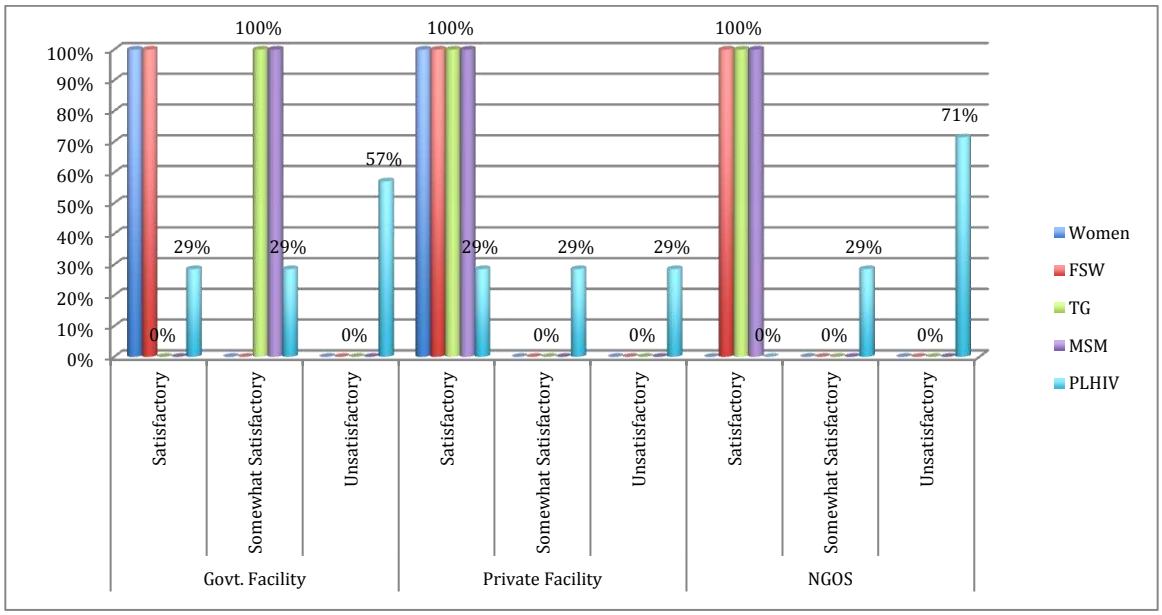
- *I had a little "pimple" at my bottom, I went to the doctor and told him about the illness but he hardly listened to me. The illness was later diagnosed as "Syphilis" which required proper treatment, which I did and my last report is negative.*
- *For treatment they visit random doctors, including the community clinics, nearest private hospitals and government hospitals.*
- *The doctors ask personal questions such as the texture of our skin and how we are able to*

[1] Low Cost ethnic group

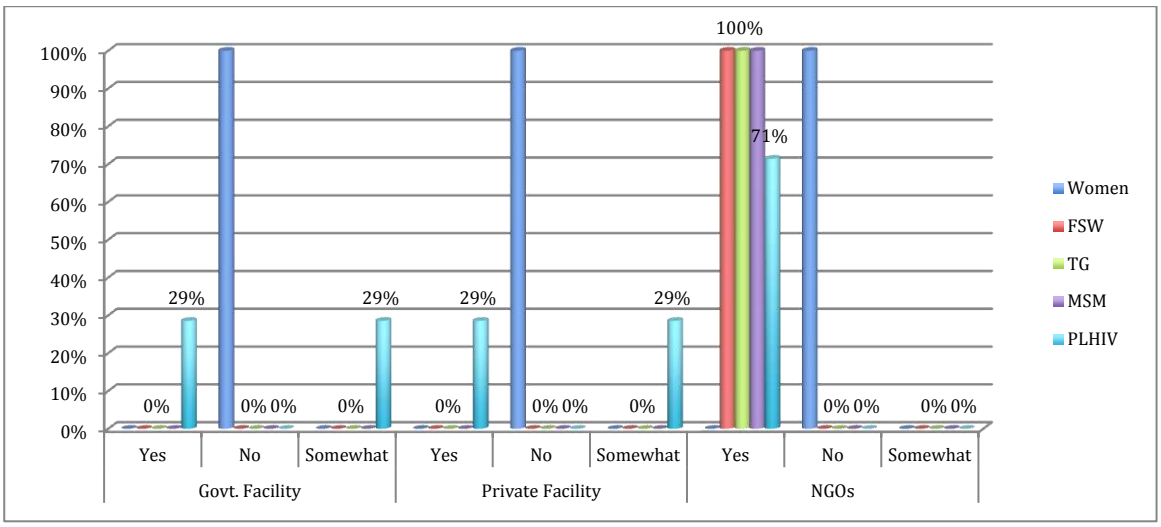
maintain it.

- *After VCT, the regular follow-up schedule and advice is mentioned in the prescription but no counseling as to why repeat testing is required after a certain period of time. E.g. most of TGs who underwent VCT did not receive post test counseling.*
- *If injections are required for treatment, doctors forced TGs to take it on hip and in the process start touching the body in strange ways.*
- *Doctors have a very callous behavior towards TGs care and treatment.*
- *A doctor in a govt. facility gave a TG an intravenous injection. The process was very painful and left the arm swollen for few days. To date, which is two months on there is a bruise on that spot, which indicates that the injection had not been administered properly. When consulted, the doctor assured that it would improve within a few days, but it still has not.*
- *One of the HIV Care and Support NGO in Lahore conducts HIV testing camps but unfortunately the technician is not qualified for the service. The person is a tailor in a nearby community and is hired by the NGO to conduct tests.*

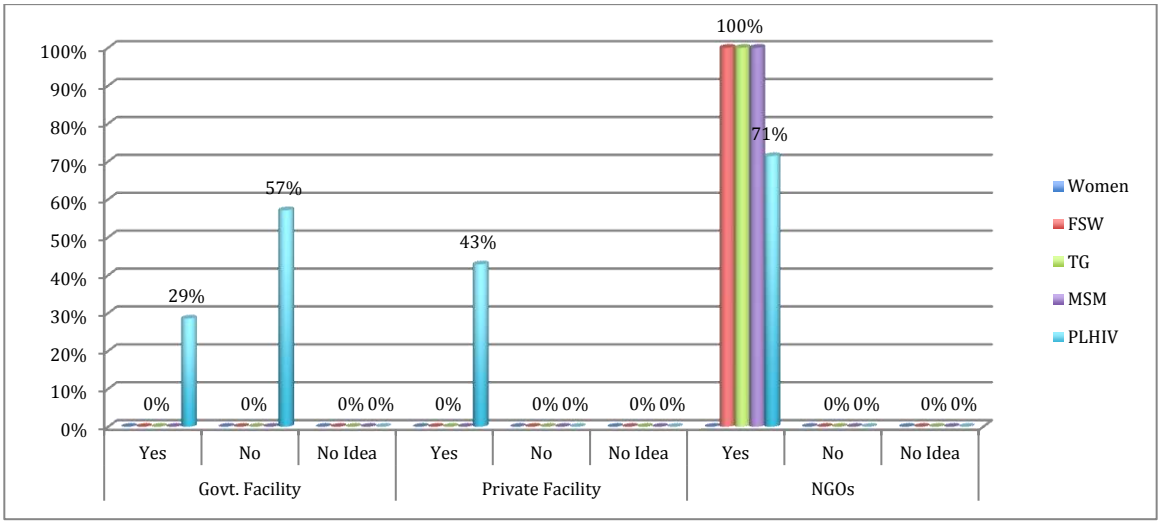
Listening and Responding to Patient



Counseling for SRH/HIV AIDS



Information about VCT Center



vi. Time Efficiency

TG/MSM	FSW	PLHIV
• The clinic should be open till at least 7 p.m. so that TGs who have regular day jobs can visit after working hours. • The clinic should also be open on Saturday since this is the only day for taking care of personal needs.	• All the facilities are well organized and patients are called to see the doctor by their token numbers and no discrimination is found even in timing or token process.	• No special timing or preference for certain days were identified by the PHLIVs

vii. Equality

TG/MSM	FSW	PLHIV
• The harassment is very obvious in these clinics. In	• Despite the difference in age and looks of the FSWs but	• Since no female PLHIV was interviewed, this cannot be

some cases doctors attend first to those TGs who are more attractive.	there is no related discrimination even in this case. • The reason may be that the well-off FSWs visit private facilities while the low-income FSWs attend government (FREE) clinics/hospitals, which automatically reduce the inequalities of treatment.	confirmed. • As far as the equality within the group is concerned, it was reported as being fine

Case Study:

The group stated that if two of them go to the doctor (TGs and MSM), the doctor will call the good-looking TG first. If two MSM visit the doctor, the one who is better looking will receive attention before the other.

viii. Counseling

TG/MSM	FSW	PLHIV
• Counseling services are available in private hospitals but at the time of treatment. There is no prescribed schedule as when a client should have a counseling prior to test and after the test (regarding VCT) The post test counseling after a negative or reactive test report is equally important but there is no emphasis on it.	• The counseling services are only provided at SHEED about the HIV and AIDS and related issues. • The government facilities only provide the health services, no counseling services available. • SHEED has provided detailed counseling about the use of condoms and safe sex. • No trainings provided on negotiating condom use, but these FSW have their own means on successfully convincing clients for safe sex.	• None of the PHLIV mentioned that they were counseled regarding this disease at any level, even at VCT Centers (pre-test or post-test) The NGOs and hospitals (Shaukat Khanum) provide them medicines but never counsel them on HIV.

Case Study:

We (PLHIV) have many problems especially related to our sexual and married life, but we don't know where to go and who to ask.

ix. Cost of Treatment

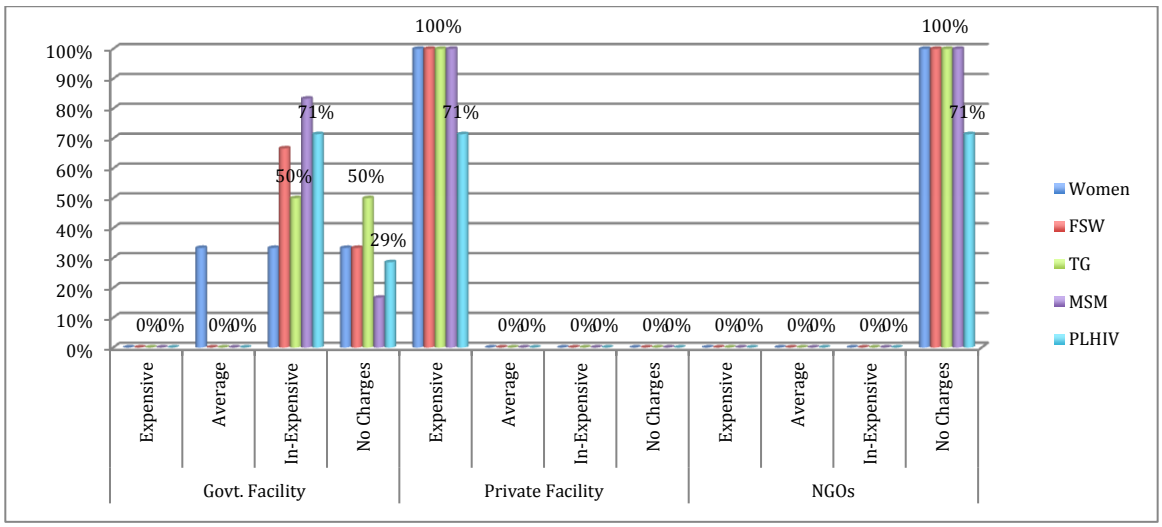
TG/MSM	FSW	PLHIV
• Private hospitals are very expensive. The private doctors	• The cost of service is well handled by the FSWs. They	• The local NGO (Pak Plus) had a referral agreement with

usually charge Rs. 1000 for a checkup	have categorized the facilities with regard to cost: free services (Chitta Hospital) low cost for minor illness (Mayo Hospital) and low cost for serious illness (Lady Willington). • In case of serious or major illness Lady Willington Hospital is preferred, but if the money cannot be arranged, they with borrow from or wait till they have sufficient money to get treated. This is a very rare happening, the FSW usually have sufficient money for their treatment. They usually don't delay treatment because it directly affects their business.	Shaukat Khanum Hospital for the provision of ART to PLHIV. Since the expiry of the agreement SKH has withdrawn its support. PLHIV purchase the medicines, if they have money, otherwise they just suffer the illness. • They also reported that they cannot afford condoms, which sometime forces them to have unsafe sex.

Case Study:

- *A TG once had a urinary problem with a purulent discharge that was also painful. The doctor received Rs. 1000 for the check up and advised surgery costing around Rs. 30,000. It is already 3 months and the suffering continues, as the required amount is still not available.*
- *The government hospitals are reluctant to treat TGs/MSM and refer them to other physicians.*
- *The NGOs are much better in providing treatment. The TGs/MSM mostly attend Dostana NGO clinic for HIV and SRH related issues. The staff and doctors have good behavior, look after the patient with full care, offer water and tea on arrival, provide a detailed checkup and supply the required medicines.*

Cost of Treatment



x. Issues and Concerns

TG/MSM	FSW	PLHIV
• The use of condoms is limited because clients insist that sex is not pleasurable with condoms. • The client is always in hurry and does not use condoms • The client does not carry condoms • TGs do not keep condoms because the police create problems for them. If found carrying condoms and lubricants the police either ask for money or for sex to release them. • There is no complaint mechanism at any facility to report on the behavior of the doctors.	• Same as MSM and TGs, police is the main problem for their business. Police harassment is common they extract dual benefits from FSWs by forcing them for unsafe sex and taking monthly payment to allow FSWs to ply their trade.	• Lack of respect in the community if they expose themselves as PLHIV • The medicines are not available • The condoms are not available when required • The behavior of staff at HIV Centers/institution is not very encouraging • No formal mechanism to participate in the forum of Association of PLHIV and its provincial chapters to raise their concerns. • No support at city, district or national level, they have to survive on their own • There is no complaint mechanism to report their issues and concerns to the higher authorities.

xi. Integrated Services

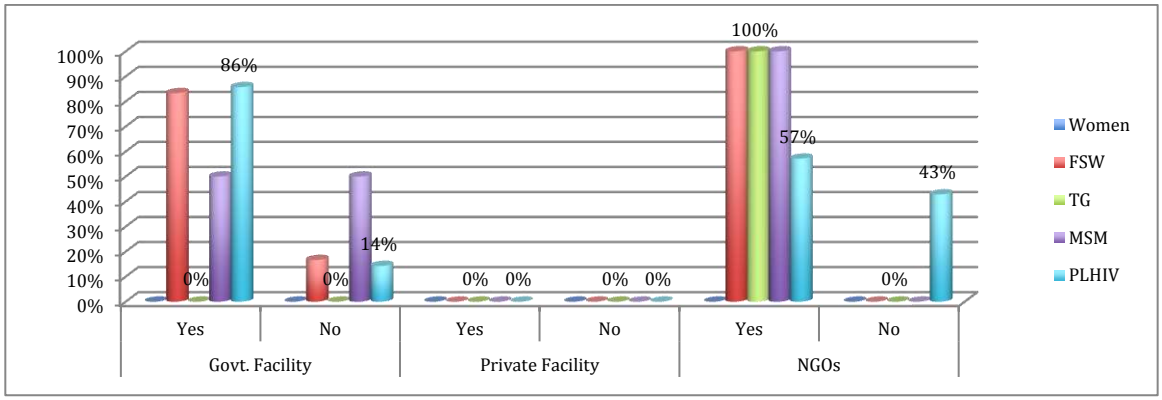
TG/MSM	FSW	PLHIV
• Would prefer integrated services, it is better to have all	• The integrated services are welcomed by the FSW if	• Would prefer integrated services. It is good to have a

services at one place • SRH HIV integrated services as HIV counseling and testing and STI management are not available at the same facility	offered. • They also reported that they are quite aware of HIV and AIDS related issues, illness and preventive measures.	'one stop shop' for all the SRH HIV related issues

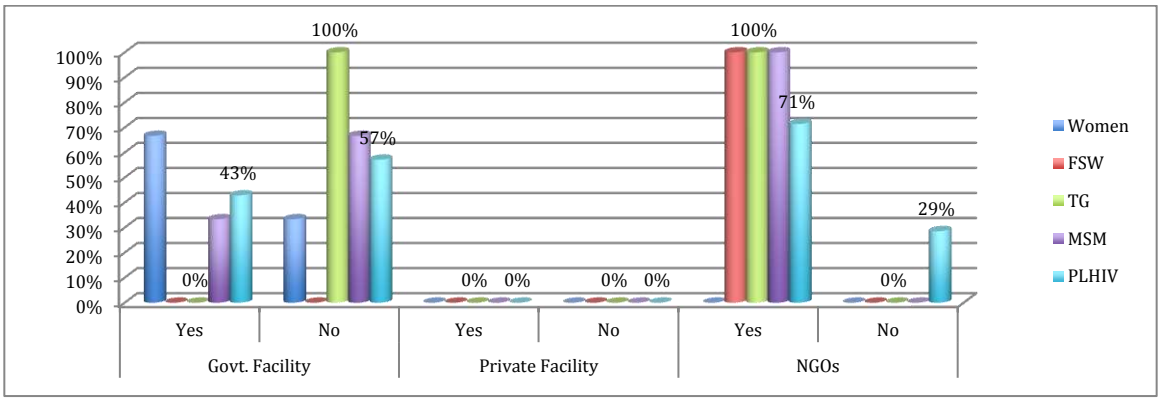
Case Study:

- *The last HIV AIDS case was reported around 20 years back, when a FSW was identified positive but she did not accept the report and continued her work without taking any preventive measures.*
- *After SHEED's campaign, almost every FSW knows the importance of the use of condoms. FSWs try to convince their customer for safe sex and if unsuccessful they refuse to have sex with them.*
- *We (PLHIV) always have to think many times prior to visiting the doctor. If we get all the services available under one roof, it will improve our health and also our self esteem.*

Provision of SRH/HIV AIDS Integrated Services



Availability of IEC Material on HIV AIDS



xii. Suggestions

TG/MSM	FSW	PLHIV

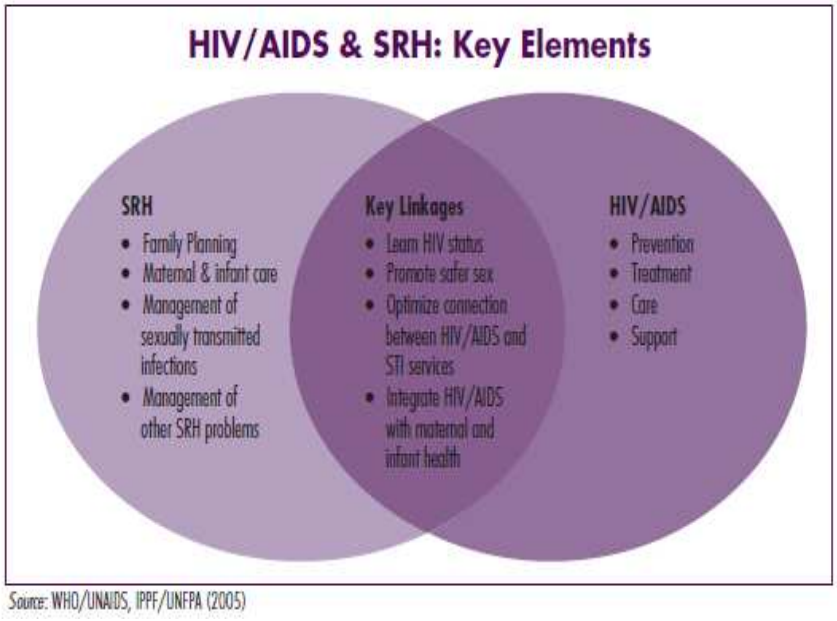
• The government should conduct attitudinal reconstruction of service providers to provide stigma and discrimination free care to these special groups. • There must be a complaint box at all facilities. A system to redress grievances should be available to all especially key populations. • There is no feedback mechanism	• Mapping of FSWs • Counseling about the consequences of sex work	• The departments should also conduct an audit of the NGOS and institutions which are providing such services. • The service standards and quality of services should also be assessed and improved. • The advocacy campaign on PLHIV rights and respect should be conducted to make space in the society for this community • Various forums should be arranged and formed. These forums can be run by community members themselves to understand their issues and constraints. These mini forums should be linked with national and international forums for funding and technical assistance. • It should be mandatory for the NGOs working on HIV/AIDS to have all PLHIV staff in the office for their economic stability and support. This initiative will also help them to unite and help each other. • A complaint mechanism or service card should be introduced to improve the service for this community. • A comprehensive information campaign should be launched for VCT promotion, the available services, locations, timing and its help line (e.g. Rahnuma VCT 080044488)

Section 5 –Assessment & Observation of Facilities

A. Types of Integration

Full integration	*Partial integration*
several services provided to client by same provider in the same room	client receiving services in specialist units under different roofs within same facility.

Related service delivery is a two- way integration process where either of the categories below are implemented: SRH elements integrated into HIV and HIV elements integrated into SRH



SRH HIV integration is of a varying degree in the facilities selected. Hence, it is important to mention that VCTC assessed fell into the partial–integration type whereas the Govt. hospital PPTCT services and the NGO Karim Park clinic providing community based services are examples of full-integration.

i. Service integration mechanism

There is no 'blueprint' for SRH/HIV integration. There are, however, a number of models that have commonly been used to put integration into action in countries throughout the world.

These models are based on where the synergies between SRH and HIV services are often:

- **Strongest:** i.e. where there is clear complementarities (such as with condom promotion – which is key for *dual* protection from both pregnancy and HIV).
- **Most logical or easiest to address:** i.e. where the processes involved (such as counseling or testing) are similar and provide an 'easy win' for integration.
- **Most efficient:** i.e. where most savings are likely to be made in money, time and human resources.

- **Most likely to have impact:** i.e. where integration would make a critical difference to the health and well-being of clients.

ii. Structure of Services

SRH Services integrated in HIV	HIV services integrated into SRH
The VCT Centers in both the Government and NGO provide HIV Pre-test and Post test Counseling, Government VCCT provided HIV testing under the same roof, while NGO VCT Center referred clients to the main laboratory of the hospital. Both facilities counseled on STIs –SRH element-but referred to the hospital's relevant units for STI diagnosis and treatment. This model appears to be based on 'being most logical and easiest to follow'.	The PPTCT services in the Government facility are integrated into MNCH services resulting in the provision of specialized ANC, natal and post natal services to HIV positive pregnant women in the Gynecological Unit of the hospital. The NGO Karim Park Clinic provides FP, STI and abortion services and integrates HIV counseling, condom promotion and referral for testing, to the community including target group of FSWs. These models are examples of full integration based on the premise of being 'most likely to have impact'.

ii. Comparison between Government and NGO facility

Determining minimum requirements for a health facility is a difficult task. Given the disparity in contexts and resource availability, no simple mechanism exists with which to evaluate each component that affects the quality of care and services. However, the self-assessment tools being used measure the readiness of VCT services to deliver according to quality standards of care. This helps facilities to assess their needs and the current state of their operations, and ultimately encourages the design of interventions aimed at improving the quality of a facility's overall service delivery program.

Information below will assess the facilities as per the models:

I. SRH Services Integrated in HIV	II. HIV Services integrated into SRH
STI Services in VCT Center (Services Hospital, Government Facility)	PPTCT in MNCH (Services Hospital, Government Facility)
STI Services in VCT Center (Rahnuma Family Health Hospital, NGO Facility)	HIV counseling, condom promotion and referral for testing in FP, STI and Abortion Services (Karim Park Clinic, NGO Facility)

I. SRH Services integrated in HIV (VCT)

The methodology of the assessment will include both physical assessment and service statistics. A detailed comparison of the physical facilities will focus mainly on quality of care criteria.

a. Physical Assessment of VCT Centers

The self assessment tool was used for the assessment conducted in both government and private facilities to assess the various components including, the policies and strategies available for the implementation and service delivery to specific groups, the availability of systems and procedures for a quality delivery of the services, the capacities and competencies of staff to provide services to specific groups, the data and information collection system, capacities to conduct analysis from the data gathered and developing findings to share with the staff and other stakeholders and the organization and basic facilities for patients when they are waiting in the facility or being examined by the service provider.

The assessment is based on the grading below:

3 = Yes or sufficient (Y)

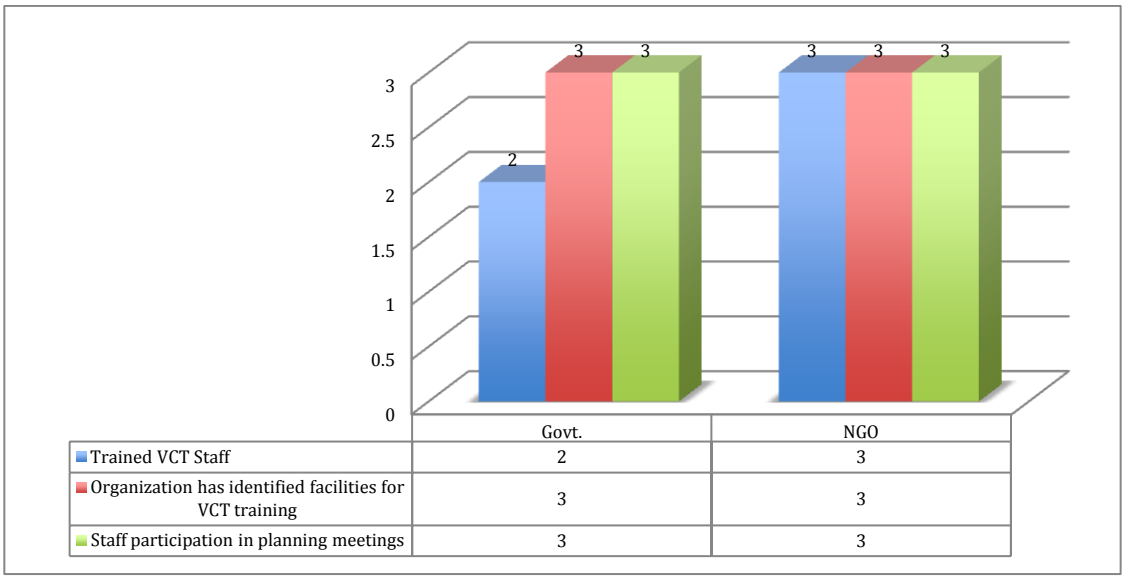
2 = In preparation but not yet implemented, or, implemented but not sufficient (IP)

1 = Being considered (BC)

0 = No, neither considered nor implemented (No)

Both government and private facilities have a system in place to analyze community needs and organizational capacity to provide VCT services. The VCT services' feedback system and information regarding HIV/STI is also available as per policy guidelines in both facilities.

Availability and Capacity of Staff: The staff in private facilities is trained with full protocols while the staff in government facility is not appropriately trained to provide the requisite counseling for VCT services.

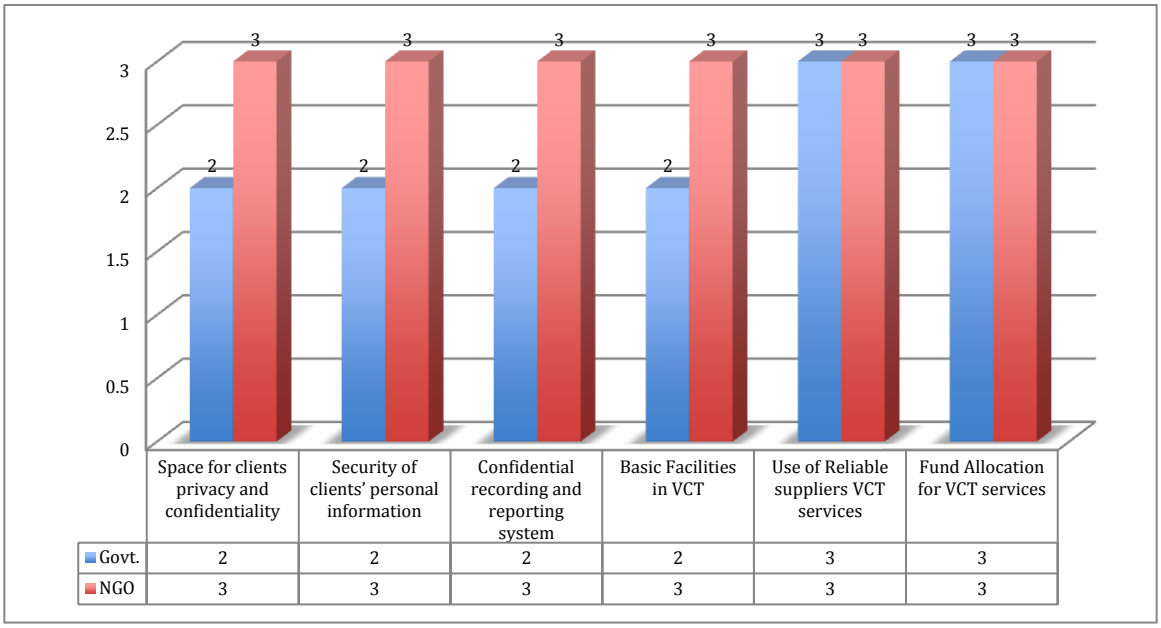


	Govt.	NGO
Trained VCT Staff	2	3
Organization has identified facilities for VCT training	3	3
Staff participation in planning meetings	3	3

***Ranking:** **3**-Yes/Sufficient, **2**-not or implemented but not sufficient, **1**-Being considered **0**-Not considered/implemented*

Physical Facility: The condition in NGO institution is much better than in the government hospital. The

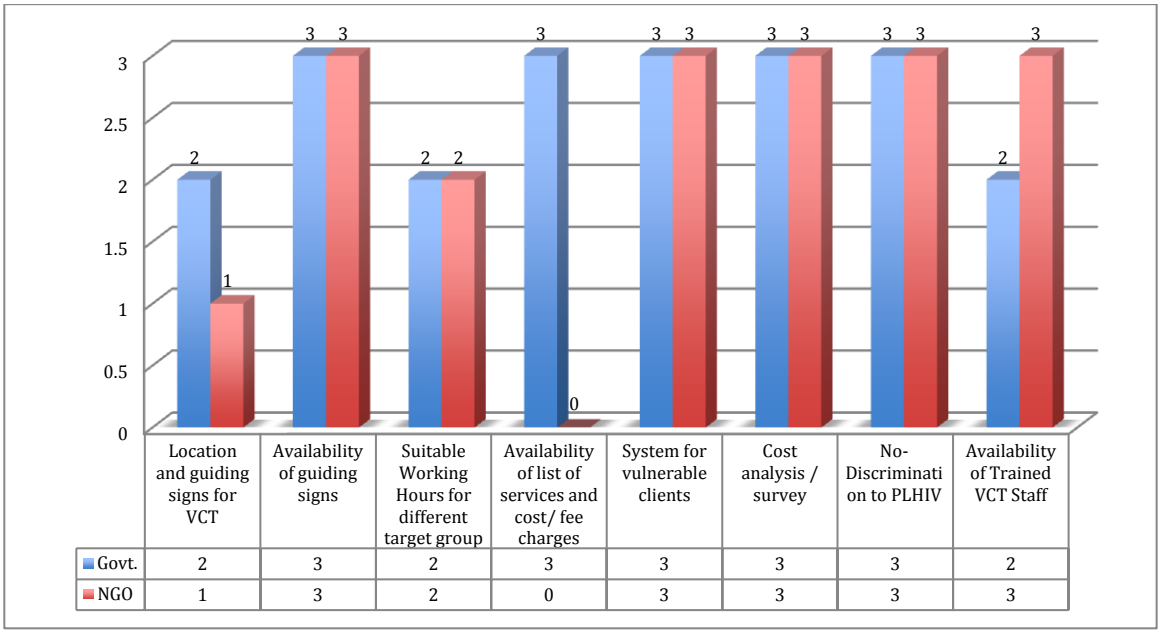
availability of supplies and medicines are satisfactory in both facilities due to the resources from the government and donor sector. The smooth funding and allocation of resources for VCT centers is not an issue in either facility.



	Space for clients privacy and confidentiality	Security of clients' personal information	Confidential recording and reporting system	Basic Facilities in VCT	Use of Reliable suppliers VCT services	Fund Allocation for VCT services
Govt.	2	2	2	2	3	3
NGO	3	3	3	3	3	3

***Ranking:** **3**-Yes/Sufficient, **2**-not or implemented but not sufficient, **1**-Being considered **0**-Not considered/implemented*

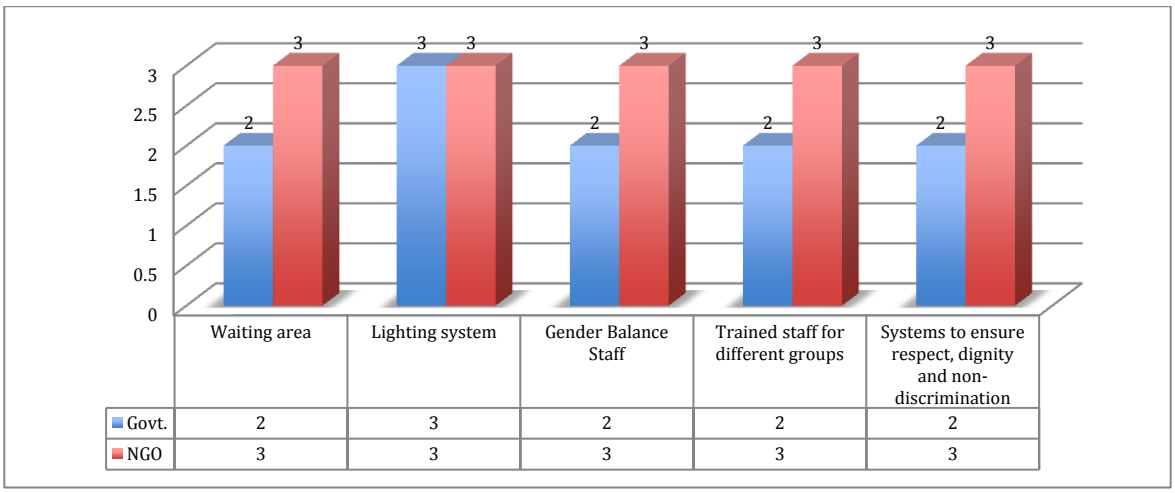
Service Provision Assessment: The information and guiding signs for VCT centers are quite satisfactory in the government facility where as an improvement is required in the NGO hospital. It was noticed that PLHIVs are not discriminated against in either the government or in the NGO facility.



	Location and guiding signs for VCT	Availability of guiding signs	Suitable Working Hours for different target group	Availability of list of services and cost/ fee charges	System for vulnerable clients	Cost analysis / survey	No-Discrimination to PLHIV	Availability of Trained VCT Staff
Govt.	2	3	2	3	3	3	3	2
NGO	1	3	2	0	3	3	3	3

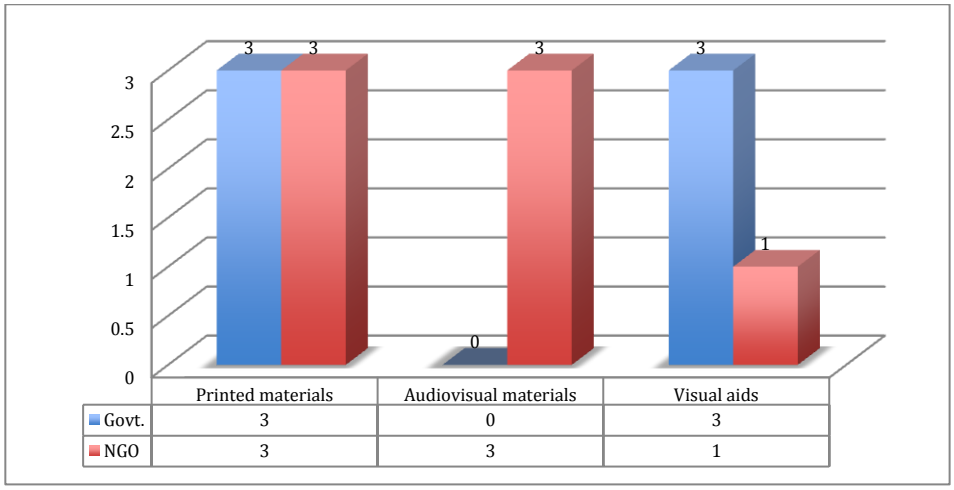
***Ranking:** **3**-Yes/Sufficient, **2**-not or implemented but not sufficient, **1**-Being considered **0**-Not considered/implemented*

Availability or Organization of Services for Client: The NGO VCT Center is well organized with regard to space availability and required amenities and in provision of gender sensitive services as compared to the government facility.



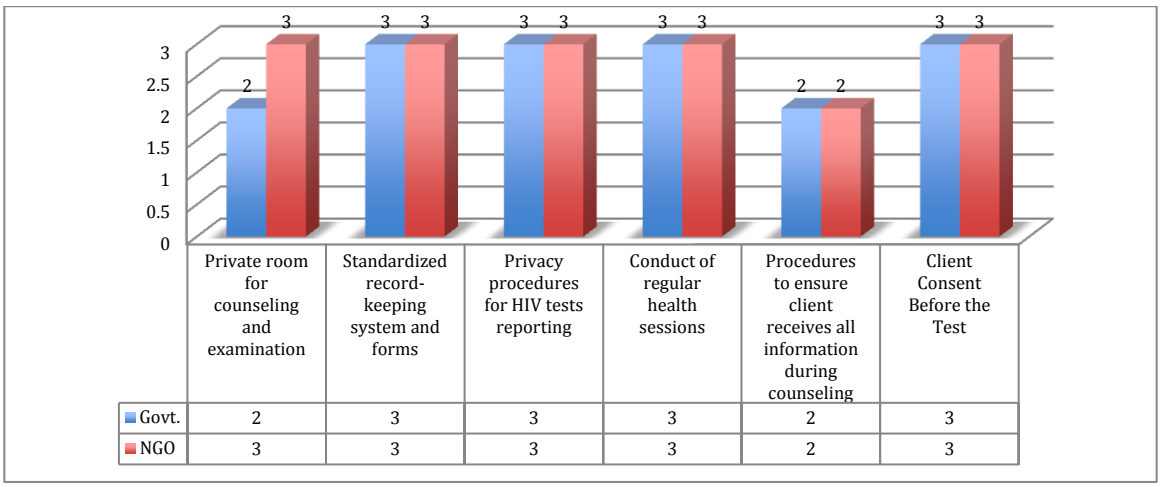
***Ranking: 3**-Yes/Sufficient, **2**-not or implemented but not sufficient, **1**-Being considered **0**-Not considered/implemented*

***Availability of IEC Material:** Printed material on HIV-AIDS is available at both facilities but no audio visual materials as films, advertisements or clips are available in government facility while the visual aids are hardly available in the NGO hospital.*



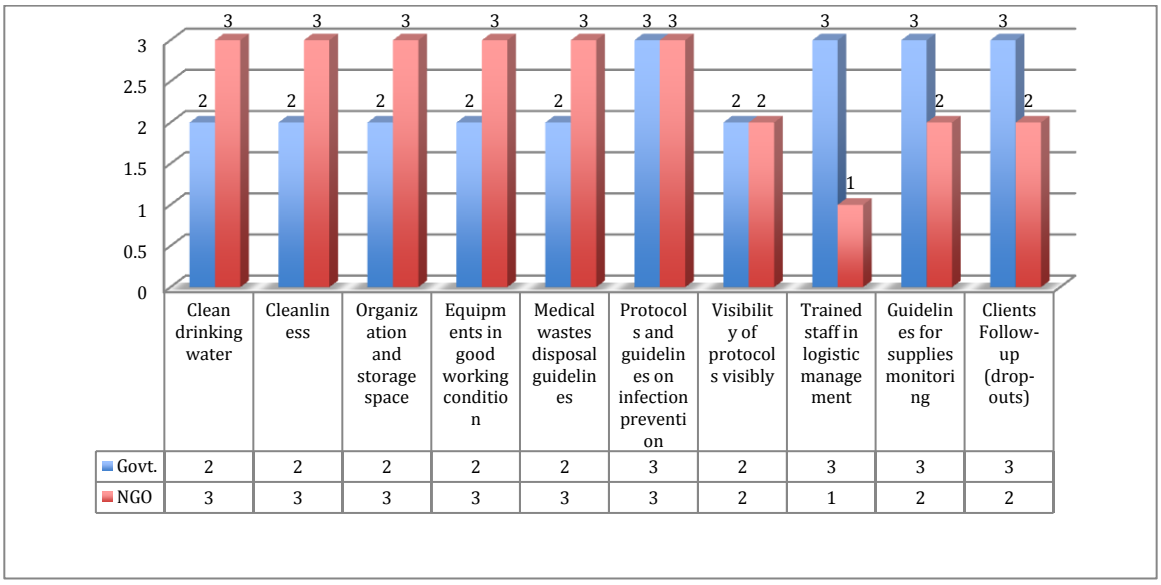
***Ranking: 3**-Yes/Sufficient, **2**-not or implemented but not sufficient, **1**-Being considered **0**-Not considered/implemented*

Privacy and Confidentiality of each client: NGO facilities have acceptable place for the counseling and examination of the patients but in the Government VCCT counseling room does not offer audio-visual privacy. Also, information collection, feedbacks, suggestions and awareness sessions on disease and preventive measures need to be reconsidered and better planned and executed in both types of facilities.



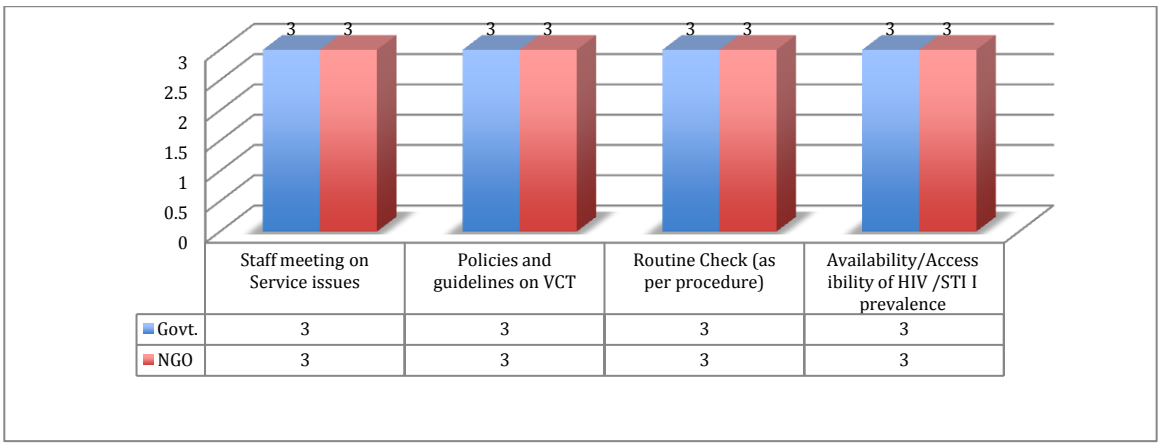
***Ranking: 3**-Yes/Sufficient, **2**-not or implemented but not sufficient, **1**-Being considered **0**-Not considered/implemented*

Safety in Facility and Supply Management: The government facility is insufficient in provision of basic amenities as clean water, safe environment, organization and storage for the supplies and in display of protocols and guidelines.



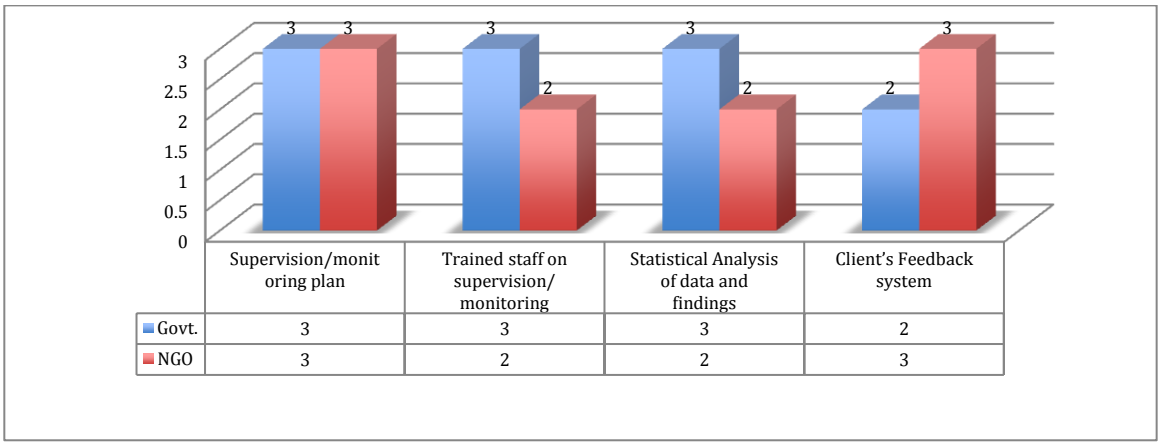
***Ranking: 3**-Yes/Sufficient, **2**-not or implemented but not sufficient, **1**-Being considered **0**-Not considered/implemented*

Confidentiality of VCT Services: The government facilities are mostly crowded, they do have specified place for counseling and testing but privacy is not ensured. There is not control on walk-in customer and staff. The staff is available but not adequately trained to provide VCT service in a confident and competent manner. The VCT counseling situation is comparatively better in NGO facility but there is space for improvement.



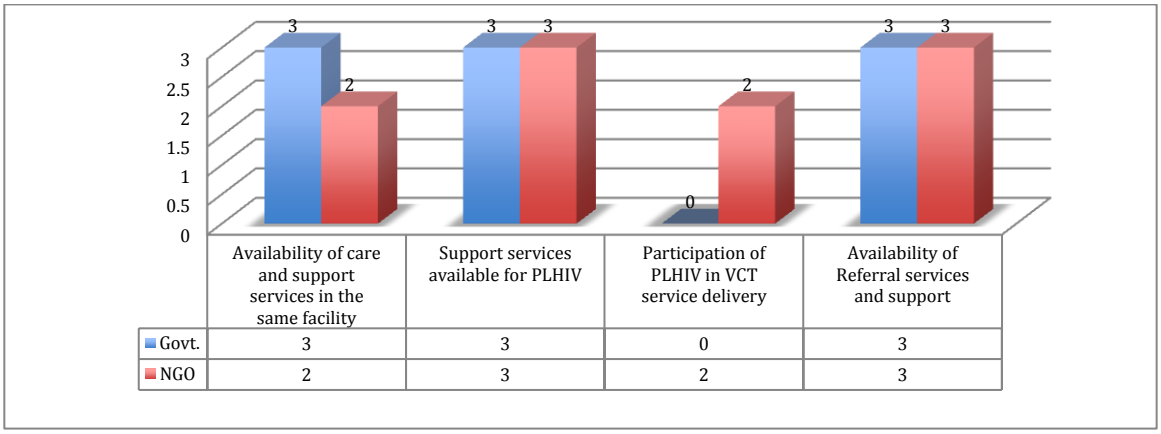
***Ranking: 3**-Yes/Sufficient, **2**-not or implemented but not sufficient, **1**-Being considered **0**-Not considered/implemented*

M&E System: The government has a comprehensive M&E system in place but feedback generation is missing in the system. The NGO facility also has a monitoring plan but do not have sufficiently trained staff to monitor and evaluate the VCT services and initiatives in their facility.



***Ranking: 3**-Yes/Sufficient, **2**-not or implemented but not sufficient, **1**-Being considered **0**-Not considered/implemented*

Support System: In government hospital services are organized in a way that fosters collaboration with other care and support services which is not sufficiently taken care of in the NGO hospital. However, in both the Government and NGO sector PLHIVs are not consulted at any level for the improvement of the services in their facilities.

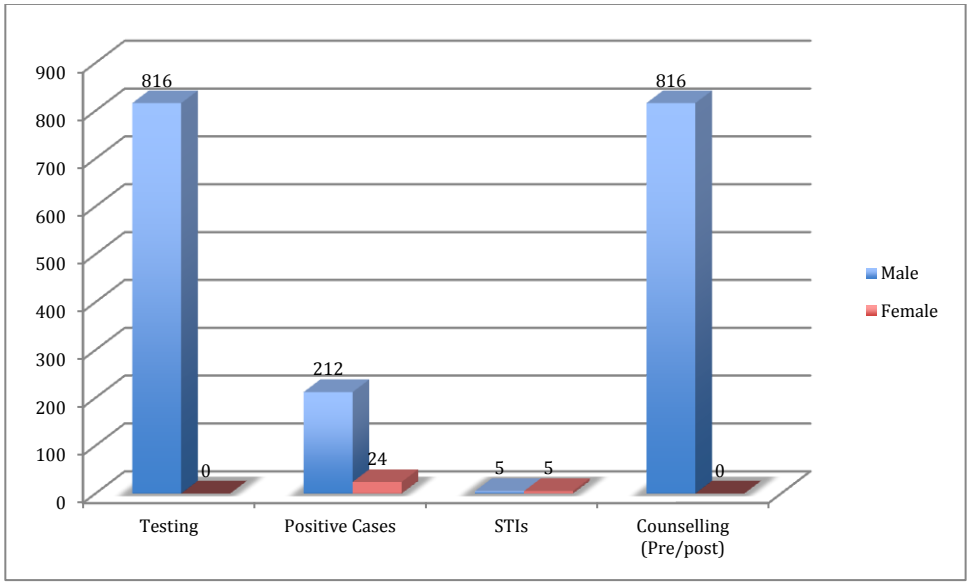


***Ranking: 3**-Yes/Sufficient, **2**-not or implemented but not sufficient, **1**-Being considered **0**-Not considered/implemented*

b. Service Statistics of VCT Centers

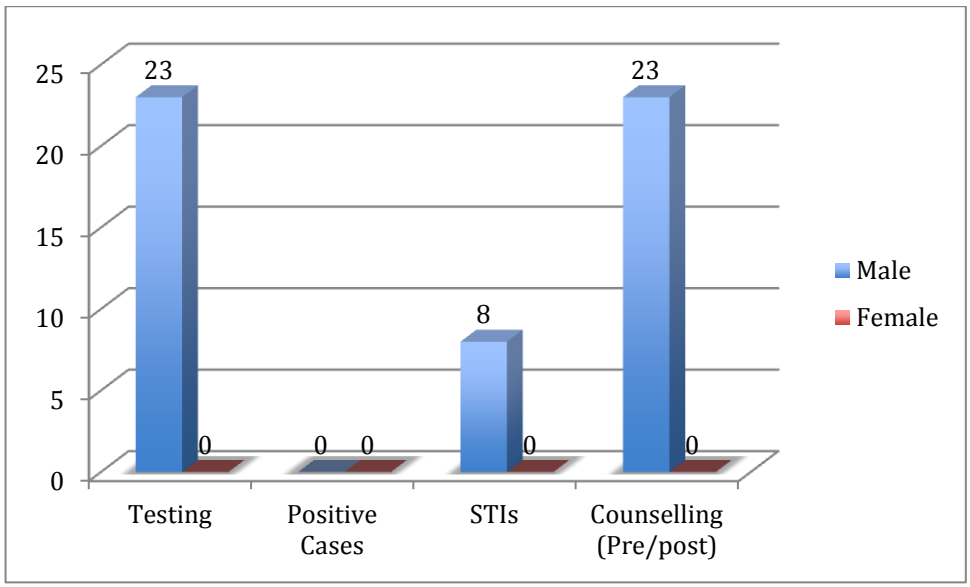
Statistics of Services Hospital (Dec-2014 to Feb-2015)

Sr.	Services	Male	Female	Total
1	Testing	816	0	816
2	Positive Cases	212	24	236
3	STIs	5	5	10
4	Counseling (Pre/post)	816	0	816



Statistics of Services Rahnuma FPAP Hospital (Oct to Dec 2014)

Sr.	Services	Male	Female	Total
1	Testing	23	0	23
2	Positive Cases	0	0	0
3	STIs	8	0	8
4	Counseling (Pre/post)	23	0	23



II. HIV Services integrated into SRH

a. PPTCT in MNCH (Services Hospital, Government Facility)

b. HIV Counseling & Testing (referrals) in FP, STI and Abortion Services (Karim Park Clinic, NGO Facility)

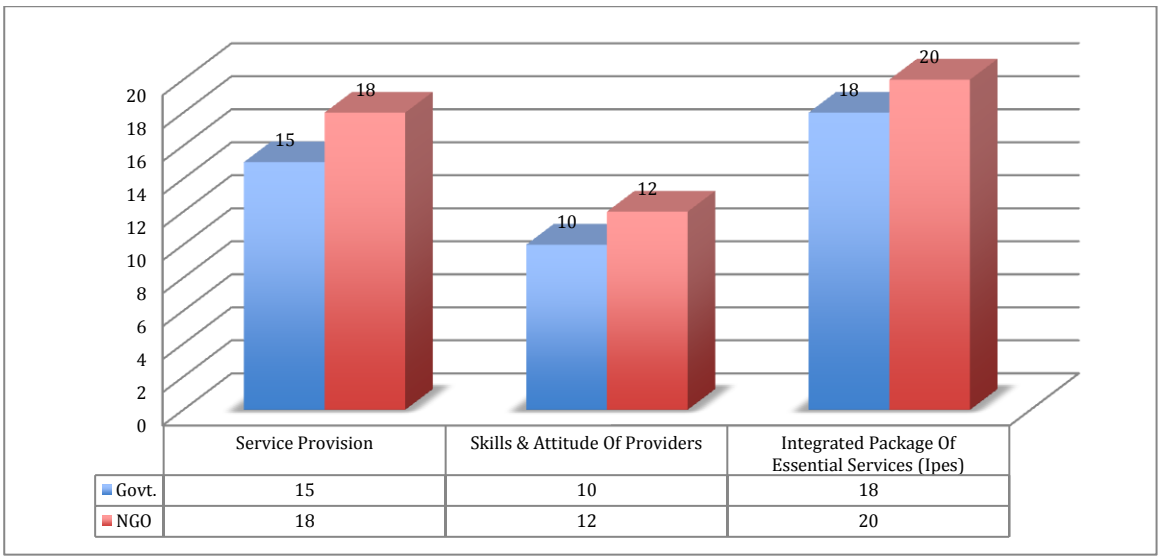
a. Summary of Observation

An adapted IPPF QoC monitoring checklist was used to review the overall service provision set up, the skills and attitude of providers and the type of services provided from within the listed Integrated Package of Essential Services (IPES) prescribed for SRH Static Clinics.

It was not possible to physically observe the technical skills of staff while providing services but existing skill sets were reviewed and confirmed by PPTCT Coordinator for Government facility and Regional Manager for the NGO Clinic.

While it is not possible to compare the integrated service provision of a major city hospital to a community-based clinic, the focus in both remains quality of care.
The scoring mentioned below is based on IPPF quality of care standards for SRH services provided by static clinics (hospitals included)

Consolidated Scoring of Quality Assessment of Govt and NGO Facility

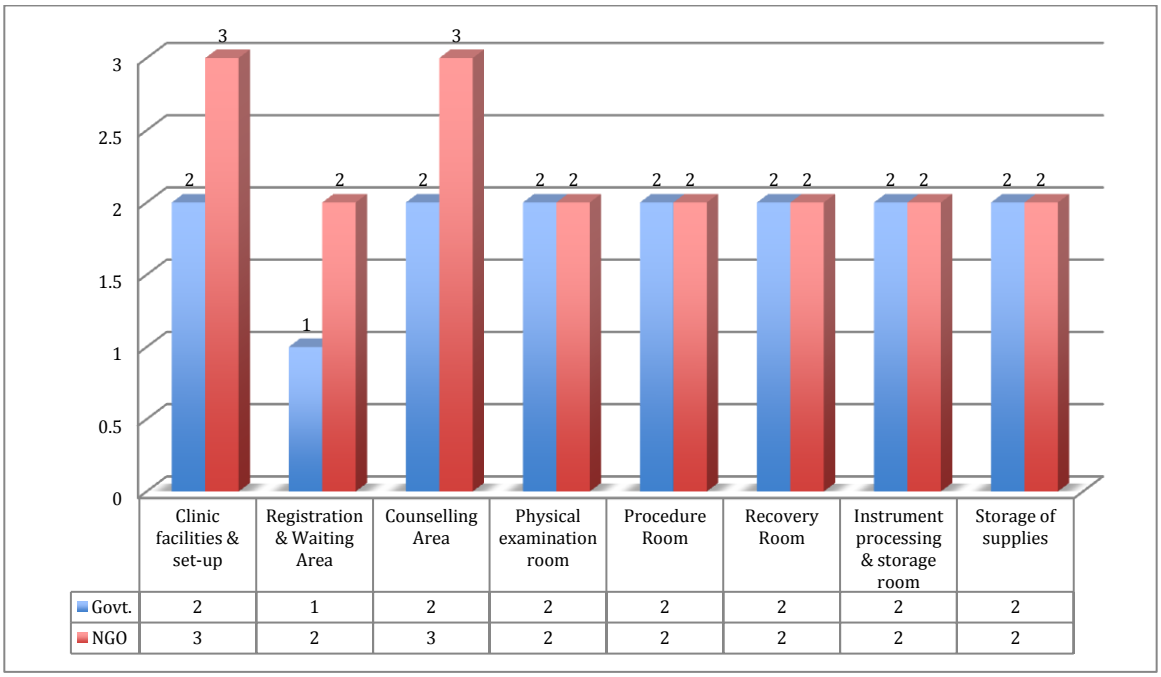


3-Meets QoC standards – 2-Meets standards but needs improvements – 1-Does not meet standards

Ranking of each category with details of observation points is given as annex 07:

Service Provision

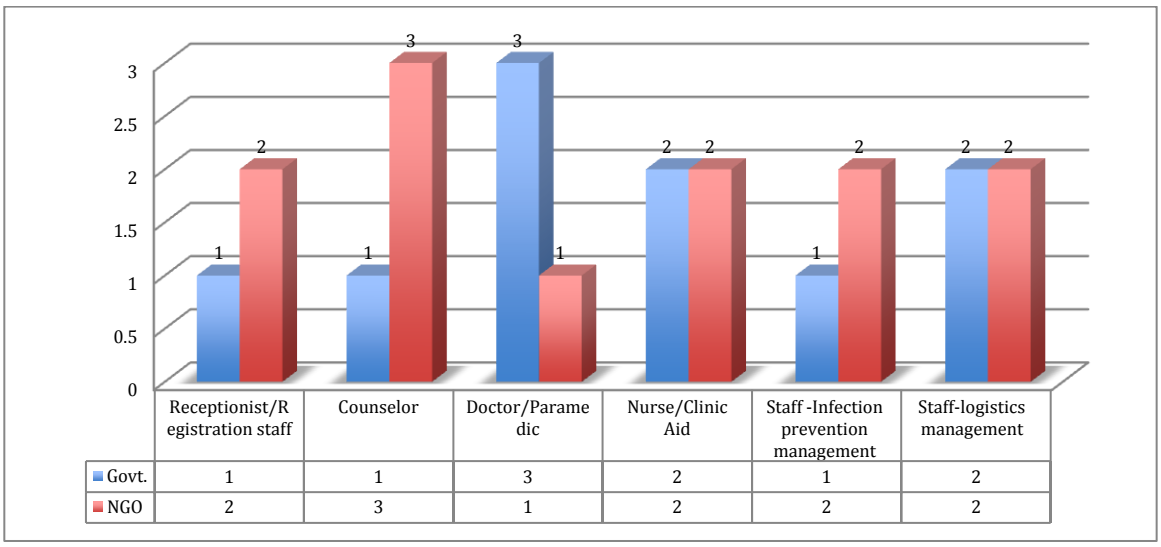
Observation included the infrastructure and setup at the clinic to facilitate service delivery according to IPPF quality of care standards.



Skills Set & Attitude of Providers

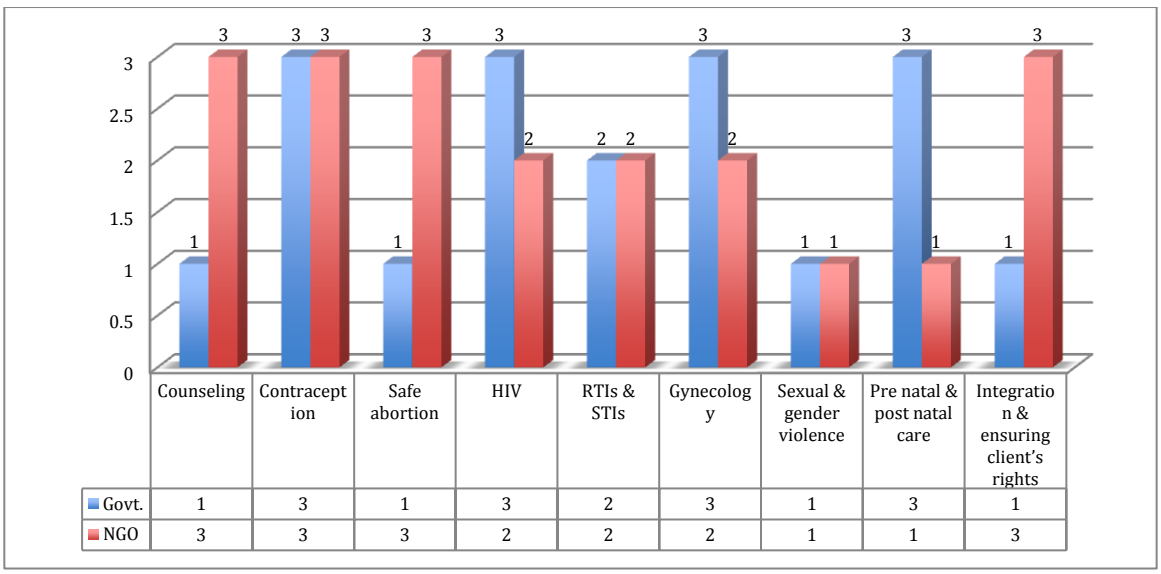
This section gathers information on the staff providing services at the facility and their training level. In order to provide good quality services, facilities must have staff that can cover all or most aspects of integrated care. This section should also collect information on a provider's clinical skills and their ability to convey information to the client in a clear and concise manner, standard components of providing high quality health care services. Due to various constraints it was not possible to observe providers conducting a physical examination, counseling on various family planning services and STI/HIV prevention, and providing antenatal, intra-partum, postnatal and

infant care. Through interviews with managerial staff, the team was able to assess the competencies and training requirements of the service providers. It is critical that all facilities meet standard counseling guidelines and that staff training programs are available to those requiring ongoing or periodic training. Determining technical competence of staff through direct observation remains outstanding and could possibly be undertaken at a later time for a more in-depth study. Scoring "1" indicates either no or inappropriately trained staff or inability to meet standard due to excessive workload.



Integrated Package of Essential Services (IPES)

The IPES includes 8 essential SRH service areas and 9th is cross cutting integration and ensuring clients rights. For the purpose of this review the types and level of services in the particular areas have been included. Scoring "1" indicates service not available.



b. Services Statistics

Service Statistics of PPTCT Center

Total Testing	Positive	Deliveries
17	**2**	**0**

Data of PPTCT center (Services Hospital) Dec-2014 to Feb-2015.

Service Statistics of Community Clinic (Karim Park)

Safe Abortion			**Family Planning**	**STI**	**HIV Counseling, Condom Promotion**
Treatment of Incomplete Abortion	Medical Abortion	Manual Vacuum Extraction			
16	08	28	**478**	**85**	**85**

Section 6 - Recommendations Conclusions and Suggestions

A. Recommendations

i. Policy Level

- The policies, law or legislation to facilitate implementation of integrated SRH and HIV services should be initiated. The role of national and provincial assemblies should be enhanced in preparing and approving relevant laws.
- Inter departmental efforts for SRH and HIV integration should be encouraged, which will help governments to fulfill key interventional commitments on both SRH and HIV, such as the MDGs 5 & 6.
- Root causes of HIV and sexual and reproductive ill-health should to be addressed. This includes action to reduce poverty, ensure equity of access to key health services and improve access to information and education opportunities.
- The people living with HIV (PLHIV) and key populations should be included to support the development of policies and laws, and to advocate for integration, mobilizing resources, etc.
- Policies to established gender equality and eliminate gender-based violence are additional requirements.
- The participation of community (including young people and key vulnerable populations) as essential partners for an adequate response to the described challenges and for meeting the needs of affected people and communities is required.
- More vigorous legal and policy measures are urgently required to protect people living with HIV and vulnerable populations from discrimination.
- The mechanism for integration at the systems and services levels should be introduced.
- The policy guidelines for QOC of integrated services should be initiated.

ii. Implementation Level

- A phased integration of SRH and HIV services should start from the program level, with the services that can be more easily integrated and a focus on high prevalence areas and groups most at risk.
- The better quality and range of SRH and HIV services (including safe abortion services and screening and management of SGBV) should be introduced at One Stop Shop to save clients time and money.
- Staff should be trained to reduce HIV related stigma and discrimination so as to provide better and more comprehensive support to key populations.
- Provide increased coverage for marginalized and under-served populations and promote an increased culture of rights-based responses
- Services support to 'hard to reach' communities should be increased. District, tehsil and union council level testing should be increased for better coverage of SRH/HIV interventions for vulnerable populations.

iii. Capacity Building

- The human resources and their capacity building are not up to mark to provide counseling for VCT services to the key populations.
- The capacity building initiative for QoC framework at the systems level should be introduced.
- The efficiency and quality of the services can be improved by building the capacity of the staff (attitudinal reconstruction trainings) to reduce service provider's stigma and reluctance to provide services to PLHIV.
- The Ministries of Health and Population Welfare should develop one curriculum to train SRH and HIV service providers on integration. The curriculum should be strengthened with latest information and skills. The curriculum should be available to all concerned stakeholders for the capacity building of their staff and service providers.
- Community orientation on sexuality, which is an essential element in human life and in individual, family and community well- being, will be very critical.

iv. M&E

- The Monitoring and Evaluation system for integration should be developed and introduced.
- The quality assessment, monitoring and evaluation of integrated programs should be clearly specified.
- A system should be developed for technical competency assessment of different cadres of staff.
- The follow-up and tracking mechanism of PLHIV (and their families) should be developed.

v. Gender Equality

- Sexual and reproductive and human rights of all people including women and men living with HIV need to be emphasized, as well as the rights of marginalized populations such as Injecting Drug Users (IDU), Men having Sex with Men (MSM), and Sex Workers (SW).
- Delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
- The checklist and procedures should be developed to assess how well gender concepts have been incorporated into the institution.
- To develop a system to evaluate the staff member's ability to analyze how well they have integrated gender concepts into their delivery of reproductive health services.
- Develop a gender perspective, with an eye toward improving gender equity and sexual rights;

vi. SRH & HIV Integration

- Awareness and information regarding importance of SRH and HIV integrated services should be increased and information should be available at all SRH and HIV facilities.
- Integrating HIV services into family planning and postnatal care should be promoted.

- Prevention/management of abortion, post abortion care and SGBV should be integrated with HIV services.

vii. Logistic and Financial Support

- Funding should be available for sustaining existing PPTCT programs once donor-financing ends.
- There must be a special budgetary allocation for SRH HIV Integration. The department (PACP) is flexible enough to make allocation for such activities if a good proposal is received.
- Linkages with IOM, Bureau of Immigration should be developed for the capacity building, counseling and tracking of PLHIV in the country.
- Funding should be made available for materials, training of service providers, procurement of equipment and monitoring and evaluation (M&E) activities. Donors and the Ministries of Health and Population Welfare could pool their resources for integration.

viii. Promotion and Information dissemination

- The availability of information, its dissemination and advertisement for outreach services for PLHIV and key populations should be enhanced.

ix. Database / Client's data

- Database of HIV positive persons and families should be available with all tracking information.
- A sex-disaggregated data of HIV positive persons should be available at both government and private facilities to monitor gender base violence and gender equality at all level.

x. Linkage Building

- Coordination between the Ministries of Health and Population Welfare on SRH and HIV should be increased.
- National level multi-sectoral collaborative working groups on SRH and HIV integration should be established to develop guidelines, curriculum and protocols for service delivery.
- Meaningfully participation of people living with HIV should be considered. Women and men living with HIV need to be fully involved in designing, implementing and evaluating policies and programs and research that affect their lives.

B. Conclusion

The study has highlighted certain concerns/issues, some of which are encouraging while some are challenges that need to be overcome for provision of quality SRH HIV integrated services.

- It is encouraging to note that national policies, laws, plans and guidelines for both SRH and HIV support linkages and that the concerned departments both at Federal and Provincial levels consider integration as a cost effective measure. HIV AIDS policy also recognizes the rights and SRH needs of PLHIV.
- Also encouraging is the policy trend that integrating services is beneficial to service provision and for the people. The example of Punjab, which generally takes the lead for such initiatives, has strategized the integration of preventive healthcare (vertical) programs to optimize healthcare service delivery arrangements through adopting models like SRH-HIV integration and revitalizing primary health care by

integrating family planning and reproductive health at least at policy level.

- At the systems level major stakeholders for SRH and HIV programs (Government and Non-Governmental Organizations) support integration and guidelines have been developed by a Technical Working Group.
- Also positive at services level is the existence of some level of HIV integration into SRH services such as HIV counseling and testing, condom promotion and provision, PPTCT (at selected tertiary care hospitals) HIV care and support and ARV treatment and prophylaxis for opportunistic infections for PLHIV and specific information /services for key populations.
- With regard to SRH integration into HIV services: the prevention and management of STIs has been integrated to a large extent. The fact that Government of Punjab has adopted the District Model strategy for SRH HIV implementation is encouraging. The model emphasizes coordination of three sections-MNCH, PACP, LHW program, of the Health Department at district level. LHWs identify high risk individuals and their families, especially pregnant wives, through their regular community level preventive health activities.
- Also heartening is the presence in all related policies of the need to provide quality services whether integrated or not and to develop guidelines on QoC and institutionalize them. Policies are mainly need based but the draft strategy 2012-2020 for the health sector mentions the development of patient rights statements with mandatory display and communication to patients.
- Both at Federal and Provincial levels there is some thinking with regard to joint purchasing of commodities and supplies for Health and Population departments. So far only Government of Punjab has a joint purchasing policy for acquiring condoms to meet the requirements of the Health Department, PACP and Population Welfare Department.

i. Challenges

The issues/challenges mentioned below are constraints to the successful implementation of quality SRH HIV Integrated services.

At Policy Level

- Having two separate departments of health and population with some integration at the lowest level of service delivery, has split SRH elements with FP falling in the purview of Population and the other elements being under Health Department. Globally, HIV integration in FP programs has worked reasonably well, but the Population department currently constrained for finances will find it difficult to commit on HIV FP integration of some degree and maintain status quo of some clinics providing limited STI services.
- There has been no progress on laws to support integration. There has been no legislative action to protect SRH rights, particularly of women, PLHIV and key populations except for the passing of two bills on domestic violence and sexual harassment of women at workplace.
- There is no focus on human rights and gender, there being no mention in any policy of the rights of persons of different sexual orientations such as TGs/MSM who would also benefit from integrated services.

ii. **At systems level** major constraints in functionalizing SRH HIV Integration include:

- There being no frameworks for implementation of SRH HIV integrated services could prove a major obstacle to institutionalizing the initiative.
- The existence of two separate budgetary streams for SRH and HIV does not facilitate integration.
- Also there being no multi-sectoral working group for coordinated action on integration and collaboration between sectors is a major issue.
- Regarding sustainability of SRH HIV integrated services currently the provinces have good level of donor funding for HIV and if it is withdrawn integrating HIV services into existing healthcare system will be a challenge.
- There is no involvement of PLHIV and key populations in SRH programs and with HIV programs their participation is limited to planning.
- Also there is neither a joint planning of SRH and HIV programs nor any collaboration for management/implementation.
- Logistics, supplies and laboratory support appear equally challenging though the latter could serve the needs of both SRH and HIV services.
- There is no Monitoring and Evaluation system for integrated services.

iii. **At service delivery level** challenges exist with regards to ownership, infrastructure, human resources and capacity building.

- Ownership of the program and provision of integrated services is more of an issue with NGOs rather than the Government. Fears that provision of HIV services especially to key populations will discourage the regular patients/clients need to be allayed for quality implementation of integrated services.
- Poor infrastructure, inadequate privacy, unclean environment are observed more with Government facilities and pose a threat to quality services. Inadequately trained staff providing services has been noted at both government and NGO facilities.
- Capacity building of staff with reference to both SRH HIV as well as QoC is a critical issue. The latter has been noted more with the Government staff being unfamiliar with even the basics of quality of care. Attitudinal reconstruction of service providers enabling them to provide stigma and discrimination free services is a major concern. Removing provider's fears of handling HIV positive cases due to inadequate infection prevention at facilities is also important.
- Moreover, there is no visibility of available services for PLHIV and key populations and very limited HIV outreach services. Government because of the Special HIV Centers with a good coverage of HIV services including supplying ARVs is able to attract more PLHIV and other key populations to its facilities. Hardly any PLHIV access the NGO facility for services-there is only one case of a HIV discordant couple whose baby was delivered in the hospital 5 years ago.
- One of the principles of building quality SRH HIV integrated services is to recognize the centrality of sexuality, which being a taboo issue, is missing from the discourse on service delivery. It could prove to be an obstacle to increasing access to services for key populations.
- Apart from the above it is equally important to address root causes of HIV and sexual and

reproductive ill-health. This includes action to reduce poverty, ensure equity of access to key health services and improve access to information and education opportunities.

C. Suggestions and Way Forward

Despite the many challenges to provide quality SRH HIV Integrated services, there is still some potential to make it work. The initiatives, which could make a difference, can be categorized into Advocacy Related, Capacity Building and Addressing Structural Determinants.

i. Advocacy

5. Legislation ensuring rights of PLHIV and other key populations in accessing SRH HIV Integrated services
6. Setting up a multi-sectoral task force to develop:
    a. Framework for institutionalizing SRH HIV Integration.
    b. Guidelines and protocols for service delivery.
    c. Relevant training curriculum for all the different cadres of staff to provide stigma and discrimination free quality integrated services.
    d. M&E framework for SRH HIV Integrated services
    e. Special funding allocation for SRH HIV Integrated services
7. All Family Planning clinics of Population Department and NGOs to provide Syndromic Management for STIs and HIV counseling, condom promotion and distribution
8. Inclusion of HIV Counseling and condom promotion and distribution in the Primary Healthcare package

ii. Capacity Building

6. All aspects of SRH HIV Integrated services
7. Quality of Care
8. Attitudinal reconstruction on provision of stigma and discrimination free integrated services to PLHIV and other key populations
9. Infection Prevention and Universal Precautions
10. Rights based and Gender sensitive SRH HIV service delivery for PLHIV and other key populations

iii. Implementation of SRH HIV Integrated Services

10. Improving visibility of services by making information and educational material (in local language) available at places of congregation of key populations
11. Strengthening outreach services for increasing VCT access of key populations and families
12. Reorganizing VCT Centers as per quality of care standards (Government)
13. Reenergizing VCT by integration with FP and Youth Friendly Services (NGO)
14. Focusing on Infection Prevention, perhaps supplying sterilized kits for C-Section delivery of HIV positive pregnant women, to allay the fears/reluctance of staff to provide them services.
15. Making appropriately trained staff available for SRH HIV integrated services (Govt.-VCT, NGO- Karim Park Clinic)

16. Increase range of SRH and HIV integrated services by including safe abortion and screening and management SGBV in the package to be delivered by appropriately trained staff.
17. Linking PLHIV and other key populations to income generation and socio-economic support programs to address barriers to access services such as poverty and illiteracy
18. Review of services of the NGOs implementing Care and Support programs for PLHIV (Govt.-ref. FGDs)

Section 7, Annexes

01 - IDI - Federal-Provincial level officials
02 - IDI NACP-PACP officials
03 - IDI Hospital-Facility Managers
04 - IDI - Client Exit Interview
05 - FGD - MSM-FSW-TGS
06 - VCT Assessment Checklist
07 - Adapted IPPF Quality Assessment Checklist

Annexure 01

Key Informant Interview Guide
Federal/Provincial Level Officials

Date: _____ Name of interviewer: _____

Position/Title:
Time in current position:
Introduction (read verbatim): Assalam o Alaikum, My name is ……. .We are Consultants with Rahnuma-FPAP working on a EC funded SRH HIV Integration project and helping them to understand the status and effectiveness of Integration projects in both public and private sectors in Pakistan. The purpose of this interview is to talk to government officials at federal and provincial levels and get your views on policy and implementation of these projects. Your answers will be kept confidential. There are no right or wrong answers; we just want to learn about your opinion.

May we proceed with the interview? If yes, please proceed with the following questions.

Could you please describe your role in the Ministry of National Health Services Regulation and Co-ordination?

How effective is your influence in advocating a trickle-down of SRH HIV integration to provincial and district levels (health and population)

What does the Health Policy of Pakistan say on the issue of Integration of SRH HIV?

Should there be integration? If so at what level should the engagement be:

i) Policy

ii) Systems

iii) Services

iv) All three

Some critical elements of SRH such as Family Planning are in the domain of Population Welfare, is there any coordination on this issue with your counterpart from that section? If so what is the level of engagement?

How do you think SRH integration can become functional? At:

i) Systems level

ii) Services level

The SRH HIV Integration issue is multi-sectoral in nature, is there a mechanism in place for it, if so at what level:

i) Federal

ii) Provincial

iii) District

What, in your opinion, are the constraints in functionalizing SRH HIV Integration in government healthcare system?

Is there any plan for a national curriculum for training SRH and HIV staff on Integration?

Has the Government allocated any resources for SRH HIV Integration? Could you please explain?

How essential, in your opinion is quality of care with regard to SRH HIV Integration? Should it be dealt at the level of:

i) Policy

ii) Systems

iii) Services

Is there in place an integrated procurement system for commodities, laboratory/other supplies?

Is there a system for assessing the quality of care for SRH HIV Integrated program and services?

Annexure 02

Key Informant Interview Guide

Federal/Provincial Level Officials: NACP and PACP

Date: _____ Name of interviewer: _____

Position/Title:

Time in current position:

Introduction (read verbatim): Assalam o Alaikum, My name is …….. .We are Consultants with Rahnuma-FPAP working on a EC funded SRH HIV Integration project and helping them to understand the status and effectiveness of Integration projects in both public and private sectors in Pakistan. The purpose of this interview is to talk to government officials at federal and provincial levels and get your views on policy and implementation of these projects. Your answers will be kept confidential. There are no right or wrong answers; we just want to learn about your opinion.

May we proceed with the interview? If yes, please proceed with the following questions.

- Could you please describe your role in the Ministry of National Health Services Regulation and Coordination (NACP) and as part of the Punjab Healthcare services (PACP)
- Is the draft HIV AIDS Policy still a viable document or will it be amended in the post 18th amendment scenario?
- Both the draft HIV AIDS Policy of Pakistan and Strategic Framework support Integration of SRH HIV. When do you feel the policy will be approved? Is there a movement in that direction?
- At the global level there has been a debate on the futility/cost effectiveness of providing integrated services in low prevalence or concentrated epidemic countries such as Pakistan. What is your opinion in this regard?
- GoP is implementing some integrated services programs, what has the experience been so far?
- Is there a special budgetary allocation for SRH HIV Integrated services?
- Is there currently a joint purchasing policy for lab kits/ commodities and supplies?
- Quality of Care (QoC) is an essential component of service delivery. Are you satisfied with the current quality of integrated services? If Yes Please explain. If No what are the major constraints?
- Has the provision of integrated HIV SRH services increased access of key populations to the services? If Yes Please explain. If No, what are the major constraints?
- What are the most critical gaps with regard to the quality of integrated services?
- How can the QoC of these programs be improved?
- Is there any integration of HIV into family planning services? What is the level of collaboration with the Population Welfare Department in this regard? How can it be improved?
- At what level: policy, systems and services does integration fall short with regard to QoC?
- Is this a successful initiative?
- What, in your opinion, are the constraints in functionalizing SRH HIV Integration in government healthcare system?
- Is there any plan for a national curriculum for training SRH and HIV staff on Integration?
- Has the Government allocated any resources for SRH HIV Integration? Could you please explain
- How essential, in your opinion is quality of care with regard to SRH HIV Integration? Should it be dealt at the level of:

  i) Policy

  ii) Systems

  iii) Services

- Is there in place an integrated procurement system for commodities, laboratory/other supplies?
- Is there a system for assessing the quality of care for SRH HIV Integrated program and services?

Annexure 03

Key Informant Interview Guide
Hospital/Facility Managers

Date: _____ Name of interviewer: _____

Position/Title:
Time in current position:
Introduction (read verbatim): Assalam o Alaikum, My name is …….. .We are Consultants with Rahnuma-FPAP working on a EC funded SRH HIV Integration project and helping them to understand the status and effectiveness of Integration projects in both public and private sectors in Pakistan. The purpose of this interview is to talk to government officials at federal and provincial levels and get your views on policy and implementation of these projects. Your answers will be kept confidential. There are no right or wrong answers; we just want to learn about your opinion.

May we proceed with the interview? If yes, please proceed with the following questions.

- How long have you been at this current position? How long has this facility existed in its current capacity of providing SRH HIV Integrated services?
- Please describe your role as in charge of facility. Include staff strength and competencies and the number and type of SRH HIV integrated services being provided.
- How many staff received training on integrated service provision and by whom?
- What is the system of client access-referral, walk-in or appointment?
- Do PLHIV and other key populations access this facility? How do they know of the services being provided? Is there any outreach services from the facility?
- Are staff able to provide stigma and discrimination free services to clients? If yes, how are they able to do so?
- Do you feel that quality integrated services are being provided at the facility?
- What is the system of quality assessment? How often and by whom?
- Is there a complaint redress system in place? Please explain the process.
- How have clients rated the service provision at the facility?
- How in your opinion can the quality of services be improved?
- Please describe the M&E framework for SRH HIV service provision in the facility?
- Please share past three months service statistics with respect to SRH HIV Integrated services.

Annexure 04

Client Exit Interview Questionnaire

1) Name of interviewer: .....

2) Name of clinic: .....

3) Date: ..... **4) Time:** .....

5) Introduction before beginning the interview

(Please read this first and explain the contents to the client)

"We are conducting this interview to assess the quality of care at this clinic and hope to use this information to improve services. We are asking clients about their satisfaction with the services provided. We hope that you can help us by agreeing to let me interview you today. I will not take your name. Your participation or refusal to participate in this interview will not affect the services you receive in any way. The interview will take about 10-15 minutes will be kept completely confidential.

6) General information

(Note for the interviewer: Tick what applies, don't read the answers)

a) Family planning consultation ☐
b) Sexuality counseling ☐
c) STI consultation ☐
d) Gynecological consultation ☐
   - ✓ Breast examination ☐
   - ✓ Pap smear ☐
   - ✓ Pregnancy test ☐
   - ✓ Infertility ☐
e) HIV testing and counseling ☐
f) Pre/post natal care ☐
g) Childcare (e.g. Immunization) ☐
h) Other (please specify) ☐

If "Other" is not related to sexual and reproductive health, then this client is not eligible. Say thank you to the client and "End the interview"

6.1 What type of service did you come for today? Yes ☐ No ☐

6.2 Is this your first time at this clinic? Yes ☐ No ☐

6.3 How old are you? .....

6.4 What is your marital status now?

a) Single ☐ b) Married ☐ c) Divorced ☐ d) Widower ☐

7) Client's right to information

7.1 Did you receive information on the following topics during this visit or previous visits? ***Tick those that apply***

		Yes, Sufficient	Yes, but not Sufficient	No
a)	The importance of having regular screening for cervical cancer and breast cancer?	☐	☐	☐
b)	How STI/HIV is transmitted?	☐	☐	☐
c)	The importance of safe sexual behavior, including use of condoms for STI/HIV prevention	☐	☐	☐
d)	Where to go for consultation and treatment of STI, if needed	☐	☐	☐
e)	The importance of antenatal and post- natal care	☐	☐	☐
f)	The importance of child care (e.g. immunization)	☐	☐	☐

7.2 Did you receive information, during this visit or previous visits, on the following topics concerning the contraceptive method you are using or going to use?

		Yes, Sufficient	Yes, but not Sufficient	No
a)	Efficiency of the method?	☐	☐	☐
b)	How the method works?	☐	☐	☐
c)	How it is used?	☐	☐	☐
d)	Common side effects and warning signs?	☐	☐	☐
e)	How and when to obtain more supplies (if applicable)?	☐	☐	☐
f)	What to do in case of a problem?	☐	☐	☐
g)	Where, when and why to return for a follow-up?	☐	☐	☐

7.3 What did you do while waiting for this consultation?

a) Talk to other client's ☐
b) Watch an educational video ☐
c) Listen to health talks ☐
d) Read educational materials ☐
e) Other, specify: _____

7.4 Do you have any suggestions as to how you could better spend your waiting time?

7.5 Did the providers clarify any concerns that you had?
Yes ☐ No ☐ Had no concerns ☐
If yes or no please explain:

8) Client's right to access
8.1 Are the clinics working hours convenient for you? Yes ☐ No ☐
If no, what would be the best day and time for you to come to the clinic?
Date: _____ Time: _____

8.2 Do you think the cost of service was acceptable? Yes ☐ No ☐
If no, what would you recommend?

9) Right to choice
9.1 Did you get the services you came for? Yes ☐ No ☐
If not, why not?

10) Right to safety
10.1 Have you had any problems or difficulties as a result of services you received from this clinic? Yes ☐ No ☐
If yes, what type of problem

11) Right to privacy and confidentiality
11.1 When you were receiving a counseling, or a physical examination did you feel comfortable when other people were present in the room? Yes ☐ No ☐
If no, describe why and what you observed:

11.1 Did Providers reassure you that any information concerning your personal situation and the service you received will remain confidential?

Yes ☐ No ☐ N/A ☐

12) Client's right to dignity and comfort
12.1 Do you feel that the time you spent at the clinic was?
Too long ☐ Just right ☐ Too short ☐
12.2 Do you think that the waiting room is comfortable? Yes ☐ No ☐
Why not?

12.3 Did the clinic staff treat you in a friendly manner?
Yes, all of them ☐ Yes, some of them ☐ No ☐
If "some of them" or "No", please explain:

13) Client's right to opinion
13.1 In the past, have you been given opportunities to express your opinion about the services provided in this clinic?
Yes ☐ No ☐ If No, Please explain

14) Right to continuity of care

Have you been informed about the following?	**Yes**	**No**
a) When to return for your follow-up visit	☐	☐
b) That you can return at any time if you have questions, or problems.	☐	☐

15) What suggestions can you make to improve this clinic and the services provided?

_____
_____

16) Was there anything in particular that you liked about the clinic?

_____
_____

17) Was there anything in particular that you disliked about the clinic?

_____
_____

18) Would you recommend the clinic to a friend or relative? Yes ☐ No ☐

If no, why not? ----------

Annexure 05

FGD Tool

Health Service seeking behavior

Group_____ Location _____ Date: _____

General

- How often do they seek medial service and for what condition
- What health issues usually your group faced?
- Where do they go for services?

Information:

- What do you know about SRH & HIV AIDs
- How do you know of the SRH providers?
- How did you come to know of the availability of the services, and where
- How do you select the facility or the provider?
- Where did you get is information
- Do you thing the information is sufficient and meet your needs
- Did the staff guide you to the doctors room or you had to find it yourself

Behavior/Care :

- How did the receptionist greet you?
- Using any number from 0-10 (good to worst), how you rate the doctor you visited last
- How about his /her verbal and non-verbal communication? Greeting, interest, etc.
- Who would be your preferred service provider in selected facility?

Safety/Privacy

- Did the doctor close the door once you were in?
- Did someone else bother you during your consultation or just popped in often
- Do you think it was a safe conversation?
- Did he/she ask you some irrelevant questions?
- Do you think the doctor will keep your health status and other information safe

Patient Care:

- Did he/she greet you with handshake, or welcome you? Or he/she was wearing a mask or some protective equipment?
- Did s/he listen to your problem carefully, are you satisfied?
- Did s/he sympathize or s/he was rude or neutral?
- If they don't have money for fee what do they do?

Time Efficiency

- How do you usually visit the doctors, appointment or drop-in?
- Did the doctor call you in time or made you wait unnecessarily?
-

Effectiveness

- Do you thing going to these facilities is worth while?
- If you have another facility for same services, will you consider, why
-

Equitability

- Do you think the doctor providing care did not vary the quality of care because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status

One stop Shop

- Did you receive SRH HIV integrated services, e.g. HIV counseling and testing and STI management at the same facility?
- Would you prefer integrated services?

Annexure 06

VCT Assessment Checklist

This tool is being developed in order to measures the readiness of VCT services to be provided according to quality standards of care following four main components:

1. **Effective integration** of the service according to community needs
2. **Accessibility** to all people
3. **Promotion of an enabling environment** – ensuring clients' privacy, confidentiality, non-coercion and dignity so that clients feel comfortable accessing the service or visiting the health facility
4. **Collaboration** with other care and support services.

When completing the tool, please include one of the following 4 answer in the assessment column:

Y = Yes or sufficient;
IP = In preparation but not yet implemented, or, implemented but not sufficient;
BC = Being considered;
No = No, neither considered nor implemented

I Code of Good Practice for NGOs responding to HIV/AIDS, The NGO HIV/AIDS Code of Practice Project, Geneva, 2004. Available at www.ifrc.org/what/health/hivaids/code/

Standard	Criteria	Assessment				Comment
		Y	*IP*	*BC*	*NO*	
Organization Preparedness Assessment						
1. Does the organization have a system in place to analyze community needs?						
1.1. Community Assessment	*1.1.1. Did your organization conduct a client survey before initiating the VCT service?*					
	1.1.2. Is relevant information regarding HIV/STI data – i.e. National AIDS Programmed strategy, epidemiological information for the region and documents from other NGOs – available in the facility or in the organization headquarters?					
2. Does the organization have a system in place to analyze the organizational capacity to provide VCT services?						
2.1. Policy and guidelines	*2.1.1. Is part of your organizational vision, mission or goal to create an enabling environment for quality series, including VCT, to all people?*					
	2.1.2. Has your organization developed policies and /or guidelines on VCT which emphasize voluntary and non-coerced counseling and testing, confidentiality and accessibility to all people without discrimination?					
2.2. Staff	*2.2.1. Does the organization have staff adequately trained to provide VCT?*					
	2.2.2. Does your organization identify training facilities that can provide VCT training to selected staff?					
	2.2.3. Does the organization undertake meeting(s) with staff in which community needs, epidemiological data, policy law, resources and staff's opinions are discussed?					
2.3. Facility	*2.3.1. Does the facility have enough private space that can be used to ensure clients privacy and confidentiality?*					
	2.3.2. Does the facility have private and secure storage space that can store clients' personal information?					
	2.3.3. Does the facility have a recording and reporting system that ensures confidentiality and can be/ is used by VCT staff?					
	2.3.4. Does the facility have the required electricity, running water and waste disposal system for successful integrated VCT or stand alone VCT services?					
	2.3.5. Has the organization identified/ used reliable suppliers for the provision of VCT services (HIV test kits and other necessary supplies)?					
2.4. Finance	*2.4.1. Have you allocated appropriate funds to provide VCT services?*					
3. Service Provision Assessment						
3.1. Access to services	*3.1.1. Are there clear signs to show the facility/ clinic location on access streets and / or outside the clinic building?*					

Standard	Criteria	Assessment				Comment
		Y	*IP*	*BC*	*NO*	
	3.1.2. Are there guiding signs indicating the location of different examination rooms and other facilities inside the facility/ clinic itself?					
	3.1.3. Are the clinic working hours convenient for different target group? (i.e. working men and women, youth, sex workers, MSM)					
	3.1.4. Are the list of services and cost/ fee charges of services clearly displayed for all clients to see?					
	3.1.5. Does the clinic have a system in place to enable clients who can not afford to pay to access VCT services?					
	3.1.6. Does the clinic have procedures in place to periodically assess and review the cost of services in accordance with clients' willingness and ability to pay??					
	3.1.7. Does the clinic have systems in place to ensure that HIV positive clients are treated in a non-discriminatory way (i.e. complaint forms/ client exit interviews/ checklists for staff)					
	3.1.8. Are there staff trained in information, education, counseling and testing always present and available during opening hours?					
3.2 Is the service organized in a way that it is client centered?						
3.2. Client Centered	*3.2.1. Does the facility/ clinic have a comfortable waiting area?*					
	3.2.2. Does the facility/ clinic have a reliable lighting system?					
	3.2.3. Is there gender equity in the staff? (i.e. male, female, transgender)					
	3.2.4. Area staff trained to provide tailored services to different groups? (i.e. youth, sex workers, MSM, IDU)					
	3.2.5. Does the clinic have systems in place to ensure that clients are treated with respect and dignity and are not discriminated against?					
	3.2.6. Are the following IEC materials available in the appropriate language?					
	Printed materials (poster, leaflets, flipchart)					
	Audiovisual materials (video, TV)					
	Visual aids (model of anatomy, etc.)					
3.3 Is the service organized in a way that protects the privacy and confidentiality of each client?						
3.3. Privacy, confidentiality and informed consent	*3.3.1. Does the facility/ clinic have a private room for counseling and examination?*					
	3.3.2. Does the facility/ clinic have a standardized record-keeping system and forms (registration, filling, recording, client's feedback that are kept confidentially?					
	3.3.3. Are there procedures in place to ensure that HIV tests are only reported to the client (unless stated otherwise by the client themselves)					
	3.3.4. Are health education talks/ sessions scheduled and carried out for clients (on a regular basis? (weekly/ monthly quarterly)					
	3.3.5. Are there procedures in place to ensure complete information is given to each client according to guidelines (checklists/ copies of guidelines distributed to all service providers/ assessment of service providers) during counseling sessions?					
	3.3.6. Are there procedures in place to ensure that the client has given informed consent before the test is performed?					
3.4 Is the service organized in a way that ensures safety in the facility/ clinic and ongoing supply of commodities?						
3.4. Safety and supply Management	*3.4.1. Are there reliable supplies of clean water?*					
	3.4.2. Is the facility clean?					
	3.4.3. It there sufficient and well organized storage space?					
	3.4.4. Is all equipment maintained in good working condition?					
	3.4.5. Is medical waste properly handled according to guidelines?					
	3.4.6. Are there protocols/ guidelines available on infection prevention (IP), HIV testing and counseling, post-exposure prophylaxis (PEP), and logistical management?					

Standard	Criteria	Assessment				Comment
		Y	*IP*	*BC*	*NO*	
	3.4.7. Are the protocols visibly displayed in order for staff to follow the protocols when performing their task? (i.e. flowcharts, testing procedures, IP and PEP checklists, etc.)					
	3.4.8. Are necessary staff trained in logistics management?					
	3.4.9. Is stock of supplies adequately monitored as per logistic management guidelines?					
	3.4.10. Are there systems in place to follow up clients and to track down drop-out clients?					
3.5 Are staff properly trained to provide VCT services in a confident and competent manner?						
3.5. Staff competency to deliver the service	*3.5.1. Are staff meetings periodically held to discuss and update information related to the service?*					
	3.5.2. Are the policies and guidelines on VCT including procedures, client flow, price, counseling, education, testing and referral available and accessible to all staff?					
	3.5.3. Are procedures in place to ensure all staff are using the materials listed above (routine checklists)?					
	3.5.4. Are documents related to HIV epidemiology and STI prevalence available and accessible to all staff?					
3.6 Does the facility/ clinic have a monitoring and evaluation system in place?						
3.6. Monitoring and Evaluation	*3.6.1. Does the facility/ clinic have a supervision/ monitoring plan which is used regularly?*					
	3.6.2. Are staff trained on supervision/ monitoring?					
	3.6.3. Are service statistics collected and analyzed periodically and finding shared with staff members					
	3.6.4. Are there systems to gather client and providers' feedback on service delivery (i.e. suggestion box, client's exit interview, etc.? are they used to bring changes to the services?					
3.7 Is the service organized in a way that fosters collaboration with other care and support services?						
3.7. Collaboration with other care and support services	*3.7.1. Are care and support services provided in the same facility? (i.e. PMTCT/MCH, OL, ARV, TB, STIs, FP, Mental health, community supports, income generating activities, food aid?*					
	3.7.2. Is the service linked to support groups for PLHIV inside or outside the client/facility?					
	3.7.3. Are PLHIV involved in VCT service delivery? (i.e. as lay counselors, peer educators, etc.)					
	3.7.4. Are addresses for referral services and support available at the clinic?					

Annexure 07

Adapted IPPF Quality Assessment Checklist

A. Service Provision Set Up

1. Observation of Clinic Facilities

- **Clinic exterior** -Good general maintenance , cleanliness around facility, no need for major repairs or painting
- **Well Sign Posted** - Sign post/s show : Logo/services provided/ days and time each service is provided/ user charges/ no refusal policy/ easily visible to clients & community
- **Clinic Entrance** - Clean/ Client - friendly
- **Opening times convenient to clients:** confirmed from clients available at the time
- **Client Flow Mechanism**: Designated client flow in place and all staff familiar with the client flow

2. Registration & Waiting Area

- Registration & Waiting area-clean/well ventilated/drinking water/ clean toilets
- IEC materials displayed (appropriate posters /take away pamphlets)
- Registration area friendly and ensures privacy & confidentiality (no risk of being overheard by other clients or staff)
- Suggestion box present and functional
- Price list clearly visible
- Client Right's Chart clearly displayed & in local language

3. Counseling Area

- Ensures privacy & confidentiality (audio & visual privacy / clean / comfortable)
- Counseling tools available- (Job-aids / samples available)
- Confidentiality of record keeping maintained

4. Physical examination room

- Space -well ventilated, clean, ensures privacy & confidentiality
- Necessary equipment available
- Access only to essential staff
- Infection prevention protocols displayed
- Post-exposure Prophylaxis for staff displayed
- Waste disposal protocols displayed

5. Procedure Room

- Easy access from physical examination area
- Adequate space, well ventilated/well lit/clean, ensures privacy
- Access only to essential staff
- Adequate water supply for hand washing of providers
- Necessary equipment & fixtures present
- Necessary equipment & fixtures present
- Clinical protocols or flow charts displayed (Emergency resuscitation, Infection prevention, waste disposal and Post exposure prophylaxis)

6. Recovery Room

- Easy access from procedure room (same floor & nearby)
- Well ventilated/ clean/ quiet/comfortable, audio-visual privacy
- Easy access to a clean toilet
- Changing space & locker facilities ensures privacy & security

7. Instrument processing & storage room

- Separate area or room for processing instruments set up as per guidelines
- Appropriate Equipment (disinfectant / brush /utility gloves) used
- Clean running water supply
- Covered containers for storage of instruments
- Equipment for sterilization present & in good working condition (autoclaves /sterilizers)
- Guidelines/flowcharts on instrument processing and storage displayed

8. Storage of supplies

- Dedicated storage space adequate to stock clinic supplies
- Space well ventilated, clean, no signs of dampness/water leaks
- No broken/ unused equipment or supplies are stored in the same room

B. Skills Set & Attitude of Providers

1.

- Receptionist/Registration staff
- Language - (local/ no technical jargon/ non-judgmental/respectful)
- Ensures confidentiality
- Registration process (walk-in & appointment systems present)
- Waiting time for clients (registration to service provider < 20 mins)
- Asks for most appropriate contact information (rather than insist on home address)
- Facilitates free /subsidized services for clients unable to pay e.g. young people/ poor
- Option for preferred provider available -male/female, young/adult (especially for young people)
- Unique Identifying Number (ID) and individual record for each client
- Master register updated and maintained (manual system)
- Effective referral & follow-up system is present

2. Counselor

Greets the client respectfully, listens patiently to client's needs/concerns, uses simple non-judgmental language, allows client to ask questions and assures confidentiality
Checks if client wants partner to be present during counseling
Provides appropriate /correct information on SRH & FP issues
Provides an informed choice of all methods/options available
Uses appropriate tools/models & displays during sessions
Explains the chosen service/ procedure (benefits, risks, side-effects, follow-up) to client
Directs client where to go after counseling
Records all relevant information in client's records
Provides post counseling after service/procedure (follow-up/referrals/complications)
Follows recommended follow up mechanism for referred clients (outbound)

3. Doctor/Paramedic

- Greets the client respectfully, listens patiently to client's needs/concerns, uses simple non-judgmental language, allows client to ask questions and assures confidentiality
- Comfortable providing services to unmarried young people, expresses kindness & empathy
- Trained in youth-friendly services & young people's sexual and reproductive rights
- Allows an appropriate individual to be involved in conversation if client desires (in the case of young people – a parent, guardian, friend, partner or peer educator)
- Obtains informed consent from the client
- Aware of parental consent laws for adolescents
- Follows infection prevention protocols (e.g. use of clean/disposable gloves)
- Conducts physical examination
- Follows all steps for the procedure as per standard protocol
- Observes client during the procedure for vital signs
- Ensures client is comfortable before leaving the area
- Competently manages complications if any
- Ensure the client understands follow-up protocol
- Provides 24x7 contact details (name, number, address) to client
- Records all relevant information in client's file
- Refers appropriately for services not available at clinic (e.g. structured slip/voucher with name, address and contact no of referral site and relevant clinical information)

4. Nurse/Clinic Aid

- Greets the client respectfully, listens patiently to client's needs/concerns, uses simple non-judgmental language, allows client to ask questions and assures confidentiality
- Comfortable providing services to unmarried young people, expresses kindness & empathy
- Trained in youth-friendly services & young people's sexual and reproductive rights
- Provides client with clean appropriate gown for procedure
- Prepares instruments for procedures
- Supports the principle provider during procedures
- Provides comfort & assurance to client during procedures
- Follow ups clients in recovery room after procedures
- Follows infection prevention /personal protection guidelines

5. Staff -Infection prevention management

- Staff member is designated/responsible for the task
- Uses utility gloves and protective eyewear for instrument processing
- Prepares correct concentrations of chlorine solution freshly
- Cleans decontaminated instruments as per guidelines
- Informs management for replacements in a timely manner
- Cleans /decontaminates procedure room as per guidelines

- Follows infection prevention /personal protection guidelines
- Disposes waste according to guidelines

6. Staff-logistics management

- Designated person in charge of store
- Commodity Tracking mechanism present & updated (Stock records/register)
- Storage of supplies - (clearly labeled / arranged in FEFO order/ away from floor and wall)
- System in place to identify and manage damaged or expired drugs as per guidelines
- Approved Disposal policy for unused/broken equipment and expired drugs operational

C. Integrated Package of Essential Services (IPES)

1. Counseling

- Provider is respectful and non-judgmental to all clients including young people
- Provider has relevant training /skills on SRH issues
- Privacy & confidentiality maintained
- Links with relevant institutions for referrals
- Referral & follow ups system in place

2. Contraception

- Assessment of clients requirements for contraception and establishing eligibility
- Availability of trained providers at all times to offer all methods
- All methods available to unmarried young people (incl. LARCs)
- Benefits of Dual Protection promoted in family planning discussions
- Barrier methods (counseling, use of penile model to demonstrate use, management of side effects,)
- Hormonal methods including Emergency contraceptive pills (counseling, contraindications, medical examination, management of side effects)
- IUDs (counseling, medical examination, procedure, management of side effects, complications)
- Other modern methods
- **NON-IPES CONTRACEPTIVE SERVICES**
- Surgical contraception-counseling, contraindications, medical examination, management of complications, side effects)

3. Safe abortion

- Provider is respectful and non-judgmental to all clients
- Privacy & confidentiality maintained
- Updated standard protocols available
- Counseling (including young pregnant women) provided with all options relating to pregnancy (continuation, termination, adoption))
- MVA/Medical abortion(procedure, follow-up & management of complications)
- Post abortion care (counseling & contraception)
- Post abortion follow up
- Management of complications

4. HIV

- Provider is respectful and non-judgmental to all clients
- Privacy & confidentiality maintained
- Updated standard protocols available
- Pre-test counseling
- HIV testing
- Post-test counseling (negative result)
- Post-test counseling (positive result)
- Condom promotion at each visit
- Referral & follow up for HIV positive clients (post-test care)
- **NON-IPES HIV/AIDS SERVICES**
- Anti-Retroviral Therapy (ART)
- Management of opportunistic infections
-

5. RTIs & STIs

- Provider is respectful and non-judgmental to all clients
- Privacy & confidentiality maintained
- Updated standard protocols available for syndromic management or etiological approach
- Pre-test counseling
- Screening for RTIs/STIs - syndromic management OR etiological approach for diagnosis
- Etiological approach - Lab tests for RTI/STIs
- Post-test counseling for all outcomes

- Follow up of clients provided treatment

6. Gynecology

CERVICAL CANCER SCREENING & PREVENTION

- Pre-screening counseling
- Cervical cancer screening procedure - Cytology (Pap, VIA or VILI)
- Post-screening counseling for all outcomes
- Treatment options available for clients after an positive result (Cryo or LEEP)
- Post treatment follow up systems
- Referral and follow-up of suspected cancer lesions or inconclusive results

NON-IPES CERVICAL CANCER SCREENING & PREVENTION SERVICES

- Provision of HPV vaccination

BREAST EXAMINATION

- Updated standard protocols available for clinical breast examination
- Pre screening counseling
- Clinical breast examination
- Post screening counseling on outcomes
- Referral and follow-up of suspected cancer lesions or inconclusive results

7. Sexual & gender violence

- IEC material displayed and distributed within SDPs
- Routine SGBV screening provided to all SRH clients
- Internal/external referrals for counseling which addresses clients SGBV experience
- Internal/external referrals for counseling which addresses clients SGBV experience
- MOUs/agreement with local individuals/organizations for survivors of SGBV
- Follow up of internal /external referrals
- Clinical management of victims of sexual assault (to be determined based on client's presentation after incident)
- Counseling - health, legal and psychosocial support
- Services to prevent an unwanted pregnancy (Pregnancy tests, full range of contraceptives including emergency contraceptives)
- Services to prevent an STI/RTIs - Prophylaxis , testing and treatment for STIs
- Services to prevent HIV infection (PEP kits and HIV counseling and testing services)
- Services for wound care (tetanus toxoid, Hep. B immunization and wound care)

8. Pre natal & post natal care

- Prenatal care - 4 ANC visits minimum (1st ANC visit before 16 weeks, 2nd ANC visit 24-28 weeks, 3rd ANC visit 30-32 weeks, 4th ANC visit 36-38 weeks)
- Provision of iron and folic acid supplements
- HIV counseling and testing / PMTCT
- Screening and treatment for Syphilis
- Provision of tetanus toxoid immunization
- Provision of treatment regimen for threadworm
- Provide external or internal referrals for treatment of any abnormalities or pregnancy-related complications detected
- Provide internal/external referrals for delivery with skilled birth attendant (includes MOU with SDUs)

9. Integration & ensuring client's rights

- Level of integration of services within IPES (based on review of client records)
- Providers respectful and non-judgmental to all clients and for all services
- Level of privacy & confidentiality (as per IPPF standards)
- Updated standard protocols available for components of IPES
- Benefits of condom use highlighted (dual protection)
- Referral to other SRH services (cervical cancer, HIV counseling & testing, SGBV, pregnancy confirmation, counseling)