Integrating the HIV Services within Sexual and Reproductive Health Services

Preface to HIV -SRH services integration Framework:

Qualitative Study

Perception of Policy makers, Stakeholders, People Living with HIV and People at most Risk (MSM, SW, PUD) towards HIV -SRH services integration

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Important note: This document is considering as a preliminary mission/task before developing HIV-SRH Integration Framework. This include: review international, regional and national literatures, key informants interviews (stakeholders, decision makers and CBOs representing districts) and focus groups discussion sessions with people living with HIV and people at most risk.

This document will be an attachment to the HIV-SRH Integration Framework

Acronyms

AIDS	Acquired immunodeficiency syndrome
BCC	Behavior Change Communication
CBO	Community based organization
CMR	Clinical Management of Rape Survivors
HPC	Higher Population Council
FOCCEC	Forearms of Change Center to Enable Community
FP	Family Planning
PUD	People Who Use Drugs
INGO	International Non- Government Organization
KPs	Key population- High risk population
MOH	MOH Ministry of Health
MSM	Men who have sex with men
NGO	Non- Government Organization
PEP	Post- Exposure Prophylaxis
PLHIV	People Living with the Human Immunodeficiency Virus
PHC	Primary Health Care
PHCF	Primary Health Care Facility
PRS	Palestinian Refugees
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Reproductive rights
STD	Sexual Transmitted Diseases
SW	Sex Workers
UNFPA	United Nations Population Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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Executive Summary

Forearms of Change Center to Enable Community (FOCCEC) consulted a team of experts in health system managements and provision to prepare a framework for integration of HIV and sexual and reproductive health (SRH) services in Jordan. This document represent the first phase of this assignment[1]; the desk research (literature review), results of key informants' in-depth interviews and FGDs with PLHIV and KPs.

The main goal of meeting key informants is to identify stakeholder, policy makers and service providers perceptions towards HIV-SRH services integration, requirement, and determine gaps and priority needs for the integration of the HIV and SRH health services in Jordan. The objectives of conducting FGDs with PLHIV and Key populations / marginalized communities is to identify challenges already experienced by health services customers' (PLHIV/KPs) during seeking health services and what consequences of that on seeking medical assistance when needed. In addition, to highlight service clients' perspectives on HIV-SRH service integration.

During October and November 2020, 54 key informants (30% of them were women) were interviewed representing Donors, political and service provision organizations' (details illustrated in table 1 and annex 1). In addition two focus group discussion sessions conducted with PLHIV and KPs (14 participants).

Summary results of in-depth interviews with key informants

While there was agreement among key informants on the need for more integrated systems of SRH and HIV care in Jordan, a range of inter-related systems factors at policy, health systems, service-delivery and community levels were identified as challenges to delivering integrated care. At the policy level these included lack of policy guidance, under-funding of SRH services, service centralization, weak referral systems and shortage of statistical data; at the service level, factors included high SRH client load, staff shortages and insufficient training and skills in HIV, resistance to change (both providers and PLHIV), and lack of monitoring systems and programs.

Informants who are less interested in services integration, attributed that to the low prevalence rate of HIV/AIDS in Jordan. Small number of informants preferred to continue providing PLHIV services in specialized facilities (as current situation) taking into consideration representation in the Kingdom's three regions; south, central and north as excellence HIV facilities in providing comprehensive and high quality services.

The main prominent of potential benefits of integrated HIV-SRH services, as stated by the in-depth participants: improved access to and uptake of HIV/KP and SRH services, timely initiation of case management, reduce loss of retention in care and reduce stigma and discrimination. In addition, service integration will improve coverage of underserved/ vulnerable/key populations, improve screening and early detection programs.

Success HIV-SRH service integration can be reached through enhancing and strengthening: health policies and strategies, health insurance coverage, referral system, service providers' capacities, community engagement and awareness, reduce stigma and discrimination and establishing effective partnerships between health providers in Jordan.

Informants had varying views on the best way to achieve integration: while some favored a one-stop shop approach, others preferred retaining sub-specialisms (treatment) in VCT while strengthening referral systems.

[1] Phase two will be: development of HIV-SRH services integration framework.

The introduction of task-shifting policies and decentralization of HIV treatment to primary care provide opportunities for integrating services.
Integration can be accomplished in a phased manner with support of decision makers, community and healthcare providers. Policy and advocacy initiatives to include STDs/AIDS and specifically targeting vulnerable groups (including refugees, KPs and PLHIV) within the National Strategy for SRHR (Higher Population Council responsibility) that will be launched before the end of this year[2], develop standard procedures to strengthen referrals within and between public healthcare facilities and health providers' capacity building through training and mentorship programs.

Summary Results of FGDs with People Living with HIV and People with Most Risk
Main finding listed below summarizing the results of the two FGDs conducted with PLHIV and key populations (SW, MSM and PUD):

- Shortage of systems and standards in public health facilities for providing health service for PLHIV/KPs;
- PLHIV and KPs lack of knowledge of where and how to seek health services;
- PLHIV and KPs avoid seeking health services from public sector due to poor quality;
- PLHIV's fear of stigma from medical staff prevent them from seeking health services;
- Cultural barriers play essential roles for KPs not to ask for health services (stigma, discrimination, scandal);
- PLHIV and KPs trust their peers more than health providers in case of complaints related to SRH;
- High cost of health services in the private sector prevent PLHIV and KPs of getting quality health services;
- PLHIV and KPs dissatisfaction of health services provided for them;
- PLHIV and KPs dissatisfaction of health providers' attitude and behaviors;
- PLHIV/KPs prefer to be referred by specialized CBOs to a trusted health provider and well informed of the needs and required services for PLHIV/KPs;
- HIV-SRH service integration success will need improvement of health system procedures, facilities infrastructure, health providers' communication methods and services procedures and processes.

[2] The study team advocate for adding specific interventions and activities about STDs/AIDS during their meeting with the Higher Population Council and their participation with the national steering committee to review the National Strategy for SRHR components.

Introduction and Background

The potential benefits of integration have been widely cited. Since 2004, the need to expand integration to include HIV and SRH services has been recognized and increasingly implemented and examined with greater rigor in the world. Integrated HIV and SRH services are proposed as an umbrella framework for delivering comprehensive services, including MCH services. As early as 2005, WHO/UNFPA /UNAIDS/IPPF documented the advantages of integrating HIV and SRH services which, according to them, included:

- ✓ Improved access to and uptake of key HIV and SRH services;
- ✓ Better access of people living with HIV to SRH services tailored to their needs;
- ✓ Reduction in HIV-related stigma and discrimination;
- ✓ Improved coverage of underserved/vulnerable/key populations;
- ✓ Greater support for dual protection;
- ✓ Improved quality of care;
- ✓ Decreased duplication of efforts and competition for scarce resources;
- ✓ Better understanding and protection of individuals' rights;
- ✓ Mutually reinforcing complementarities in legal and policy frameworks;
- ✓ Enhanced program effectiveness and efficiency;

The International Conference on Population and Development (ICPD) in 1994 marked a global movement towards the provision of comprehensive and integrated sexual and reproductive health (SRH) services for universally accessible health care. Nowadays, this movement continues to be promoted under SDG 3 target 3.7: "By 2030, ensure universal access to sexual and reproductive health care services, including family planning, information, and education, and the integration of reproductive health into national strategies and programs", Service integration, including effective and efficient SRH delivery, is at the heart of successful implementation to support SDG 3. As well under SDG 5 target 5.6: "ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences"

A core principle of the 17 Sustainable Development Goals (SDGs), and of the AIDS response, is that no one should be left behind. The AIDS epidemic cannot be ended without the needs of people living with and affected by HIV, and the determinants of health and vulnerability, being addressed. People living with HIV often live in fragile communities and are frequently discriminated against, marginalized and affected by inequality and instability—their concerns therefore must be at the forefront of sustainable development efforts

SDG 3 contains the following HIV specific targets:

- **Target 3.3**: end AIDS as a public health threat by 2030
- **Target 3.8**: achieve universal health coverage, access to quality health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

However, a number of other SDGs also relate to the HIV response. These are

SDG 4: Quality education, including targets on comprehensive sexual and reproductive health (SRH) education and life skills

SDG 5: Gender equality, including targets on sexual and reproductive health and rights (SRHR) and the elimination of violence, harmful gender norms and practices

SDG 10: Reduced inequalities, including targets on protection against discrimination, and the empowerment of people to claim their rights and enhance access to HIV services

SDG 16: Peace, justice and strong institutions, including reduced violence against key populations and people living with HIV.

Epidemiology:

It has been nearly four decades since the first known cases of Human Immunodeficiency Virus (HIV) and the Acquired immunodeficiency syndrome (AIDS) appeared, which was associated with high mortality rates that increased steadily during the eighties and reached its peak in the year 2004. However, fortunately, infection-related death rates have decreased significantly in the past ١٥ years, and the reasons behind this decline can be attributed mainly to the introduction of the Highly Active Antiretroviral Therapy (HAART). As a result of this significant reduction in the death rate, there are more people living with HIV (PLHIV) who are living longer, enjoying good health and practicing normal activities - including sexual activity- resulting in shifting of focus toward prevention efforts. The world is witnessing a decline in the number of infections - where the number of PLHIV is estimated at 38.0 million (with an estimate of 1.7 million new infections in 2019), 67% of them are receiving treatment services- including (HAART)[3].

According to the Joint United Nations Program on HIV / AIDS (UNAIDS)[4] , The epidemic in the Middle East and North Africa continues to grow, with a 22% increase in new infections and a 9% increase in the annual number of AIDS-related deaths between 2010 and 2019. Access to HIV testing, treatment and care in the region is well below the global average. 52% of people living with HIV are aware of their status, 38%were accessing antiviral therapy and less than one third are virally suppressed. The increase in annual new infections-٢٠,٠٠٠ is a sign that prevention programs in many countries are not reaching sufficient numbers of people at high risk of HIV infection. Almost all new HIV infections are among key populations (12%sex workers, 43%people who inject drugs and 23% men who have sex with men (MSM) and their sexual partners.

In Jordan[5], a total of 1635 HIV cases were reported from ١٩٨٦ until 2019, of which Jordanians represent 28% with a total of ٤٦٣ cases - and a significant increase (25% of all cases were reported during the previous ٣ years and most new infections are concentrated in the age group of 20-40 years (a percentage exceeding 70%, out of them men representing 80%).

Regardless of the extent of the problem in any country, certain groups (Key Populations KPs) are at increased risk of contracting HIV due to certain behaviors that expose them to the possibility of infection, and the social/structural barriers facing these populations including stigma, discrimination, marginalization and violence, criminalization, gender and human rights issues. These groups include men who have sex with men, people who inject drugs and sex workers. The lack of programs that work with KPs leads to the loss and dispersion of efforts aimed at addressing HIV, therefore, their access to prevention and treatment services must be enhanced in order to achieve prevention and reduce the prevalence rate and they should be taken into account in the national strategies aiming to combat HIV.

I. Literature review, previous experiences, lesson learned

In response to the increasing need to ensure the provision of HIV/AIDS high quality, integrated and comprehensive services that respond to the prevention and treatment dimensions of care, ensuring sustainability and continuity of care, many international, regional and local institutions developed guidelines and protocols and strategic directions on different modalities to integrate HIV/AIDS related services within other services; namely primary health care and Sexual and reproductive health services. In addition, many institutions conducted assessment of implemented integration modalities and lesson learned.

Many relevant international and regional documents reviewed and assessed to collect pertinent data and experience related to integration modalities and approaches.

[3] UNAIDS data 2020
[4] UNAIDS data 2020
[5] National AIDS program statistical report, 2019

As well, many Jordanian relevant documents were reviewed to assess the strategic direction toward the provision of sexual and reproductive health services in general and specifically the interrelation with HIV/AIDS related services and programs.

International documents

The "***UNAIDS 2016-2021 Strategy "on the fast track to end AIDS[6]"*** defines the linkages between SDGs and HIV/AIDS programs and interventions. Of most important intervention areas that are related to integrated HIV services are:

GOOD HEALTH AND WELL-BEING (SDG 3)

Result area 2: New HIV infections among children eliminated and their mother's health and well-being is sustained.

Action: HIV, sexual and reproductive health, including family planning, tuberculosis and maternal and child health services integrated and accessible for women, especially women living with HIV

REDUCED INEQUALITIES (SDG 10)

Result area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Action: Youth-friendly HIV, sexual and reproductive health and harm reduction information and services accessed independently and equally by young women and men

GENDER EQUALITY (SDG 5)

Result area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Action: Sexual and reproductive health and rights needs fully met to prevent HIV transmission

PARTNERSHIPS FOR THE GOALS (SDG 17)

Result area 8: People-centered HIV and health services are integrated in the context of stronger systems for health. HIV-sensitive universal health coverage schemes implemented

Action: People living with, at risk of and affected by HIV access integrated services, including for HIV, tuberculosis, sexual and reproductive health, maternal, newborn and child health, hepatitis, drug dependence, food and nutrition support and non-communicable diseases, especially at the community level

Action: Comprehensive systems for health strengthened through integration of community service delivery with formal health systems

Action: Human resources for health trained, capacitated and retained to deliver integrated health and HIV services. Stock-outs prevented through strengthened procurement and supply chain systems

The WHO-GLOBAL HEALTH SECTOR STRATEGY ON HIV 2016–2021,TOWARDS ENDING AIDS[7]" outlines a vision, goals and actions for the global health sector response, all of which are fully aligned with the vision, goal and targets of the multi-sectoral UNAIDS strategy and the Sustainable Development Goals.

The strategy defined five strategic directions:

1. strengthening and focusing national HIV programs and plans through sound strategic information and good governance;
2. defining a package of essential HIV services and high-impact interventions along the HIV services continuum;
3. adapting and delivering the HIV services continuum for different populations and locations to maximize quality and achieve equitable coverage;

[6] https://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

[7] https://apps.who.int/iris/bitstream/handle/10665/246178/WHO-HIV-2016.05 eng.pdf;jsessionid=A7DF7188B88F1909CEBB63FDFA545701?sequence=1

4. Implementing systems to fully fund the continuum of HIV services and to minimize the risk of financial hardship for those requiring the services; and embracing innovation to drive rapid progress. As well, the strategy indicates some actions- that are most appropriate to their HIV epidemics and country contexts, considering national jurisdictions and legislation- that would respond to the strategic direction:

a. The need to Link and integrate HIV strategic information systems with broader health information systems and identify opportunities for integrated strategic information platforms.
b. Diversify testing approaches and services by combining provider-initiated and community-based testing, promoting decentralization of services and utilizing HIV testing services to test for other infections and health conditions
c. Adapt service delivery models to strengthen integration and linkages with other health areas and to achieve equity, with a particular focus on reaching adolescents, young women, men and key populations.
d. Integrate HIV into national emergency plans to ensure the continuity of essential HIV services during emergencies and in settings of humanitarian concern,
e. Reform policies, laws and regulations that hinder equitable access to HIV-related services, especially for key populations and other vulnerable groups.
f. Strengthen coordination with other health programs including identifying opportunities to consolidate underlying health systems, such as those for strategic information, human resources, and procurement and supply management.

Many countries are now seeking to develop essential packages of SRH services. Each country's essential SRH package should be determined and defined by the particular SRH needs of its population, with particular attention to the most vulnerable and marginalized populations. Central to every essential package, is the need to organize service delivery so as to maximize the integration of complementary services that can be delivered effectively, safely and with cost-efficiencies over the delivery of individual services, and in combinations that are both acceptable to the client and feasible to the health system, and especially the provider.

The UNFPA's framework or the Steps for Planning and Implementing an Essential Package of SRH services provides a five-step guide to lead UNFPA Program Officers and national partners through a process of developing, implementing and expanding an essential package of SRH services. The five steps include 1) Prepare; 2) Assess and Analyze; Identify Facilities for Initial Program/Phase Implementation; 3) Define and Operationalize the Essential SRH Package; 4) Assess the Initial Phase and Plan for Expansion; and 5) Maintain Commitment and Sustain.

The "***Consolidated guideline on sexual and reproductive health and rights of women living with HIV***[8]" is meant to help countries to more effectively and efficiently plan, develop and monitor programs and services that promote gender equality and human rights and hence are more acceptable and appropriate for women living with HIV, taking into account the national and local epidemiological context. It discusses implementation issues that health interventions and service delivery must address to achieve gender equality and support human rights.

The guidelines defined a summary list of recommendations related to:

A. Creating an enabling environment; with specific focus on healthy sexuality, integrated SRHR and HIV service, protection from violence and Community empowerment
B. Health interventions: with focus on counseling and services delivery of all components of SRH

The guidelines as well introduces eight topic areas as new recommendations or good practice statements covering: psychosocial support, ageing and healthy sexuality, economic empowerment and

[8] World Health Organization, 2017, https://apps.who.int/iris/bitstream/handle/10665/254885/9789241549998-eng.pdf?sequence=1

resource access (including food security), integration of SRHR and HIV services, empowerment and self-efficacy around safer sex and reproductive decision-making, facilitating safe disclosure for women living with HIV who fear or experience violence, modes of delivery for best maternal and perinatal outcomes (specifically caesarean section), and safe medical and surgical abortion.
Specific recommendations on Integration of SRHR and HIV are introduced, e.g.:

- Antiretroviral therapy (ART) should be initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings, with linkage and referral to ongoing HIV care and ART, where appropriate.
- Sexually transmitted infection (STI) and family planning services can be integrated within HIV care settings.
- Decentralization of HIV treatment and care should be considered as a way to increase access to and improve retention in care: e.g.
    - Initiation of ART in hospitals with maintenance of ART in health facilities;
    - Initiation and maintenance of ART in peripheral health facilities;
    - Initiation of ART at peripheral health facilities with maintenance at the community level.

The "***HIV and Sexual and Reproductive Health Programming: Innovative Approaches to Integrated Service Delivery, Compendium of Case Studies***[9]", indicated that in light of recent progress towards eliminating pediatrics HIV, strong momentum for integrating HIV and sexual and reproductive health (SRH) (including maternal, newborn and child health (MNCH), family planning (FP), and sexually transmitted infection (STI) programs; and the recent WHO guidelines on the use of antiretroviral drugs (ARVs) for the prevention and treatment of HIV infection, there has been growing demand for practical country-level guidance to optimize integrated service delivery models.
The Global Plan towards Eliminating New HIV Infections among Children by 2015 and Keeping Mothers Alive (Global Plan) explicitly calls for integrated HIV and SRH programming. It urges national leaders to "build a vibrant coalition between the HIV and maternal, newborn and child health constituencies around the goals of eliminating new HIV infections among children by 2015 and keeping their mothers alive…" and "promote greater synergies and the strategic integration of prevention of mother-to-child HIV transmission programs and maternal, newborn and child health programs, as well as family planning services."
The study found that there are several common threads that make integrated service delivery successful, these included:

1. Sustained political commitment and coordination in nearly all of the case studies, the Ministry of Health was in the driver's seat and advanced the adoption of an innovative practice related to integrated service delivery models.
2. Clear, streamlined and documented strategies and policies once support for a particular change in approach or innovation was articulated, clear policies and strategies were developed to provide a framework for all interested parties.
3. Training, mentorship and supportive supervision significant investment in health workers', continued education and professional and leadership development including, but not limited to, mentoring and supportive supervision is needed to ensure that frontline health workers are equipped to deliver services, using a new, more integrated approach.
4. Community engagement is vital to demand creation and retention as clinical program components become increasingly more integrated, community engagement can magnify the benefits achieved by such models.
5. Integrated M&E system, the integration of M&E systems should follow the integration of service delivery models.

[9] the Inter-Agency Task Team (IATT , World Health Organization (WHO), UNICEF, and UNFPA, Dec. 2014

According to the study ***"Assessing the Benefits of Integrated HIV and Reproductive Health Services[10]"*** that aimed at assessing Integration of HIV and Sexual/Reproductive Health Services and to generate rigorous evidence on the feasibility, effectiveness, cost, and impact of different models for delivering integrated HIV/SRH services in settings with high and medium HIV prevalence in sub-Saharan Africa. Specifically, the study aimed to:

1. Assess the extent to which different models of integrated service provision increase the range, use, and quality of selected SRH and HIV services, and lead to a greater diversity in the profile of clients.
2. Explore whether the provision of integrated HIV and SRH services leads to reductions in HIV risk-behavior, HIV-related stigma, and unintended pregnancies.
3. Assess the efficiency of using different models for delivering integrated services in terms of cost, use of existing infrastructure and human resources services for HIV-positive mothers and infants, as well as referrals for clients requiring additional services.

The study demonstrated that:

1. Integrating HIV services into family planning and postnatal care services can improve the use of HIV counseling and testing.
2. Integration does not reduce the overall quality of care as is often perceived, but can increase the quality of family planning and postnatal care.
3. There is potential for integrated delivery of services to improve cost efficiencies but this is often unrealized at the facility level.
4. Most clients prefer fully integrated services to save time and money. Yet many women living with HIV prefer sexual and reproductive health services, such as family planning, to be integrated into specialist HIV units as they trusted the providers at these facilities, enjoying continuity of care from them, had reduced fear of stigma within specialist sites, and benefited from the opportunity to meet other clients living with HIV.

The study "***Family Planning (FP) and HIV Integration: Approaching the Tipping Point***[11]",aimed at studying the relationship and existing models of HIV services integration within FP services and vice versa. The study found out that family planning and HIV integration is an important strategy for addressing the reproductive health rights and needs of women living with and at risk of HIV. As because clients seeking HIV services and those seeking family planning services share many needs and concerns, integrating services enables providers to address them efficiently and comprehensively. However, implementers of HIV and family planning programs have been constrained in translating integration goals into practice. Rates of unintended pregnancies remain alarmingly high in women with HIV, and family planning interventions have been underutilized in HIV prevention, care, and treatment programs effectively implemented. Integrated family planning and HIV programs have the potential to produce tangible gains against the HIV epidemic, as well as to improve the overall health of mothers and their children. However, the study recommended that as implementers work to establish and enhance the ties between these two fields, we must continue to invest in research and expand the evidence base of cost-effective, integrated, service delivery best practices.

In a study "***Integrating HIV Services with Other Health Services to Improve Care Retention and Adherence***[12]". This paper helped to define the HIV services integration approaches with other services and their impact. This study was consisted of three approaches, literature review, evidence gap map, and stakeholders' interviews. The literature review showed that there are many initiatives working on services integration and many approaches tried, most of the results were positive, HIV services uptake

[10] The Integra Initiative, Kenya and Swaziland, Charlotte E. Warren Senior Associate, Washington, DC, The Bill & Melinda Gates Foundation, 2008 – 2013.

[11] FHI 360, 2010

[12] International Initiative for Impact Evaluation (3ie), Anna Heard, Katia Peterson, Shilpa Modi, Hisham Esper, Flor Calvo, and Annette N Brown, 2015-2017.

and health outcomes improved on both HIV services as well as the other health services, but with limited evidence of cost effectiveness although it was not found that integration is not less cost effective. The gap map constructed the evidence between the literature review of integration performed and the rigorous measurement of impact evaluation to assess the effect of the integration.
The stakeholder's survey assessed the perceived state of evidence and asked about ideal indicators for outcomes measurement. Stakeholders reported that relative to other services, there is a strong evidence supporting the integration of maternal, newborn and child health, sexual and reproductive health and family planning with HIV services.
This study recommends that there is a need to inform researchers, implementers and policy makers of the existing evidence and also that more rigorous evaluation of the integrated services is highly needed.

Illustrating a useful case study, the ***"Minimum Package for RH and HIV Integrated Services in Kenya***", developed by the National MOH showed that integrating Reproductive Health and HIV and AIDS policies, programs and services has been considered essential for meeting global and national goals and targets including Vision 2030 and the United Nations Millennium Development Goals particularly goals 4, 5 and 6.
The National Reproductive Health and HIV and AIDS Integration Strategy (2009) lay down the framework for the integration of RH and HIV services. The goal of integration is to provide more comprehensive, convenient, acceptable and cost effective RH and HIV and AIDS programs.
In a low resource country like Kenya, wholesale operationalization of the strategy is not feasible hence the need to develop a minimum package that seeks to provide guidance to implementers or service providers on the minimum requirements in terms of infrastructure, human resource, skills set and training materials, equipment, commodities and supplies, and M&E that are necessary at any level of care for effective service provision. The use of this package will guide the delivery of standardized, coordinated and integrated services.

The study ***"Integrating HIV Care and HIV Prevention: Legal, Policy, and Programmatic Recommendations***[13]", addressed the challenges and how to better utilize opportunities created by the antiretroviral (ARV) roll-out to achieve more effective prevention with PLWHA. The study results showed that ART availability has necessitated improvements in the logistical systems needed for the planning, purchasing and distribution of medications and commodities required by care and treatment programs. These same systems can be used to supply currently available HIV/STI prevention technologies (e.g., male and female condoms) as well as non-barrier contraception that allow HIV-affected families to plan their parenting options, and could be used for the distribution of future interventions if shown to be effective in reducing HIV transmission. Linkage of HIV care and treatment programs with antenatal clinics (ANCs), obstetric services, and Maternal and Child Health (MCH) programs more generally has been achieved in some settings. Connecting rapidly expanding HIV care and treatment services with existing Prevention of Mother-to-Child Transmission (PMTCT) programs has the potential to improve coverage and ultimately reverse the public health shortcomings of stand-alone PMTCT programs throughout much of Sub-Saharan Africa.
This study recommended that donors and Governments should be encouraged and assisted to more effectively integrate appropriate aspects of HIV prevention with HIV care and treatment. Ultimately, there is a need to expand the types of services delivered to people living with HIV on the ground. Specifically, the triad of HIV care/treatment, PMTCT, and reproductive health care, should be coordinated at the policy, planning and operational levels as a seamless continuum. Integrated services would provide opportunities to deliver interventions across the spectrum of needs of women living with HIV. Orienting services to the particular needs of women, which include care of their partners and

[13] Robert H. Remien, PhD, Alan Berkman, MD, Landon Myer, PhD, Francisco I. Bastos, MD, PhD, Ashraf Kagee, PhD, MPH, and Wafaa El-Sadr, MD, MPH

children when appropriate, is a strategic way to improve adherence to care and treatment programs, which can be reached by:

1. Development of guidelines for safer reproductive strategies for HIV-infected women and men with training of health care workers on the sexual and reproductive rights of the patient
2. Human right advocacy for changes in policy and law and their implementation to ensure access to services for all HIV-infected individuals, including high-risk marginalized populations
3. Scale-up" of effective behavioral interventions and training of staff to provide these interventions

The study "***Integration of HIV Care with Primary Health Care Services: Effect on Patient Satisfaction and Stigma in Rural Kenya***"[14], piloted a system of integrating HIV services into primary care in rural Kenya for three years between 2008 and 2010. Given the potential positive aspects. The study recommended exploring integration as one innovative way of improving primary care services that receive little donor funding, while at the same time maintaining the achievements of donor-supported HIV care at the patient level. Larger, cluster-randomized or stepped-wedge and longitudinal studies should be conducted to confirm these findings and address other critical issues, including the effect of integration on quality of care, long term health outcomes, and cost-effectiveness.

In the "***Prevention of Mother-To-Child Transmission (PMTCT) - Briefing Note***" by WHO, Department of HIV/AIDS in 2007, indicated that a public health approach should be applied to PMTCT services to ensure access to high quality services at the population level, while striking a balance between the best proven standard of care and what is feasible on a large scale in resource-constrained settings.

As a mode of transmission, MTCT accounts for more than 10% of all new HIV infections globally, the risk of MTCT can be reduced to less than 2% with a package of evidence-based interventions including ARV prophylaxis and treatments combined with elective caesarean section and avoidance of breastfeeding.

This comprehensive approach includes the following four elements:

1. The primary prevention of HIV infection among women, especially young Women Avoiding infection in parents-to-be will help to prevent HIV transmission to infants and young children. In addition, special effort should be made to prevent future infection among women diagnosed HIV-negative especially in antenatal care settings.
2. The prevention of unintended pregnancies among HIV-infected women. Reproductive health (including family planning) services need to be strengthened so that all women, including those who are infected, can make informed decisions about their future reproductive life. Increased availability of counselling and testing services would enable them to obtain essential care and support services,
3. Provision of specific interventions to reduce HIV transmission from HIV infected women to their infants. It includes antiretroviral drug regimens for HIV-infected pregnant women and their newborn, safe obstetric practices and counseling and support for HIV-infected pregnant women on infant feeding options.
4. Provision of treatment, care and support for HIV-infected mothers, their infants and family. Care and support must be fully integrated into ongoing efforts to improve maternal and child health services, and be tailored to the needs of women for safe and effective antenatal, obstetric and reproductive health.

[14] Thomas A. Odeny,Jeremy Penner, Jayne Lewis-Kulzer, Hannah H. Leslie, Starley B. Shade, Walter Adero, Jackson Kioko, Craig R. Cohen, and Elizabeth A. Bukusi, April 2013

The Guttmacher-Lancet Commission's report "***Accelerate progress—sexual and reproductive health and rights for all***[15]"focused on the Sexual and reproductive health and rights (SRHR) as one the fundamentals' to people's health and survival, to economic development, and to the wellbeing of humanity

The report stressed on specific issues related to SRHR such as

1. Sexual and reproductive health and rights (SRHR) are essential for sustainable development because of their links to gender equality and women's wellbeing, their impact on maternal, newborn, child, and adolescent health, and their roles in shaping future economic development and environmental sustainability.

2. Everyone has a right to make decisions that govern their bodies, free of stigma, discrimination, and coercion.

3. Decisions include those related to sexuality, reproduction, and the use of sexual and reproductive health services. 4. SRHR information and services should be accessible and affordable to all individuals who need them regardless of their age, marital status, socioeconomic status, race or ethnicity, sexual orientation, or gender identity.

In addition, the report also draws attention to typically under-served populations including adolescents, people with disabilities and LGBT-identifying individuals, among other.

This report proposed a comprehensive and integrated definition of SRHR and recommends an essential package of SRHR services and information that should be universally available that includes the commonly recognized components of sexual and reproductive health—ie, contraceptive services, maternal and newborn care, and prevention and treatment of HIV/AIDS. Additionally, the package includes less commonly provided components: care for STIs other than HIV; comprehensive sexuality education; safe abortion care; prevention, detection, and counseling for gender-based violence; prevention, detection, and treatment of infertility and cervical cancer; and counseling and care for sexual health and wellbeing.

Regional experiences, case studies

A study "**Integration of sexual and reproductive health services in the provision of primary health care in the Arab States: status and a way forward**"16, aimed to assess gaps in the delivery of SRH in PHC services, identifying challenges and proposing action towards universal health coverage in Arab countries.

The assessment of integration of SRH into PHC in 11 Arab countries showed that SRH services are partially integrated in PHC. The only SRH services provided within PHC in all eleven countries are antenatal and postnatal care, in addition to neonatal and child health care. Services such as screening for sexually transmitted infections and breast cancer services are available at the PHC level in eight countries. Cervical cancer screening, and gender-based violence prevention and/or management are only delivered as part of PHC in six countries. Abortion care is only legal in Tunisia and is provided through specialized services at the PHC level. Post-abortion care and emergency contraception are not commonly provided in PHC, except in four countries. Family planning is included in PHC in all countries, except in Libya, where only a form of counselling is provided, without provision of contraception.

In the Arab region, HIV/AIDS prevalence is considered low and comprehensive HIV services appear to be lacking. The assessment of the integration of HIV services into PHC showed that Saudi Arabia, Libya, Jordan, Oman and Palestine do not have integrated HIV services. There is minimal integration of HIV services in antenatal care in Sudan and Egypt; however, comprehensive services are provided in

[15] the Guttmacher–Lancet Commission, Ann M Starrs, Alex C Ezeh, Gary Barker, Alaka Basu, Jane T Bertrand, Robert Blum, Awa M Coll-Seck, Anand Grover, Laura Laski, Monica Roa, Zeba A Sathar, Lale Say, Gamal I Serour, Susheela Singh, Karin Stenberg, Marleen Temmerman, Ann Biddlecom, Anna Popinchalk, Cynthia Summers, Lori S Ashford, 2018

[16] Sexual and Reproductive Health Matters, https://doi.org/10.1080/26410397.2020.1773693 ,2020

specialized centers. Only Morocco, Tunisia and UAE have integrated HIV services within the already available SRH services. Morocco is the only country that provides comprehensive integrated HIV services, with referral only needed in the case of a few of the services. Tunisia and UAE follow closely, while Egypt has a wide range of integrated HIV services provided in the form of a "pilot", relying more on referral, and yet to be scaled up according to the study, in Jordan, HIV related services offered at PHC facilities are STI screening, diagnosis and treatment and condom provision.
As a conclusion, the study indicated that action is required at the policy, organizational and operational levels. SRH services provided through PHC must ensure that no one is left behind. Prioritization of services can guide the development of essential packages of SRH care. Developing the skills of the PHC workforce in SRH services and the adoption of the family medicine/general practice model can ensure proper allocation of resources.

"**A Rapid Assessment of Sexual and Reproductive Health and HIV Linkages-Lebanon**"[17], conducted on 2014 aimed to: assess SRH and HIV bi-directional linkages at policy, systems and service-delivery levels; identify gaps between SRH and HIV linkages at all levels; and contribute to developing a country-specific action plan to forge and strengthen linkages.
The assessment showed that barriers exist at
1. Policy level; no clear national laws, programs, policies, plans or procedures related to SRH and HIV integration. All national stakeholders showed strong support for SRH and HIV services being integrated and in one package. The benefits were seen to include increased quality and reduced costs. Identified challenges including service providers' lack of willingness to be trained and poor monitoring and evaluation processes specifically for integration.
2. Systems level; strong partnership is developed among different sectors and actors within HIV/CVT centers including civil society groups. There are few joint planning platforms for HIV and SRH programs, there is no or limited integration of HIV into SRH services and mainly is limited to awareness, prevention and counselling services. There is little attention to monitoring indicators for integration, Monitoring data is much more likely to be disaggregated at HIV/VCT than at SRH services.
3. Services level; The HIV services that are most often integrated within general SRH services are condom provision, provider-initiated HIV counselling and testing and HIV prevention for the general population. The main barrier to SRH and HIV integration was identified as cultural issues and lack of awareness, lack of support (financial, government and equipment) and lack of coordination, and the facilitator of integration was awareness raising.
The assessment developed recommendations that are summarized as:
Policy level; Advocacy on the importance, effectiveness and usefulness of SRH and HIV integration – to gain further commitment and understanding.
Systems level; Reviewing and upgrading the reproductive health (RH) program and the National AIDS Control Program (NACP) to harmonize integration of HIV in both. Strengthening and supporting joint planning and programming of SRH and HIV initiatives. Developing and agreeing core training guideline principles and values (such as confidentiality, gender sensitivity, male involvement, etc.) for integration, as well, reviewing and developing training materials/curricula on SRH that include HIV prevention, treatment and care. Developing and adopting a monitoring and evaluation scheme to capture progress, identify bottlenecks and record results of integration in both SRH and HIV program.
Service level; Developing core list of HIV services to be integrated in SRH services, and vice versa. Developing protocols and guidelines that support integrated services.

[17] Assessment of Linkages between Sexual and Reproductive Health and HIV in Lebanon, UNFPA, American University of Beirut, Republic of Lebanon Ministry of Public Health and the National AIDS Control Program in Lebanon, April 2010

"**A Rapid Assessment of Sexual and Reproductive Health and HIV Linkages-Tunisia**"[18], conducted in 2010 showed that:

1. Policy level: Tunisia reports regularly against the HIV indicators for the United Nations General Assembly Special Session on AIDS. A number of programs and initiatives have a direct bearing on SRH and HIV such as; National SRH policies address emergency contraception, abortion, improvement of SRH service quality, family health and GBV; The national MCH program includes some integration of HIV services, in particular VCT for pregnant women and referrals for HIV-positive mothers and babies; The strategic plan of the National AIDS Program (NAP) focuses on treatment, most-at-risk populations and the rights of PLHIV, but does not address SRH; The National Program on Health of Adolescents in School (2007) promotes counselling facilities (in place since the 1990s) and youth-friendly services.

2. Systems level: HIV services are more specialized than SRH services. In general, the capacity of the health sector to provide tailored services to marginalized groups and young people is perceived as being limited. There is no joint planning mechanism for SRH and HIV. The national SRH plan and national STI/HIV program are implemented by different entities. There is no M&E framework that is common to SRH and HIV.

3. Services level; a large proportion of SRH providers provided some HIV-related services mainly counseling and referral to testing and psychosocial support. HIV practitioners are more specialized and less likely to provide SRH-related services when compared with SRH practitioners providing HIV services.

The assessment developed recommendations that are summarized as:

Improving access to sexual and reproductive health (SRH) and HIV services by developing and/or expanding: provision of services; tailored services for key populations and young people; in-service training for practitioners; and SRH and HIV outreach services. Training should cover stigma and discrimination, particularly in relation to key populations and people living with HIV (PLHIV).

Developing functional networking between SRH and HIV practitioners and between governmental actors and non-governmental organizations (NGOs).

Developing protocols, guidelines and training programs that aim to enhance linkages between SRH and HIV services, including guaranteeing confidentiality

At systemic level, developing a national strategy to create and strengthen SRH and HIV integration. Strengthening networking and partnership between organizations involved in each area. Developing joint monitoring and evaluation (M&E) for HIV and SRH programs and outcomes. Developing an SRH and HIV coordination mechanism to coordinate and monitor integration.

"A Rapid Assessment of Sexual and Reproductive Health and HIV Linkages-Morocco"[19], conducted in 2009 showed:

1. Policy level: The term 'sexual health' is not in common use. Reproductive health is, but no entity has overall responsibility and there is no specific RH action plan or funding. The only document with an integrated approach is the National AIDS Strategy, MNCH and FP services are identified as priority sites for introducing and strengthening HIV-related interventions.

2. Systems level: The 'vertical' policy approach is reflected in systems. Some components are grouped together by necessity rather than design – in small facilities, MNCH and FP services are provided together. HIV services are provided through specialized referral centers and NGOs. There are no integrated SRH and HIV indicators.

3. Services level; HIV services are mainly provided in specialized facilities and by NGOs. • RH services are generally not provided in the context of services for PLHIV.

The assessment developed recommendations that are summarized as:

[18] Évaluation des Liens entre la Santé Sexuelle et de la Reproduction et le VIH en Tunisie, by Amel Ben Said and Senim Ben Abdallah, September 2010.

[19] Evaluation Rapide de la Situation pour l'Intégration de la Prévention du VIH/ SIDA dans la Santé Sexuelle et Reproductive, Ministère de la Santé, Morocco, and UNFPA, February 2009.

The report of the assessment outlines a strategy for integration, with five main points:

- Developing a coordinated global response on SRH and HIV.
- Improving the quality of care.
- Better targeting of those at risk.
- Better access to services.
- Strengthening prevention and testing for HIV.

In a review study "Reproductive Health in Arab Countries20" that aimed at exploring the Reproductive health issues in the Arab region, it reviewed the availability and accessibility to full range of reproductive health care services in different Arab countries, with a focus on the general situation in the Arab region and a comparison between various Arab countries. The study found out that RH issues are of great local interest. And the traditions and local cultures with the differences in healthcare policies help to shape RH services available in the region. In general, the lack of awareness and poor resource availability negatively affect women in the region, particularly related to their reproductive health and rights. The study indicated:

a limited data on the epidemiology of STI in the Arab countries, which affects the ability to create accurate view of the general situation of the region.

The prevalence of HIV/AIDS in the Arab countries is generally low, but is increasing in the region.

The epidemic is concentrated in key populations at risk of HIV. The unavailability of data on key populations in several countries and the underestimation in other countries are another difficulty.

Obtaining an STI surveillance system remains very challenging due to social barriers, the stigma affecting utilization of healthcare services, and the limited diagnostic capacity.

Improving sexual and reproductive health outcomes for women is a critical step in improving their well-being;

Sexual and reproductive health for the adolescent and young population is a very critical issue in the region, especially with traditional taboos about sexuality and in a male-dominated culture. Access to information and friendly sexual and reproductive healthcare services are a top priority to increase the health well-being of the new generation.

The study showed that the Arab region is diverse economically, many high income countries and some middle- and low-income countries. However, the Arab countries face major challenges in maintaining sufficient funds to meet the need for sexual and reproductive healthcare; reasons for this likely are related to financial constraints, male-dominated governments and policymakers, ignorance, and gender inequity in terms of prioritizing healthcare expenditures, the study recommended that more resource mobilization activities are needed at the national level to bridge the gaps in financing reproductive health activities in Arab countries.

National statistics and strategies

The National Population and Family Health Survey21 showed very low awareness related to HIV/AIDS among married women and men (age15-24 yr), as only 7%, 8% -respectively- indicated a comprehensive knowledge related to HIV/AIDS. It showed that only 52% of women and 54% of men are aware that condom use is protective against acquiring the infection and only 27% of women and 40%of men know where to get tested for HIV.

"The National Health Sector Strategy 2016-2020" aimed to describe the health sector, analyze it, and define the priorities and objectives for the advancement of the sector in a comprehensive manner. The strategy has identified the most important factors that determine challenges to the health system,

[20] M. A. Abdelbaqy, Research Department, Alexandria Regional Centre for Women's Health and Development, Alexandria, Egypt, 2019

[21] Department of Statistics, 2017-2918

which are the increase in demand for health services as a result of the steady population growth and the epidemiological shift of diseases (high rates of non-communicable and chronic diseases) and the presence of refugees. The strategy identified the most important challenges related to health system governance:
The strategy highlighted the importance of communicable diseases-including STIs and HIV- reporting system and national registry, however, it didn't consider the importance of integrated services.
Prepared by the Higher Population Counsel in partnership with many government and non - governmental organizations, "The National Sexual and Reproductive Health Strategy"22 (2020-2030) aims to create an appropriate and supportive environment of sexual and reproductive health and to achieve population opportunity and contribute to the well - being of Jordanian citizens. The strategy cover five themes:

1. Enabling environment; related to policies and legislation
2. Service delivery and information; comprehensive and integrated quality sexual and reproductive health services
3. Community; positive attitudes , beliefs and behaviors of community members towards issues of health sexual and reproductive
4. Governance and sustainability;
5. Integrated, institutionalized and sustainable sexual and reproductive health services and information through effective inter-sectoral partnerships

The strategy defined STIs and HIV/AIDS as one of the component of sexual and reproductive health, however, doesn't define specific HIV/AIDS objectives nor interventions
The strategy as well defines one indicator related to HIV/AIDS: number of identified new HIV cases per 1000.

The Ministry of Health Strategy 2018-2022 adopted seven strategic objectives:

1. Providing quality and fair healthcare services;
2. Increase the efficiency of human resources management
3. Increase the percentage of citizens being included in universal health coverage;
4. Increase efficiency and effectiveness of infrastructure management
5. Increase the data management efficiency and effectiveness
6. Increase the efficiency and effectiveness of financial resources management
7. Maximizing governance and the supervisory role of the Ministry of the Decentralized Region

The strategy defined priorities related to SRH/FP as reducing maternal morbidity rate and decreasing fertility rate, however, the strategy didn't specify any objective or interventions related to HIV/AIDS or integration of SRH services.

There were no studies in Iordan on integrating HIV services with other health services, however, in a study " ***Social Barriers Preventing Access of People Living with HIV (PLHIV) and the key Populations to HIV (KPs) into Services[23]"*** aimed to determine and analyze the challenges and social barriers that prevent equitable access for (PLHIV) and KPs to health, social and other services, and to come up with recommendations about the proposed mechanisms and programs to reduce the social stigma that creates an obstacle to accessing services. The most important results of the study is that the societal perception of (PLHIV) and KPs is negative and leads to non-acceptance and reinforces societal ostracism and has a major impact on the ability of (PLHIV) and KPs to obtain health and social services and community integration. One of the study recommendations made by PLHIV was promoting the integration of HIV services within other services and the provision of different services (medical, social, psychological, … etc.) in accordance with the human rights -based approach, to

[22] Still a drafted version, not launched officially
[23] Forearms of Change Centre to Enable Community (FOCCEC), Dr. Manal Tahtamouni, 2020.

ensure quality control standards in the provision of services related to the right to service and prevent violations, that would affect the reduction of social stigma and thus increase the access of (PLHIV) and KPs to services.

II. Qualitative Study: In-Depth Interviews with Key Informants and Focus Group Discussion Sessions with People Living with HIV and People at most Risk

II.1 Methodology

Key Informants Interviews

In order to better understand stakeholders, policy makers and service providers' perceptions towards HIV-SRH services integration, in-depth interviews implemented with relevant key informants. The main reason of using this approach; key informants interviews, is because information comes directly from knowledgeable people, key informant interviews often provide data and insight that cannot be obtained with other methods. Key informants offer confidential information that would not be revealed in other settings. In addition, key informant interviews provide flexibility to explore new ideas and issues that had not been anticipated in planning the study but that are relevant to its purpose. During October 2020, the study team conducted 23 in-depth interviews with representatives from government, international and national NGOs, CBOs specialized in providing help for PLHIV/KP and HIV/AIDS consultants.

The main purpose of these interviews is to look into decision making and implementers' perspectives and opinion about HIV-SRH services integration in terms of feasibility. Objectives in details are to:

1. Identify the services provided in HIV and SRH fields as well as the organizations work in these fields in Jordan.
2. Determine the gaps and priority needs for the integration of the HIV and SRH health services in Jordan.
3. Define which services can be integrated and integration mechanisms.
4. Identify the specific interventions that are needed for service integration.
5. Define the available financial and human resources for the services' integration, and what additional resources will be required.
6. Identify key partners with their roles and responsibilities for advancing an integration agenda.
7. Identify opportunities for partnering with public sector, national partners, international organizations and UN Agencies

PLHIV/KPs FGDs

FGDs followed the qualitative approach in method, tool (thematic approach), data collection process (FGDs), data analysis and reporting. Data was collected through conducting focus group discussion sessions (two) with PLHIV and KPs.

The perception of People Living with HIV/AIDS on how the public feels about them could influence their willingness to seek medical care, interaction with the society and their coping strategies. The importance of conducting FGDs with PLHIV and people with high risk behaviors is to identify challenges already experienced by health services customers' (PLHIV/KPs) during seeking health services and what consequences of that on seeking medical assistance when needed. In addition, to highlight service clients' perspectives on HIV-SRH service integration.

FGDs logistics and target groups recruitment

Forearms of Change Center to Enable Community (FOCCEC) took the responsibility for recruiting participants (PLHIV & KPs) and hosting the FGDs. FOCCEC communicated[24] with the PLHIV and KPs personally to invite them to attend the FGDs. Verbal (during the phone call) and written (FGDs participants signed written consent) consent were obtained. FGDs purposes, importance, rules and procedures was stated to participants by the FGDs moderator before starting. PLHIV/KPs personal data was anonymous for the FGDs team (moderator and note-taker).

II.2 Study Tools

In-depth Interviews Tool

Before conducting interviews the study team developed a well -structured tool (annex # 2) that serve the study objectives and facilitate interviews conductions. The main content of the tool were:

- The roles that the interviewed organization/entity is playing as part of Jordanian health sector (policy makers, services providers);
- SRH and HIV services provided (In case of representing service provision entities)
- Perception towards HIV-SRH service integration (why yes or no);
- Interviewees perspectives towards service integration effect on services quality provided for PLHIV and KP and better access;
- Main factors that will lead to success HIV-SRH service integration;
- Main factors that will hinder HIV-SRH service integration;
- Interviewees' perspectives of the integration framework.

FGDs Tool

The main purpose of conducting focus group discussion sessions with people living with HIV and high risk groups (MSM, SW and PUD) is to look into PLHIV/KPs perceptions toward HIV- SRH services integration. For this goal, the study team prepared few questions to guide and facilitate the discussion with PLHIV/KPs during the focus group discussion sessions (annex # 3). The main discussion themes included in the FGDs protocol were:

- Health Facilities usually utilized by PLHIV/KPs to obtain health services in general for any illnesses or health problems;
- Health Facilities usually utilized by PLHIV/KPs to obtain SRH related complaints/ illnesses;
- Challenges PLHIV/KPs facing during obtaining health services;
- PLHIV/KPs perception towards integrating HIV services within the sexual and reproductive health services.

II.3 Data Processing

In-depth Interviews

[24] FOCCEC is well-trusted by PLHIV/KPs

Data collection phase was implemented by high qualified experts. The study team conducted face to face and virtual[25] interviews according to the interviewees' preferences. Before start data collections, the study team prepared a list of all relevant key informant taking into consideration variation of background, representation (represent policy makers, stakeholders and service providers) and gender. Due to the fact that most of organizations' headquarter located in Amman, geographical representation only considered for CBOs providing support for PLHIV/KP.
Before starting the interview, interviewers briefly explained the purpose of the study, the objective of the interview, the selection criteria (why he/she was selected in specific), the importance of the interviewees input, the possible uses of the information and ideas provided by the key informant. In addition, interviewers assured about the voluntarism of participation and confidentiality of the collected information. The interviews were audio recorded after seeking consent and then transcribed by the research team. The transcriptions were coded for main themes, which guided our findings described below.

FGDs

The average length of each focus group is ninety minutes. Notes were taken, responses were audio recorded and both were transcribed before final reporting and recording of responses. The two FGDs were audio recorded after possessed participants' approval. Qualitative responses were analyzed using simple content analysis (i.e. in terms of nature and responses to questions as well as cogency and frequency of points raised in the various questions).

II.4 Data Analysis[26]

Content thematic approach was used for data analysis. Data analysis was done manually. This involved reading transcripts several times and generating the major themes and sub-themes which were used to code the data. Direct quotations were identified and presented in the study findings. The identities of individual study participants were masked.

II.5 Study Results

II.5.1 Key Informants In-Depth Interviews Results

This study findings cover key informants perspectives towards integrating HIV services within sexual and reproductive health services, success factors and challenges. In addition, to their viewpoint about the applicable framework for HIV-SRH integration.

II.5.1.1 Description of KIIs Participants

KIIs respondents were policy makers, stakeholders and health providers represented; Donors, public, NGOs, independent HIV/AIDS expert and CBOs specialized in providing support[27] for PLHIV/KP. Females represent around 30% of informants interviewed. As illustrated in table (1) below.

[25] Response to Covid-19 crisis
[26] Details on qualitative data analysis listed on Annex five
[27] CBOs from Zarqa, Irbid and Mafraq governorates provides rapid test, education, awareness and referrals to obtain health services for PLHIV/KP.

Table 1 List of Key Informants Interviewed

Sector	# of interviews	Organization	Policy /decision maker/managerial/ service delivery/donor	# of interviewees	Interview method	Provide SRH services	Provide services for PLHIV/KPs	Governorate
Public sector	8	MOH	Policy maker/service delivery/managerial	5	Face to face Virtual	Yes	Yes	Amman
		The Jordanian Senate	Policy	1	Face to face	NA		Amman
		Higher Population Council	Policy	2	Face to face	NA	NA	Amman
		Jordanian Nursing Council	Policy	2	Face to face	NA	NA	Amman
Donors[28]	3	USAID	Donor[29]/Policy	2	Virtual	NA	NA	Amman
		Health System Delivery/USAID funded Project	Donor	1	Virtual	No (provide tech for MOH/SRH programs)	No	Amman
		UNFPA	Donor	3	Virtual	No (provide fund for SRHR programs in camps and host communities for refugees)	No (UNFPA is providing commodities and emergency kits that include treatment for STDs	Amman
International NGOs	3	International Rescue Commission (IRC)	Donor	4	Virtual	Yes	No	Amman
		International Organization for Migration (IOM)	Donor	1	Virtual	Yes	No (provide commodities and rapid test for MOH directorates in district)	Amman
		Jordan Health AID Society (JHAS)	Service delivery	3	Virtual	Yes	No (CMR service for refugees in camps)	Amman
National NGOs	4	Institute for Family Health/ Nour Al Hussein	Service delivery	1	Face to face	Yes	No (CMR services)	Amman

[28] UNRWA is one of the primary health care providers in Jordan, where the study team tried to reach out several times but because of the global pandemic the UNRWA offices where locked down. UNRWA operates 25 health clinics and four mobile clinics across Jordan. All PRS are eligible to access UNRWA primary health-care services. PRS also benefit from UNRWA-funded referrals to secondary and tertiary services.

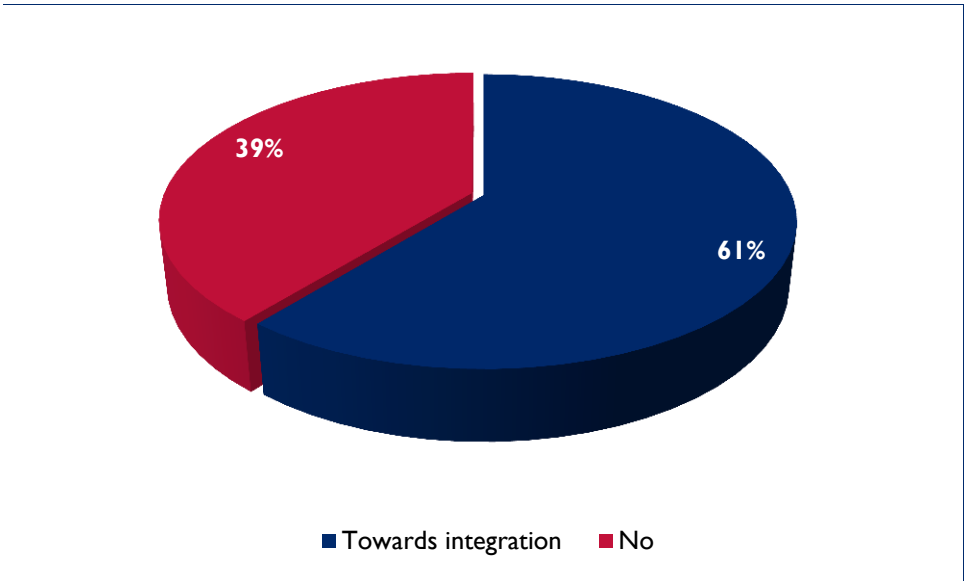
[29] Donors fund programs and activities implemented by either government and local NGOs

Sector	# of interviews	Organization	Policy /decision maker/managerial/ service delivery/donor	# of interviewees	Interview method	Provide SRH services	Provide services for PLHIV/KPs	Governorate
		Foundation (IFH)						
		Communicable and Infectious Disease Society	Policy/service delivery	1	Face to face	No	No	Amman
		The Islamic Charity Center Society (ICCS)	Service delivery	3	Face to face	Yes	No	Amman
		Jordanian Society for Family Planning and Protection	Service delivery	3	Face to face	Yes	No	Amman
HIV/AIDs expert (former MOH/NAP employee)	1	HIV/AIDs independent consultant	Consultant	1	Virtual	NA	NA	Amman
CBOs specialized in providing help for PLHIV/KP	4	Irbid Family and child community center	Service delivery Advocacy, rapid test	1	Virtual	No	Rapid test, Advocacy , awareness Provide condoms	Irbid
		Bushra Society for community development	Service delivery	1	Virtual	No	Rapid test, Advocacy , awareness Provide condoms	Zarqa
		Family affairs Society	Advocacy, rapid test	1	Virtual	No	Rapid test, Advocacy , awareness Provide condoms	Zarqa
		Al Mafraq Society	Service delivery	1	Virtual	No	Rapid test, Advocacy , awareness Provide condoms	Mafraq
Total	**23**			**54**				

II.5.1.2 Perception towards HIV- SRH Services Integration

Most of informants (around 61%) believe integration is desirable, but the majority don't think it's really feasible. Around 88% of the interviewed key informants perceive that integration will be difficult to be implemented in Jordan. They pointed out several reasons why this would be difficult to achieve. Challenges as mentioned by informants related to; health providers, health system, culture barriers, PLHIV/KP perceptions, health facilities, data unavailability and HIV low prevalence rate in Jordan.

Figure 1 Stakeholders/policy makers' perception towards integrating the HIV services within sexual and reproductive health services



II.5.1.3 Advantages of Integrating HIV-SRH Service as Stated by Key Informants

In general, informants perceive that HIV-SRH services integration will enhance the epidemic control and management that will lead to improve health system in Jordan. From most of key informants' perspectives, service integration will improve:

- Early detection and prevention of STDs and potential HIV cases;
- Screening processes (partners, family members, peers);
- Improving and maximizing access to high quality provided for PLHIV/ KP;
- Response to KPs health needs and encourage to seek health services;
- Access to counseling (social, psychological, health);
- Reaching out high risk groups;
- Reach out vulnerable youth, males and females exposed to sexual abuse;
- Services provided for female vulnerable groups such as; prevent unintended pregnancy, avoid contraceptives' unmet need, abortion complications, illegal abortion, recurrent vaginal infections and sexual exploitation and abused;
- High risk groups' knowledge and awareness towards risk behaviors, infectious diseases, transmission, infection progress, prevention methods;
- Advocacy initiatives to fight stigma and discrimination:
- PLHIV/KPs knowledge about their rights:
- Health providers attitudes and behaviors:
- Service sustainability:
- Provide proper and specialized counseling on contraception for PLHIV/KPs.

Avoid unsafe and illegal abortion sex workers forced to perform in case of unintended pregnancy, young sex workers are unaware of contraception (female, CBO supporting PLHIV/KPs in district)

One of the KP came from Al Karak to Al Mafraq to do the rapid test when he hear from his peers

that we perform the test here in our center (female, CBO supporting PLHIV/KP in district)

Provide proper and specialized counseling on contraception for PLHIV/RP (male, NGO, service provision)

Women will encourage to discuss their fears about partners' risk behaviors (female, NGO, service provision)

Decrease chances for disease transmission to partners/family members and community (male, HIV/AIDS expert)

II.5.1.4 Challenges Raised by Key Informants towards HIV- SRH Services Integration

II.5.1.4.1 Health Service Providers

An essential ingredient to effectively integrated HIV and SRH services in PHC facilities is the presence of adequate well-trained health workers who are motivated to serve clients and provide integrated services. Health providers' lack of knowledge and skills for providing services for PLHIV/KP sit on the top of the pyramid (as stated by the majority of informants).

Most of the interviewees mentioned several challenges related to human resources in PHC facilities (include public, private sectors and NGOs) such as lack of knowledge, inadequate number of staff, limited training on how to provide integrated services, and demotivation leading to low retention of qualified staff, health providers' lack of experience and knowledge in providing health services for PLHIV, deficiency of performing required infection control procedures and precautions.

Health providers in PHC facilities are not capable to provide care for PLHIV (female, public sector, policy level)[30]

When women in reproductive age come to PHC facility with complaint of recurrent vaginal infection (some time with clear specious of Chlamydia, herpes) instead of doing further investigations, the health provider send her home with irrelevant medication (male, public sector, managerial level)

Service integration will add an extra layer of work and thus health provider will not feel motivated to integrate services (male, NGO, service provision)

Health providers in public sector usually exposed to periodic relocation, which will hinder service provision quality. In addition, not all required human resources to provide services for PLHIV are available in PHC facilities, shortage of staff include experts in; counseling (psychological and social), HIV case management, and control infection experts and supervisors.

MOH staff position relocation affecting negatively any progress and sustainability (female, Donor)

Social and psychological counseling is highly required for providing services for PLHIV, this is currently not available in PHC (male, INGO, service provision)

[30] Quotations as mentioned by informants

Ensuring privacy and confidentiality is a challenge (as stated by informants from public sector) based on the practices of health providers. Informants from CBOs who are in direct contact with PLHIV/KP perceive that PLHIV/KP do not prefer to seek help from MOH facilities to take services due to lack of privacy and confidentiality, improper communication and fear of accountability (especially drug users and MSM).

> One of our clients, HIV young man, suffered of health provider' offended behavior when he went to obtain care from public health facility (male, CBO supporting PLHIV/KP in district)

> Confidentiality is not applied in health facilities, all the facility clients and staff will know that he/she has HIV (male, public sector, service provision)

PLHIV/KP sometimes exposed to violence (verbal/sexual) upon seeking help from public facilities. Health providers violate KP behaviors' by words or impressions, while sexual exploitation mostly occur with females sex workers.

> PLHIV/KP exposed to verbal and sexual exploitation (female, CBO supporting PLHIV/KP in district)

II.5.1.4.2 PHCs Infrastructure and Essential Supplies

Poor health facilities' infrastructure to provide integrated services was brought up in several interviews as a key concern in integrating services. Facilities providing SRH either in public, private or charitable NGOs usually have limited spaces for specific services, informants reported that; service delivery for PLHIV/KP need a private spaces for counseling, lab test and care that is currently not available. Insufficient medical supplies usually affected service quality provided (such as infection control procedures).

Informant pointed to the fact that HIV treatment nationally covered by Jordanian government, so in case of service integration, this will be a huge challenge to provide medicines for PLHIV entire the Kingdom.

> Clinics currently have no space to practice counseling in privacy (female, public sector, service provision

> What about PLHIV treatment, medicines only provided by VCT (female, public sector, service provision)

II.5.1.4.3 Culture and Community

Lack of knowledge towards HIV (as one of the STIs), leads to cultural misconception of infection and transmission method. Such factors will affect the acceptance of providing services for PLHIV within PHC facilities, taking into consideration that Jordanian culture is conservative.

Informants pointed to a challenge related to community (male in specific) misconception of SRH as a 'women's issue', which will affect PLHIV/KP attendance to services.

The unacceptance of KPs behaviors and practices is main part of the Jordanian culture, which will affect PKs fear to reveal themselves in society and seek health services.

> Men usually do not seek help from facilities providing RH services, they convinced that this services only for women, so we will lose men with risk behaviors (female, public sector, policy level)

II.5.1.4.4 PLHIV/KP Knowledge, Attitude and Practices

Most of interviewing key informants mentioned that lack of information about STIs (including HIV/AIDS) delivered wrong attitudes of PLHIV/KP towards seeking assistance from health facilities. They are unaware about their health needs, or the consequences of risk behavior they practices in increasing the opportunity to acquire infections, as mentioned by respondents from CBOs supporting PLHIV/KPs.

From other key informants perspectives, PLHIV/KP less trust in the quality of services provided by public health facilities, affecting their behaviors and practices. They added that PLHIV refuse to attend MOH health centers due to the stigma and discrimination they faced there. KIs pointed to the fact that PLHIV/KP prefer not to seek services from PHC facilities in their neighborhood as most of the facility health workers are from the same area.

Finally, some KIs mentioned that PLHIV/KPs prefer to communicate and receive help from CBOs that able to reach them and response to their needs. Although PLHIV in Jordan rarely seek any service related to their HIV status outside MOH VCT center, mainly due to the availability of HIV medication only in MOH and the financial burden of services, as mentioned by informants.

> How I will convince a sex worker resident south the Kingdom to seek services from PHC located in her neighborhood (female, public sector, service-provision)

> Public health centers are providing poor service quality in general, staff are unqualified to provide essential services of their scope of work, not to provide services for PLHIV/KP (male, CBO supporting PLHIV/KP in district)

> KPs prefer to arrange for and go with them to gain health services either in private or public clinics, they will refuse to go alone, they afraid of mockery and scandal (female, CBO supporting PLHIV/KP in district)

> One of sex workers died as result of illegal and unsafe abortion (female, CBO supporting PLHIV/KP in district)

II.5.1.4.5 HIV/AIDS Prevalence in Jordan

Informants represented public sector, donors, INGOs and national NGOs pointed out to the fact of low prevalence rate of HIV/AIDS in Jordan. Although, they were aware that service integration will increase early detection and diagnosis of potential HIV cases and the prevention of new infections. Some informants expressed that low prevalence rate will hinder service integration advocacy initiatives.

> low prevalence rate in Jordan will play main role in rejecting HIV-SRH services integration (male public sector, managerial level)

> As Jordan is of low prevalence, I think it is not a good idea to integrate such services within FP/RH services (male, NGO, service provision)

> With the current case load, no need for establishment of new VCT centers or integration (male, public sector, policy level)

With low prevalence rate, it is important to invest in the available center, strengthen referral pathways and train staff to provide quality services rather than establishing new centers (male, NGO, policy /service delivery)

II.5.1.4.6 Shortage of National Data

Jordan epidemic situation is still foggy because of data inaccuracy. MOH registry is the only source of data about PLHIV in Jordan, in fact, what registered in MOH is not representing the real number of PLHIV, as no screening activities took place recently for general population or groups at risks. The need for evidence based data will provide crucial information for integration planning and implementation as well as for initiative evaluation.

Informants reported that deficiency of data and information (numbers, age groups, gender, marital status, networking, geographical distribution partners, practices and behaviors) about people with high risk (MSM, SW, PUD) will negatively affect efforts towards HIV-SRH integration (as stated by most informants).

For better planning, problem identification initiative should be implemented before service integration (female, public sector, policy level)

It is very important to conduct a multi-dimensional epidemiological assessment before services integration (female, Donor)

Conduct outreach activities for KPs to collect essential information; ages, gender, risk behaviors (male, INGO)

II.5.1.5 Essential Factors to Success HIV-SRH Integrating Service as Perceived by Key Informants

Various stakeholders pointed to the need to work more closely for HIV-SRH integration. Informants discuss the main factors that will lead to the success of integrating HIV services within sexual and reproductive health services:

II.5.1.5.1 National Policies, Regulations and Strategies adaptation

In this regards, informants reported to the need of reviewing and updating national regulations, policies and strategies in the fields of HIV and SRH; such:

- National SRH strategy 2020-2030 to Include HIV/AIDS –SRH integration provision[31]. Interventions and activities that will be included in the strategy action plans (annual

[31] HPC is willing to add to the SRH strategy 2020-2030 components and articles that will advocate positively towards the integration of HIV services within SRH services.

implementation plans including M&E plan, KPIs) need to identify in specific actions related to PLHIV at all levels; prevention, treatment and care;

- Regulations related to PLHIV and KPs health insurance coverage in primary and secondary health care services ;
- MOH internal by-Laws crucial to facilitate health coverage, service provision, linkages between MOH related directorates, referral system and case management.
- Legal instruments of communication, advocacy, community engagement, rights for health (response to DSGs);
- Political commitment to prioritize the integration of HIV- SRH services strategically and financially.

II.5.1.5.2 Service Providers' Capacity building: Training and Mentorship

Building the capacity of healthcare providers to offer integrated services was an essential component mentioned by the majority of key informants. Providers training and mentorship program need to respond to the particular needs of PLHIV/KPs attending health facilities for any complaint. Importantly, providers' capacity building program should include in addition to the health services provision processes, systemic issues, such referral systems, follow up procedures, privacy, confidentiality, infection control, records' keeping and communication skills (accepting others, decrease stigmatization). Capacity building should underpinned activities directed at health systems strengthening and interventions designed to improve the quality of individual services.

Providers in MOH health centers should communicate properly with PLHIV/KP, away of mockery (female, INGO)

Health providers "afraid of contaminations and disease transmission" (male, public sector, policy level)

Mentorship program include training, mentoring and observation procedures (female, NGO, service provision)

II.5.1.5.3 Health Systems Strengthening

Informants stated challenges associated with implementation of integrated services from systemic weaknesses, where the health system itself is burdened by infrastructural, logistical, training and service management limitations. In addition to the shortage of human resources quantity and professionally (position such as: counselors, social and psychological experts, infection control supervisors).

Before drawing the integration model framework, an action plan should developed based on an evidence based data to strengthen health system[32] in which services were couched. Informants reported two key interventions were therefore included, to contribute to health systems strengthening: improve referrals and linkages between services and wideness of health insurance coverage.

[32] The WHO describes the categories of health system functions according to six health system blocks, including governance, financing, service delivery, human resources, medical and health technology, and health information (WHO, 2012)

We need to ask first, are primary health care facilities ready to provide appropriate services for PLHIV? (Male represent INGO provide technical assistant for Jordanian health sector)

Need to provide health facilities with counselors, infection precautions employees and social workers (male, HIV expert)

for example woman who will be afraid to access VCT to discuss hear fears of her partner risk behaviors' will encourage to seek this help from trained counselor or physician in PHCC in her area (male, NGO, service provision)

II.5.1.5.4 Community Engagement

Community involvement will play essential role in HIV-SRH service integration success. Currently, very few number of non-governmental and community-based organizations (not in all district) are working to address human rights-related barriers to HIV (CBOs interventions associated with funds availability).

Informants stated the fact of empowering and fund CBOs to promote target groups (include partners and families) participation, reaching out and involvement as community engagement should accompany the process of integration design.

From the perspective of the local CBOs currently supporting PLHIV/KPs, acceptance, confidentiality and privacy they applied during their communication with these target groups built bridges of trust and played essential role in identifying risk groups through peers connections (youth, vulnerable adolescents), provide awareness and education, provide commodities (condoms) and seeking health services (CBOs support PLHIV/KPs build paths of connections with local public/private health facilities for referrals). In addition, they call to unify efforts by establishing alliance for CBOs provide.

PLHIV/KP trust CBO and NGOs more that government entities, CBOs can provide the initial counseling and refer them to health facilities (female, CBO supporting PLHIV/KPs in district)

II.5.1.5.5 Reduce Stigma and Discrimination:

Reducing stigma and discrimination for PLHIV/KPs need to a comprehensive approach for multi layers; policy, service providers and community:

- Promote for human rights instruments to advocate for PLHIV/KPs rights to obtaining health services with respect not humiliation. In addition to, develop protocols and other standards and mechanisms of accountability to uphold human rights and reduce stigma and discrimination;
- Conduct Attitude Change Communication program for health workers (different levels) towards PLHIV/KPs rights, acceptance, respect, soft communication skills, privacy and confidentiality. Followed by a mentorship program to observe, monitor and document changes of as results of the program;
- Fund and empower CBOs working with vulnerable population in districts to; promote and advocate through community dialogues implemented entire the Kingdom to increase people awareness and information and to engage key populations, community leaders (religious leaders, governors), media representative, policy makers and service providers to reduce stigma and discrimination;

- Engage and empower community based organizations working with vulnerable groups on surveillance and document statistical data related to KPs, their partners and families.
- Enhance local communities participation (involve youth, people living with HIV and other most-affected communities)

PLHIV avoid to attend any health facility because of humiliation (female, INGO)

Engage community leaders in a national advocacy program ((female, CBO supporting PLHIV/KPs in district)

Establish alliance and develop a guide/ protocol for CBOs to unify and standardized efforts of services provided for PLHIV/KP (female, CBO supporting PLHIV/KPs in district)

II.5.1.5.6 Financial Resources Sustainability

Health system financial sustainability has always been a central health policy issue, but the recent financial crisis has forced it to the top of the policy agenda the world over. Politicians need to reconsider the budget located for the Primary Health Care to overcome the shortages of health personnel and enable the health facilities environment and infrastructure, as well as to advocate for investment in STIs/ HIV/AIDs prevention (community, KP, youth).

The question as to whether health systems will be financially sustainable in the future to cover integration expenses, health coverage of uninsured PLHIV/KPs? (female, policy level)

Current financial resources is very limited with decreasing funding to HIV (limited to medications) no outreach activities , no communication channels, financial sustainability should be a national priority (female, Donor)

II.5.1.5.7 Awareness and Education

Increased popular awareness of civil, political, social, economic, and cultural rights, gender sensitization and freedoms, including; right to privacy, and the right to health. Awareness intervention should include all population segments with focus on youth and people with risk factors.
Awareness-raising efforts may include the following activities: conducting social media campaigns, issuing press releases, briefings and commentaries; disseminating reports, studies and publication.

Disseminate specific messages targeted youth, and most affected communities through media campaign (male, HIV/AIDS expert)

It is very important to develop good awareness campaign (male, NGO)

Local community based organizations can reach out and educate vulnerable populations (youth and KPs (MSM, SW, PUD)) (male, CBOs support PLHIV/KPs)

II.5.1.5.8 Partnerships and Networking

Informants highly recommended strengthening partnership between health sectors in Jordan, through establishing partnerships between the private, charitable and public health sectors, including universities. As well as, strengthening partnerships between the national AIDS Program/VCT and other government non-government agencies to prioritize and respond to PLHIV/KPs needs. In addition to developing close partnerships and coordination between and within local based organizations to standardized services and supporting. Effective partnerships and coordination should include strengthening health policies, health system, and service delivery points.

Unify efforts and develop partnership between private and public sectors (females, INGO, service provision)

II.5.1.6 HIV-SRH framework Suggested by Key Informants

Informants had varying views on the best way to achieve integration: while some favored a one-stop shop approach, others preferred retaining sub-specialisms (treatment) while strengthening referral systems.

In-depth interviews participants were more aware of the integration framework essential elements (what will be needed) rather than integration components/content. The integration can be implemented depending on a phased manner approach by steps sequence:

Phase one: Enabling environment

- Policies, regulations, and strategies adaptation (include health insurance regulations and by-laws);
- Standardize health system referral procedures for all health sectors parties. And develop referral system to be used by CBOs in the field;
- Develop specific national and regional guidelines to broaden skills on components of SRH care;
- Develop well- structured monitoring and evaluation system to measure achievements, track case management, health records and progress.

Phase two: Improve service provision facilities

- Develop continuous education and training programs for health service providers (staff with appropriate knowledge and skills to deliver services);
- Improve primary health care facilities infrastructure to ensure customers privacy and confidentiality;
- Recruit personnel; counselors, social workers, psychologists, supervisors;

Phase three: community engagement, advocacy and awareness

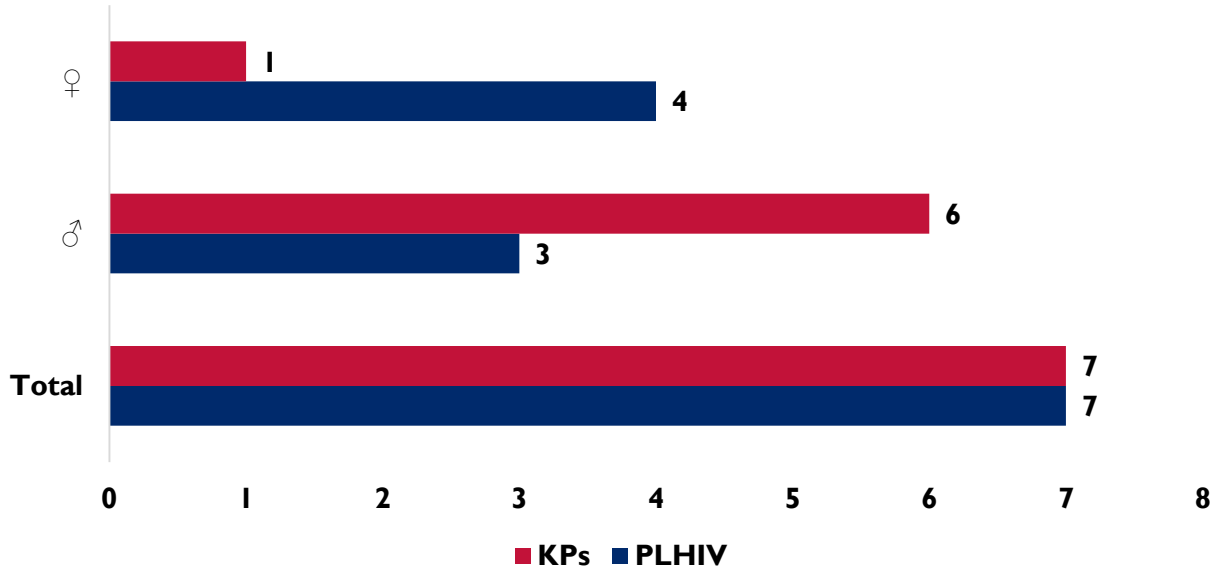
- Establish national alliance for CBOs provide support for PLHIV/KP under one umbrella to unify efforts;
- Establish peers education approach guided by CBOs, NGOs working in districts to build trust and provide initial counseling and refer them to health facilities
- Provide community –based awareness and mobilization through NGOs and SRH providers
- Supply and empower local CBOs to perform the rapid test and refer positive cases to the MOH VCT for confirmation and treatment

II.5.2 Results of Focus Group Discussion Sessions with People Living with HIV and People at most Risk

II.5.2.1 FGDs participants

Two FGDs were conducted during November 2020 with PLHIV and people with high risk behaviors (MSM, WS and PUD). Total number of Participants attended the FGDs was 14 (7 PLHIV and 7 KPs), figure 1.

Figure 1 FGDs participants distributed by gender



II.5.2.2 Health facilities utilized by PLHIV/KPs' to obtain health services in general for any illnesses or health problems

In general both PLHIV and KPs attending the available health facilities (private or public) in their areas when they have general complaints (flu, cold, abdominal pain, and headache). Although, most of them mentioned that they avoid to visit health facilities excluding for emergencies for below reasons:

- Poor quality of public health services (mentioned by the majority of PLHIV and KPs participants);
- Disadvantageous communication of health workers (including physicians) from public sector (mentioned by the majority of PLHIV and KPs participants);
- Crowdedness (overload) of the public health facilities (few participants);

- High cost of health services in the private health sector (most of them mentioned that they can't afford services);
- Cultural barriers; avoid to visit health providers in their neighborhood; not to be known;
- Stigma and discrimination they faced when health providers know about HIV (mentioned by the majority of PLHIV participants);
- Main challenge stated by PLHIV in getting health services was stigma and discrimination.

The majority of physicians insulting PLHIV and communicate improperly with us (female, PLHIV)

Pejorative method health workers communicate with us is the most barriers for seeking services, even from private or public health sector (male, KPs)

I went once to a public hospital with my mother, the center was so crowded and we waited three hours to see the doctor (male, KPs)

II.5.2.3 Health facilities utilized by PLHIV/KPs' to obtain SRH related complaints/ illnesses

PLHIV and KPs prefer to seek SRH services from the private sector, although they can't afford services.
PLHIV pointed to the fact that they hide their HIV status when they visit private health facilities, otherwise, providers will not accept them in their clinic (this is based on their past experience with service providers).
KPs prefer to receive health services from a providers recommended by one of their peers (known by them) in order not to reveal their risk behaviors to new persons.
Most KPs stated that they prefer not to attend health facilities in their resident area afraid to be known. From other perspective, they prefer to solve their health problems related to their risk behavior by asking friend (peer) help or buy medicine without need of physician prescription. Worth mentioning, some participants pointed to the sexual exploitation females faced during seeking SRH services by health provider.

I'll never reported HIV to any health provider (male, PLHIV)

Through my labor five hospitals refused to receive me, after that I hide my case (female, PLHIV)

Physician in public and private health sector appear negative attitudes against PLHIV and us (male, KP)

Health providers abuse unmarried female attending health facility with SRH problems (two participants: male and female, KPs)

II.5.2.4 Challenges PLHIV/KPs facing during obtaining health services (before seeking and during obtaining health services)

PLHIV identified a number of problems and challenges faced them during and before seeking health services in common: patient's fear of stigma; dissatisfaction with some of the services provided by counselling or medical centers; violation of confidentiality by medical staff; difficulties in accessing specialized services; inequity in services provided in centers; financial difficulties of PLHIV and their families; lack of employment for PLHIV (can't afford health services); stigma and discrimination.
KPs participants recorded same challenges as PLHIV, and increased on that, fear of attending health facilities due to the humiliation and mockery of health workers.

> Lack of privacy and confidentiality in public and private health centers preventing us of attending health facilities (female, PLHIV)

> I always hide my disease when going to health facilities, otherwise health workers will scandal be (female, PLHIV)

> I use to trust one physician in Al Basheer hospital, but unfortunately he is retired now (male, PLHIV)

II.5.2.5 PLHIV/KPs perception towards integrating HIV services within the sexual and reproductive

Most of the FGD sessions participants were not aware of the concept and the importance of HIV-SRH service integration. The sessions' moderator explained the concept to participants. PLHIV/KPs reported their needs to receiving quality health services with preserve dignity and respectful regardless integration or not.
From other participants' perspective, integration is being able to timely access comprehensive, quality services as much as possible at the same time and in the same place, assurance of continuity of care, and referral when necessary. They focused to the importance of services can be co-located in the same room with the same provider (e.g., 'one-stop shop').
KPs participants pointed to the importance of service integration if services provided by qualified health providers who capable of properly communicate with customers despite their behaviors and attitudes. They add that, integration usefulness in early diagnosis of STIs related to risk behaviors and prevention of HIV.

> Service integration will success if physicians and other health workers treat us respectfully (male, KPs)

> Of our simple rights is to receive quality services without humiliation (Female, PLHIV)

> Service integration will help in early diagnosis of STIs and HIV (female, PLHIV)

III. Conclusion

To develop an integrated approach to the provision of SRH and HIV services, actions are needed at both policy and service-delivery levels. Review of national policies to deliver HIV care within a primary health care facilities should be the initial step towards service integration advocacy.

Effective integration of HIV and SRH services requires not only behavior change communication interventions for health care providers (Provider Behavioral Change) but also increased understanding of beneficiaries to respond adequately to their needs based on their knowledge, attitude, and risk perception.

Model of integration could be implemented in low-resource, high-burden public healthcare systems such Jordan, if it is done in a phased manner with support of decision makers, community and healthcare providers. The process of design and implementation needs to take local context and facility level into account, and should be flexible to suit the needs of both the health system and the clients in order to have optimum effect. There need to be linkages between multiple health systems functions and components, including policy, financing mechanisms, supply chain management, and healthcare workers training.

IV. Recommendation

- **Policy level**
  - Review and adapt policies, regulations, and strategies to enable integration environment (including MOH health insurance regulations and by-laws);
  - Conduct a multi-dimensional epidemiological assessment to identify target population in Jordan(people living with HIV and key populations);
  - Conduct an assessment of the current organizational structure for health directorates primary health care facilities in districts to define logistics needed;
  - Form a national committee consist of highly level decision and policy makers' to advocate towards services integration;

- **Health System Level**
  - Focus on health system strengthening (regulations, policies, practices, processes and procedures);
  - Standardize health system referral procedures for all health sectors parties.
  - Develop module/guideline to provide standard services;

- Develop a mentorship program to build the capacity of GPs and family medicine practitioners to provide specialized services;
- Developed M&E system to follow up implementation process success, failure and areas of improvements and modifying;
- Develop protocols, standards and mechanisms of accountability to uphold human rights and reduce stigma and discrimination, including stigma associated with being a member of a key population;

➢ **Service Level**

- Build the capacity of health providers to provide quality care and acquire soft skills (proper communication, accept others, reduce stigma and discrimination);
- Develop national campaign to increase people's awareness and information towards human rights, gender and reduce stigma and discrimination;
- Improve PLHIV services provided by the current VCT/MOH through; renovate infrastructure, recruit essential staff, supplies, test in VCT premises, follow up procedures and standardized referral processes.
- Assess the extent to which different models of integrated service provision increase the range, use, and quality of selected SRH and HIV services, and lead to a greater diversity in the profile of clients

➢ **Community Level**

- Strengthening community leaders input and involvement;
- Strengthening partnership with PLHIV to increase their capacity and visibility at national and community levels;
- Strengthening partnership with local CBOs in district to facilitate reaching out and identify targets;
- Empower and build the capacity of local community based organizations for improving community outreach program (vulnerable groups, KPs);

V. Annexes

Annex 1: List of Key Informants Interviewed

#	Organization/Entities/program	Name	Position
1.	Ministry of Health (MOH)	Dr Gazi Sharkas	Primary Health Care directorate
2.	Ministry of Health (MOH)	Dr. Malak El Ori	Mother and Child health Care Directorate
3.	Ministry of Health (MOH)	Dr Abeer Mouswas	Media and Communication Directorate
4.	Ministry of Health (MOH)	Dr Samer Abadi	Sexual Transmitted Diseases Directorate
5.	Ministry of Health (MOH)	Dr Hiam Mqatash	VCT Manager
6.	HIV/AIDs expert (former MOH/NAP employee)	Mr Ahmad Nasrallah	Independent consultant
7.	Higher Population Council	Dr Ali Matleq Ms Rania Abadi	Head of research and planning Secretary General Deputy
8.	The Jordanian Senate	Dr Sawsan Majali	Health system, SRH Expert
9.	Institute for Family Health/ Nour Al Hussein Foundation	Dr Ibrahim Aqel	IFH CEO
10.	Jordan Health AID Society (JHAS)	Mr Waseem Al Deek Doha Al Omari Ghada Al Saed	SRH project Manager Quality assurance manger Al Zaety Camp primary care clinic manger
11.	USAID, population and family health office	Andrea Halverson	Deputy Director
12.	Health System Delivery/USAID funded Project	Dr Sabri Hamzeh	Project COP
13.	Communicable and Infectious Disease Society	Dr Firas Al Bakry	Society manager
14.	The Islamic Charity Center Society	Mamdouh Mhaisen, Mahmoud Ftaihah, Hussam Al Saed,	Deputy of the Society Director Health Directorate manger Medical manager
15.	Jordanian Society for Family Planning and Protection	Mr Bassam Anis Mr Islam Alqam,	CEO Knowledge Management Information manger
16.	International Organization for Migration (IOM)	Ms Hiba Abaza	SRH project Manager
17.	International Rescue Committee IRC	Mo'taz rawashdeh Mohammad Masaedeh Neveen Kholoud qaisi	health manager Mafrq clinic manager Ramtha clinic manager Zaatri camp clinic manager
18.	UNFPA	Jehan Salad Deema Hamasha Ali Gharabli	SRH specialist SRH Program Officer SRH program analyst
19.	Jordanian Nursing Council	Dr Hani Nawafleh Dr Wael Naja	Secretary General Continuous training director
20.	Irbid Family and child community center	Mr Fadi Dawagreh	Social worker
21.	Bushra Society for community development -Zarqa	Ms Jihan Morjan	Founder and CEO
22.	Family affairs Society -Zarqa	Ms Amal Wahdan	CEO

23.	Al Mafraq Society	Ms Rosan Shdefat	Social worker

Annex 2: In-depth Interviews Tool

Integrating the HIV services within sexual and reproductive health services.

Key Stakeholders' Interview Tool

Interview date: Organization/Entity:
Interviewee's position: Interviewee's name
Governorate: Interview method (virtual/physical)

Section one: General Information about the interviewed organization/entity		
Introductory information about this organization/entity		
Question	Responses	Probes/notes
1. What is the role that this organization/entity is playing	• Policy making /advocacy • Service providing • Community mobilization • Awareness/ education • Outreach • Other (mention)	Investigate more: a. Which marginalized populations the organization serves (women/people living with HIV, sex workers (all genders), women and men who use drugs, adolescent girls and young women, PWD, refugees b. How these populations are meaningfully involved c. Are they represented in decision making processes

2. What SRH services this organization/entity is providing (if none please write here_____)

Services	Yes/No	Target group		Geographical distribution (entire Kingdom/specific governorates (mention)	Sustainability This service is part of the entity strategy/periodic response (funded project)
		Gender (F/M)	Age group		
• Safe motherhood /pre and post- natal care					
• Infertility management					
• Family Planning/ Contraception					
• Abortion (including prevention and management of					

complications)					
• Breast and cervical cancer' early detection					
• Menopauses services					
• SRH services for adolescents					
• Management of sexually transmitted infection					
• Male's integration/participation in RH programs and interventions					
• GBV (prevention and care)					

3. Do this organization/entity provide services for PLHIV/KP? Yes No					
4. What services this organization/entity is providing for PLHIV /people with risk factors					
Services	Yes/No	Target group		Geographical distribution (entire Kingdom/specific governorates (mention)	Sustainability This service is part of the entity strategy/periodic response (funded project)
		Gender (F/M)	Age group		
Prevention (awareness and education include pre-post exposure prophylaxis)					
Prevention of vertical transmission					
Treatment (enrolment on ART, retention in care)					
Counseling & VCT					
Care (follow up, viral load testing, medical care for other diseases (TB, Hep C, Cervical Cancer, …)					
Management of NCDs					
Support (social, financial, medical equipment, psychological)					

Section two: stakeholders/policy makers' perception towards integrating the HIV services within sexual and reproductive health services

5. I would like to know your opinion about integrating the HIV services within the sexual and reproductive health services (probe):
    - Why you are in favor of integrating the HIV services within sexual and reproductive health services? What are any advantages?
    - Why you are against integrating the HIV services within sexual and reproductive health services? What are any disadvantages?

6. Based on international experience and WHO recommendations, multi countries already integrated HIV services within sexual and reproductive health services and other countries are planning for that. From your point of view, how this process will affect the following:
    - Services quality provided for PLHIV and KP
    - Equality and better access of PLHIV and KP to services/remove barriers to access services for PLHIV and KP
    - Equity in access of PLHIV and KP to services

7. From your point of view, who are the best player/s that should take the responsibility of the integration process;
    - Policy makers, why?
    - Service providers, why?

    7.1 What should be the role of most affected communities in promoting/contributing to the process of integration

8. What are the main factors that will lead to the success of integrating HIV services within sexual and reproductive health services:
    - Legislation availability
    - Policies/strategies
    - Financial resources
    - Human resources
    - Human resources capacity building programs
    - Local communities participation (involve youth, people living with HIV and other most-affected communities)
    - Awareness campaigns implementation (specific messages for youth, and most affected communities)

9. From your perception, what are the factors that may hinder the integration process? obstacles related to:
    - Policies and legislations
    - Service' providers' knowledge and attitudes
    - Service' beneficiaries' knowledge and preferences
    - Cultural perceptions including gender and social norms
    - Stigma, discrimination and violence including gender based violence
    - Lack of information and awareness on sexual and reproductive health and rights (including comprehensive sexuality education in and out of schools)
    - Financial factors
    - Facilities' infrastructure
    - Equipment and supplies

Section three: the Suggested framework on the integration of the HIV services and the reproductive health services.
10. If you are a member of the national team/ committee that assigned to draw the roadmap of the this program (integration of the HIV services within SRH services), what will be/ what will be needed: • Implementation approach • Services included • Framework content • Advocacy plan (political, social) • Engagement of young people and most affected populations • Awareness raising and demand creation • Health facilities (geographical distribution (governorates/districts) • Health provider should be involved • Target groups access • Resources needed • Sustainability plan • Networking and partnerships (specify)

Annex 3: FGDs protocol/ Guide

FGDs protocol /Guide

1. Usually, where you go to obtain health services (for any illnesses or health problems)
2. If you have a sexual and reproductive health complaint, where do you go to get it?
3. What are the challenges or problems that you face when you need to obtain health services (before seeking and during obtaining health services)

I would like to know your opinion about integrating the HIV services within the sexual and reproductive health services (probe):

- Why you are in favor of integrating the HIV services within sexual and reproductive health services? What are any advantages?
- Why you are against integrating the HIV services within sexual and reproductive health services? What are any disadvantages?

Annex 4: List of International, Regional and National Documents reviewed

#	Title	year	publisher	Comment
1	HIV and Sexual and Reproductive Health Programming: Innovative Approaches to Integrated Service Delivery	2014	WHO,UNFPA ,UNICEF	Case studies from different countries
2	Assessing the Benefits of Integrated HIV and Reproductive Health Services: The Integra Initiative	2013		Kenya
3	Family Planning and HIV Integration: Approaching the Tipping Point*	2010	Fhi360	
4	FAMILY PLANNING AND HIV INTEGRATION IN MALAWI□*	2015	USAID, Health policy project	Key Stakeholder Interviews
5	Integrating HIV Care and HIV Prevention: Legal, Policy, and Programmatic Recommendations			
6	Integration of HIV Care with Primary Health Care Services: Effect on Patient Satisfaction and Stigma in Rural Kenya	2013		Kenya
7	Integrating HIV services with other services to improve care, retention and adherence*	2017	The International Initiative for Impact Evaluation 3ie	
8	Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*	2018	Lancet Commission	Rich text with background information
9	Minimum Package for RH-HIV Integration in Kenya		MOH	
10	Prevention of Mother-To-Child Transmission (PMTCT)	2007	WHO	
11	Monitoring and Evaluation Framework for Sexual and Reproductive Health Integration in Primary Health Care of the Arab States*	2019	UNFPA	M&E integration framework indicators
12	State of Florida Integrated HIV Prevention and Care Plan 2017–2021	2016	Florida Health	
13	UNAIDS 2016–2021 Strategy: targets, goals, vision			Global view, SDGs
14	Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services	2010	UNFPA, Population Counsel	
15	Integration of HIV and Family Planning Health Services in Sub-Saharan Africa	2012	USAID	
16	Towards universal access by 2010 How WHO is working with countries to scale-up HIV prevention, treatment, care and support	2006	WHO	
17	GLOBAL HEALTH SECTOR STRATEGY ON HIV 2016–2021	2016	WHO	

18	THE GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH (2016-2030)		WHO	
19	REGIONAL INTERVENTIONS ACTION PLAN FOR ARAB STATES 2018-2021		UNFPA	
20	Integrating sexual and reproductive health and rights package in national health policies, programmes and practices in the Eastern Mediterranean Region	2019	WHO	
21	Integration of sexual and reproductive health services in the provision of primary health care in the Arab States: status and a way forward	2020	SRHM	
22	Reproductive Health in Arab Countries	2019		
23	United Nations Population Fund UNFPA strategic plan, 2018-2021	2017	UNFPA	
24	Demographic and Health Survey DHS 2018	2018	DOS	
25	الخطة الاستراتيجية العربية متعددة القطاعات لصحة الأمهات والأطفال والمراهقات 2030 - 2019	2019	UNFPA, مجلس وزراء الصحة العرب	
26	مسودة الاستراتيجية الوطنية للصحة الجنسية والانجابية ٢٠٢٠-٢٠٣٠+ annexes	٢٠٢٠	HPC	
27	تقرير مؤشر ولوحات متابعة تحقيق اهداف التمية المستدامة في المنطقة العربية	٢٠١٩		
28	استراتيجية وزارة الصحة ٢٠١٨-٢٠٢٢			
29	استراتيجية قطاع الصحة ٢٠١٦-٢٠٢٠		Higher Health Counsel	
30	Jordan Response Plan 2018-2020		MoPIC	
31	التقرير الاحصائي السنوي	٢٠١٨	MOH	
32	HEALTH STATISTIC REPORT 2019- Jordan in Figuers	2019	DOS	
33	POPULATION STATISTICS	2019	DOS	
34	الالتزامات الوطنية بقمة نيروبي	٢٠١٩	HPC	
35	FOCEC studies سواعد			
36	Social Barriers Preventing Access of People Living with HIV		FOCCES	
37	Linkages between HIV and GBV in the MENA Region, LEARN MENA Project			

Annex 5: Qualitative Data Analysis Approach

Qualitative Data analysis[33]

Qualitative data analysis start upon developing the data collection tool/s. the tool should answer the research question/s and provide deep look into intended results. In qualitative data we are looking on the depth of the data not volume. We have to look into what the participants say about the research question/s. The approach used to analyze these data is depend on the content (breaking data into meaningful parts (Saven-Baden & Major, 2013). The major steps followed are:

Reading, comparing and interpretation (main phases):

1. Reading data many times, in different lines and different focus
2. Reading data for very close details
3. Familiarize analyst with every detail of the data
4. Breaking data into meaningful part
5. Make sense of the data
6. Systematic search for meaning
7. Integration data, summarize it and putting connection across it
8. Summarize the clots
9. Categorize differences
10. Categorize themes
11. Describe and explain
12. Integrating data, summarize and but connections in cross it

1) Reading and familiarization:

- Reading-read again-understand data –write the findings
- Content analysis (literary what people say)
- Thematic analysis
- Discourse analysis (how people say things what kind of word they use)
- What people don't said
- Steps to easiest reading data
- Start to structure it using quotes (this is called sometimes coding)
- Coding data= labeling, categorizing data

2) Comparing:

- Looking to see what different about the data –what different across people, specific ideas, categories, what thing is the same and what is different and why, and try to understand that

[33] https://www.youtube.com/watch?v=KRHvxY3N708, https://www.youtube.com/watch?v=peQBZNWM6w8

3) Interpretations:

- Analysis involve uncovering pattern in data and interpretation means uncovering meaning, messy, multiple meaning, very different stage, different part of analysis. Interpretation is about what the data means- analyzing the analysis, looking at summaries, notes in order to explain the story behind the data.
- Try to test hypothesis (what's going on), look for new hypothesis = does this data match what we think
- Support the way we interpreting the data, looking for codes – which ones have meaning
- Sub codes or themes
- Write narratives describe and connect themes