RAPID ASSESSMENT
OF SEXUAL AND
REPRODUCTIVE HEALTH
AND HIV LINKAGES
This summary highlights the experiences, results and actions from the implementation of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages in Zimbabwe\(^1\). The tool – developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives in 2009 – supports national assessments of the bi-directional linkages between sexual and reproductive health (SRH) and HIV at the policy, systems and services levels. Each country that has rolled out the tool has gathered and generated information that will help to determine priorities and shape national plans and frameworks for scaling up and intensifying linkages. Country experiences and best practices will also inform regional and global agendas.

**RECOMMENDATIONS**

**What recommendations did the assessment produce?**

- Sensitizing policy-makers and planners on the bi-directional SRH and HIV integration and building national consensus on its operational definition.

- Establishing a broad-based national taskforce on SRH and HIV integration. It is recommended that this should be a high-level committee headed by the Principal Director Preventive Services, Ministry of Health and Child Welfare (MoHCW), who reports to the Permanent Secretary.

- Developing a national policy and operational plan for SRH and HIV integration, including the roles and responsibilities of both SRH and HIV stakeholders in promoting integration. The operational plan for rolling out SRH and HIV integration should include clear milestones.

- Recruiting a technical officer, placed within the office of the Principal Director Preventive Services, to support coordination of SRH and HIV integration and to ensure the development and implementation of the national SRH and HIV integration service guidelines.

- Strengthening national dialogue between SRH and HIV stakeholders.

- Engaging and advocating with donors on the need to support SRH and HIV integration through the existing donor coordination fora.

- Developing a community strategy for SRH and HIV integration.

- Redesigning monitoring and evaluation (M&E) tools to ensure collection of data on integrated services such as family planning (FP) in antiretroviral therapy (ART) clinics etc.

- Targeting provincial hospitals, urban council clinics and private health facilities for training.

- Involving personnel in training institutions in SRH and HIV integration policy development and trainings.

- Reviewing health care workers’ (HCWs’) training curricula to incorporate SRH and HIV integration.

- Strengthening referral systems to ensure effective SRH and HIV integration.

- Addressing infrastructure needs within health facilities to ensure the effective provision of integrated services.

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1. Who managed and coordinated the assessment?
The assessment was carried out by the MoHCW with technical and financial support from UNFPA. Other technical support partners included WHO, UNAIDS, UNICEF and the UK Department For International Development (DFID).

2. Who was in the team that implemented the assessment?
The assessment was implemented by one international and one national consultant, under the leadership and technical guidance of the MoHCW and UNFPA. Field assessments were undertaken by a team of five people comprising two consultants and UNFPA and MoHCW staff.

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

4. Was the assessment process gender-balanced?
• It is impossible to provide a definitive answer.
• The assessment involved both men and women, and addressed issues relating to both women/girls and men/boys, although there is no data on the sex of interviewees.
• The assessment data collection team comprised 4 males and 1 female.

5. What parts of the Rapid Assessment Tool did the assessment use?
The generic Rapid Assessment Tool was reviewed and adapted to the national context, mainly by the inclusion of a community component, so that it could capture the status of integration at this level.

6. What was the scope of the assessment?
The rapid assessment targeted the four levels of policy, systems, service delivery and community addressing, specifically:
• At the policy level, the existence of SRH and HIV policies and the extent to which these are in support of SRH and HIV integration.
• At the systems level, exploration of how funding, partnerships, planning, human resources and logistics support or hinder integration.
• At the service delivery level, ‘from policy to practice’ – the extent to which SRH and HIV services are integrated at the service delivery point, and the gaps and operational challenges.
• At the community level, the extent of integration and opportunities that exist.

Assessment methods included:
• Literature review.
• In-depth interviews with 143 SRH and HIV stakeholders at the four levels.
• Exit interviews with clients at service delivery points, and observations at the visited facilities.

Visits were made to a total of 12 health facilities from four provinces: Manicaland, Masvingo, Matebeleland North and Midlands.

Data collection and report writing was conducted between October and November 2010. A national stakeholders’ dissemination and validation meeting was held with SRH and HIV stakeholders from the MoHCW, UN agencies and civil society organizations (CSOs). The assessment report was finalized after the national stakeholders’ dissemination meeting in March 2011.
7. Did the assessment involve interviews with policy-makers from both SRH and HIV sectors?

Interviews were conducted with a total of 40 policy-makers: 31 at national level and 9 at provincial level. Key informant interviews were held with both SRH and HIV policy-makers and planners, mainly from the MoHCW, National AIDS Council (NAC), Zimbabwe National Family Planning Council (ZNFPC), UN agencies, CSOs and other development partners.

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

Interviews were conducted with 64 service providers and 11 community-based agents.

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

Exit interviews were conducted with 28 clients in services from 12 facilities in 4 provinces.

10. Did the assessment involve people living with HIV and key populations?

Members from key population groups were not involved in the assessment.

FINDINGS

1. Policy level

There is a weak policy environment for integration at the national level. The National AIDS Council’s mandate is to coordinate the HIV response. Although a parastatal, the NAC is a constituent of the MoHCW. The HIV and Tuberculosis (TB) Unit sits within the MoHCW, and is responsible for providing policy direction for the health sector HIV response. The Reproductive Health (RH) Unit is also within the MoHCW and is responsible for providing national leadership on RH programming. Both the HIV and TB Unit and the RH Unit report to the Principal Director Preventive Services. The ZNFPC is responsible for the coordination and implementation of FP interventions.

There is no specific policy or standard operating procedures to guide national SRH and HIV integration. While some policies call for SRH and HIV integration (such as the MNH Roadmap, RH Guidelines, Adolescent Sexual Reproductive Health/ASRH Strategy 2010–2015, ZNFPC Strategy, the Behaviour Change Strategy and the ART Guidelines), major policy documents guiding implementation of SRH and HIV interventions are weak on promoting integration, for example, the National Reproductive Health Policy 2003 and the National HIV/AIDS Strategic Plan 2006–2010.

Other challenges:
- Funding inadequate and inequitable; HIV was reported to continue to receive more funding over time than SRH.
- Donor-specific interests in HIV or SRH, and conditionalities on use of funds for specific HIV or SRH interventions.
- With most donors channelling their funding through CSOs, the MoHCW was finding it increasingly difficult to coordinate SRH and HIV integration among development partners.

2. Systems level

In practice, SRH and HIV stakeholders operate vertically and in most cases do not participate in joint planning, and SRH and HIV integration are weak, uncoordinated and ad hoc. Despite the existence of ASRH, PMTCT and RH joint planning committees, there are no formalized mechanisms to ensure that the SRH and HIV units participate. SRH and HIV policy-makers and planners interviewed demonstrated inadequate knowledge of the contents of...
the other’s policies and strategy documents, and of bi-directional linkages.

Fora such as the PMTCT Partnership Forum, RH Steering Committee, National ASRH Coordination Forum, National Behaviour Change Technical Working Group, Condom Programming Technical Working Group, National RH Commodity Security Committee and the MNH Forum have been established; however, in practice, participation by both SRH and HIV stakeholders was rare, making these fora not very effective in promoting integration.

**Systems-related challenges**

- Lack of joint planning between RH and HIV and TB Units and poor coordination.
- Inadequate coordination within RH and HIV Units at the national level.
- RH Unit had been reported to have had inadequate capacity until recently, when UNICEF supported recruitment of some technical officers. This was reported to have hindered effective SRH and HIV integration over time.
- Development partners were reported not to be promoting SRH and HIV integration, as they had different technical people in both SRH and HIV focus areas and these provided vertical technical and uncoordinated support to the MoHCW.
- The nursing department and health training institutions are not often targeted for integration trainings and policy development, which has led to gaps in nurses’ training curricula.
- Human resource challenges included inadequate capacity among HCWs to offer integrated services, increased staff workload, low staff motivation and lack of supportive supervision. HCWs noted that integrated services required more time spent with each client, which is a challenge where there are few HCWs.
- Acute staff shortages meant that only one or two HCWs were available to offer services in some facilities. Combined with poor staff motivation and increased workload, this hindered access to integrated services.
- At the provincial level, providing supportive supervision to district and rural health facilities was a challenge, due to transport and communication challenges.

- HCWs reported that there were inadequate rooms and space to provide services, and that the way service points are arranged does not favour integration. For example, some clients had to walk long distances to access inter-facility services.
- Reporting was found to be poor and uncoordinated, with most monitoring tools not integrated. For example, ART registers cannot be used to identify the uptake of FP methods by clients, and FP registers do not indicate the HIV status of clients, or whether HIV counselling occurred as part of HIV counselling and testing (HCT).
- Poor national coordination has resulted in confusion at the service delivery level. There is a lack of clarity among different government ministries and parastals as to their areas of responsibility. For example, what are the specific roles of ZNFPC, RH Unit, NAC and the MoHCW with regard to addressing the SRH and HIV needs of young people.
- Poor targeting of provincial hospitals and urban council clinics on SRH and HIV integration was a barrier to effective integration at those levels.

**Capacity building**

HCW training on provision of integrated services has been mainly for rural and district health centre facilities, and not provincial and urban council health facilities. There has been some training of over 500 HCWs on RH and PMTCT integration conducted through a partnership of the AIDS and TB Unit, Family Health International (FHI) and ZNFPC. As part of integrating PMTCT into broader MNCH activities, the MoHCW – with support from UNFPA and Elizabeth Glaser Pediatric AIDS Foundation – conducted trainings in integrated Emergency Obstetric and Neonatal Care, and More Efficacious PMTCT Regimen (MER). Efforts to promote integration in training curricula include the National Behaviour Change Training Manual, which integrates PMTCT, condom programming and male circumcision (MC).
3. Services level

Types of integration identified:

1. Both SRH and HIV services were offered by the same provider at the same service point, for example, in family and child health (FCH) clinics, pregnant women received antenatal care and HCT services from the same provider.

2. Clients were referred within the same facility, for example, from opportunistic infection (OI)/ART clinics, HIV-positive women were offered FP information, and those interested were referred to the FCH clinics for services.

3. Clients were actively referred to another facility, for example, in one Catholic Mission Hospital health care workers in the OI/ART clinic identified that as it was a Catholic institution, HIV-positive women requiring FP services for Prong 2 were referred to government health facilities.

While there is some degree of integration at the service delivery level, this, however, is uncoordinated, uninformed by policies, and HCWs were found to be inadequately trained. Respondents described “integration by default”, “just because there is only one service provider providing all the services”. Furthermore, SRH HIV integration was not routine in some facilities. Sometimes HCWs would forget to provide integrated services to clients: for example, this was observed at one hospital family support centre, where a sexually abused child had not been offered HIV information, counselling and testing services.

Integration was stronger in rural health facilities and district hospitals than in provincial hospitals, as in the former it is possible for clients to see one service provider. Some clients felt that integrated services, especially when one is used as an entry point to promote other services, caused unnecessary delays. For example, in MC clinics, male clients would not accept referrals to FP clinics as they felt that was unnecessary and a waste of time.

Service delivery-related challenges

- Stigma and discrimination, especially among people living with HIV referred to SRH service points within the same facility.
- Services for sexual gender-based violence and cervical cancer screening are virtually non-existent in most facilities.
- In some cases, especially in Mission Hospitals, there were no RH supplies such as modern contraceptives.

Referrals:

- Even when clients were referred for services within the same facility, some did not reach the service they were referred to and were not followed up.
- Many clients would not go for the services mainly due to lack of time, money for transport, and also fear of stigma and discrimination.
- Some clients referred from lower-level health facilities were not offered integrated services at the higher levels, as it was assumed that they had already received the services.
- There is no clear follow-up mechanism to ensure that referred clients receive the services for which they were referred.
- Most HIV services are provided free, while some SRH services were available on a user-pays basis, which discourages the uptake of SRH referrals.

Community-based cadres

The MoHCW, NAC and ZNFPC, with support from development partners, have established community-based cadres, including Village Health Workers, Community-Based Distributors of Contraceptives, Home-Based Care Givers, Behaviour Change Facilitators, and Health Promoters [urban areas]. All community-based organizations and cadres interviewed stated that there is weak SRH and HIV integration within programmes, mainly due to limited capacity and poor SRH and HIV coordination at community level. Other barriers included:

- a lack of basic resources for community-based agents to work, such as bicycles;
- the lack of an integrated community-based strategy to guide SRH and HIV integration; and
- in most areas there are no Community-Based Distributors of Contraceptives.

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ZIMBABWE
LESSONS LEARNED & NEXT STEPS

1. What lessons were learned about how the assessment could have been done differently or better?
Non-inclusion of people at higher risk: these could have been involved in the assessment from the beginning.

2. What ‘next steps’ have been taken (or are planned) to follow up the assessment?
The results of this assessment are expected to guide programme development. A programme on SRH and HIV linkages has been developed and funding secured from the European Union.

3. What are the priority actions that are being taken forward as a result of the assessment, at the:

- **policy level?**
  - Advocacy with policy-makers for strengthening SRH and HIV programme linkages.
  - Coordination capacity strengthening.
  - Development of SRH and HIV service provision guidelines.
  - Revision of M&E tools to enable collection of indicators on SRH and HIV integration.
  - Capacity building for management and service providers on SRH and HIV linkages.

- **systems level?**

- **services level?**

4. What are the funding opportunities for the follow-up and further linkages work?
The National AIDS Trust Fund had been used to fund SRH- and HIV-related activities, including procurement of HIV and syphilis test kits. Some Youth Friendly Centres (normally established to provide ASRH services) have been constructed through support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). GFATM Round 8 provided funding for integrating PMTCT into the National Behaviour Change Programme and FP/HIV integration through ZNFPC.

Due to the approach taken by some donors to fund programmes through CSOs and not the government, it was difficult to ensure that funds were used to provide integrated SRH and HIV services. Donors also hindered integration through conditionalities and a narrow focus on either SRH or HIV.

With the renewed global focus on maternal, new-born and child health (MNCH) towards the attainment of UN Millennium Development Goals nos. 4, 5 and 6, some donors have expressed interest in funding MNCH interventions. This is expected to present an opportunity for integrating HIV-relevant interventions into MNCH services.

Furthermore, donors have been promoting the inclusion of SRH-related issues in national GFATM proposals, for example, Round 10, which addressed strengthening aspects of SRH and HIV integration. SRH interventions included Provider-Initiated Testing and Counselling training for FP and MNCH service providers, integrated PMTCT and MNCH training, training of nurses and midwives in long-term FP methods, procurement of delivery kits, transport for integrated supportive supervision, integrated PMTCT and MNCH job aids, information, education and communication/behaviour change communication for PMTCT and MNCH, community capacity building on PMTCT and MNCH integration, and some M&E tools such as ANC registers were integrated to capture PMTCT data.

Interviews with both HIV and SRH stakeholders identified the GFATM as being more active in promoting integration of SRH into Rounds 8 and 10 applications. It was reported that GFATM funds can be used to procure RH commodities.