Report
On

Mapping and Reviewing of National Health Policies and Other Related Tools to Ascertain Bidirectional SRH and HIV Linkages Status

By

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1. Acknowledgements
2. List of Acronyms

AIDS  Acquired Immune Deficiency Syndrome
AFIDEP  African Institute for Development Policy
ARV  Anti-Retroviral
BCC  Behaviour Change Communication
CARMMA  AU Campaign on Accelerated Reduction of Maternal Mortality
CBD  Community Based Distributor
CBHC  Community Based Home Care
CHAL  Christian Health Association of Lesotho
CHW  Community Health Worker
CMR  Child Mortality Rate
DHP  District Health Package
DHS  Demographic Health Survey
DHT  District Health Team
DHMT  District Health Management Team
DHS  Demographic Health Survey
DMO  District Medical Officer
DS  District Secretary
FP  Family Planning
GBV  Gender Based Violence
GNP  Gross National Product
GNP+  Global Network of People Living with HIV/AIDS
GOL  Government of Lesotho
HC  Health Center
HIV  Human Immune Defficiency Virus
HTC  HIV Testing and Counselling
ICW  International Community of Women with HIV/AIDS
IEC  Information Education and Communication
IMR  Infant Mortality Rate
IPPF  International Planned Parenthood Federation
KAP  Knowledge Attitude and Practice
LB  Live Births
MDR-XDR TB  Multiple Drug Resistant/Extremely Drug Resistant Tuberculosis
MMR  Maternal Mortality Ratio
MNH  Maternal Newborn Health
MOH  Ministry of Health
PHC  Primary Health Care
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<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PPP</td>
<td>Private Public Partnership</td>
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<td>QMMH</td>
<td>Queen ‘Mamohato Memorial Hospital</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RTI</td>
<td>Reproductive Tract Infections</td>
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<td>SRH</td>
<td>Sexual reproductive Health</td>
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<td>SSS</td>
<td>Sentinel Surveillance Survey</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TFR</td>
<td>Total fertility Rate</td>
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<tr>
<td>TOR</td>
<td>Terms of Reference</td>
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<tr>
<td>UCSF</td>
<td>University of California, San Francisco</td>
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<td>UNAIDS</td>
<td>United Nations AIDS Programme</td>
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<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<td>UNICEF</td>
<td>United Nations Children’s’ Fund</td>
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<td>VHW</td>
<td>Village Health Worker</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WHO - AFRO</td>
<td>World Health Organization African Region</td>
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1.0 Introduction

Historically SRH and HIV have been approached separately and their programming has not recognized the close linkages between the two. Universally over the last decade there is agreement and recognition that universal access to SRH and HIV services may only be attained through linking and integrating HIV and AIDS and Sexual and Reproductive Health services/responses.

In Lesotho, like many other countries, the programming for HIV and AIDS and SRH is separate although there is consultation through specific committees and Technical groups. The European Union has provided funding through UNFPA for ensuring the linkages between the SRH and HIV/AIDS. The expected outcome of this support/project will be an improved and conducive environment for the national institutions to deliver an integrated package of sexual and reproductive health and HIV prevention, treatment, care and support services.

One of the project outputs that is critical for success of the project is to map and review on-going and upcoming national health and development policies and review development processes to identify the opportunities and define priorities for SRH-HIV linkages.

2.0 Background

The Population and Housing census of 2006 estimated the population of the Kingdom of Lesotho at 1.8 Million (1,876,633) with an estimated annual growth rate of 1.9%. According to the 2001 Demographic Survey (DS) the urban population is 17% of the total; children below 15 years comprise 36% of the total population, 58% are 15 to 64 years, and 6% 65 years and above. The age dependent ratio is estimated at 0.72, with 4 out of 10 members of household children of the head of the household. The orphan population (0-17 years) is estimated at 130,245. The life expectancy at birth is 41.2 years (42.9 women and 39.7 men). The crude economic activity rate is 29.6% and the Gross National Product (GNP) per capita is estimated at US $ 5414. The adult literacy is estimated at 87% (79.7 male and 93.6 females). The Infant Mortality Rate (IMR) is estimated at 94/1000 Live births, Child Mortality Rate (CMR) 23.7/10000 Live births, and Maternal Mortality Ratio 1152/100,000 Live births.

Lesotho adopted the Primary Health Care (PHC) strategy in 1979. With the decentralization of Government the services are now delivered through 10 districts, 18 general and 2 referral Hospitals and about 158 Health centers. The public health facilities are almost equally divided in ownership between the Government (9 hospitals and about 50% of the health centers) serving 52% of the population, and the Christian Health Association of Lesotho (CHAL), a conglomerate of facilities owned by 6 churches, serving 48% of the mainly rural population. The 3 referral hospitals are all in the capital Maseru: Queen 'Mamohato Memorial Hospital (QMMH), a Public Private Partnership (PPP) central referral Hospital; Mohlomi Mental Hospital; and Botšabelo
Leprosy as well as Multi Drug Resistant/Extremely Drug Resistant Tuberculosis (MDR/XDR-TB) Hospital. A military and two (2) private hospitals are also located in Maseru. Two other privately owned primary/mini hospitals are located in the two urban areas of Leribe District. A myriad of privately owned facilities providing outpatient and other services, owned by Medical Doctors of different cadres but primarily General Practitioners, as well as nurses are spread across all the 10 districts with the highest density in the capital Maseru.

The community level services are delivered through community owned Village Health posts where they exist. Lesotho has around 5639 Village Health Workers (VHWs)** (Community Health Worker [CHW] Inventory 2004). While VHWs had been interchangeably also referred to as CHWs, HIV initiatives introduced a new cadre of community based workers and also referred to them as CHWs; these has remained a cause of confusion to the sector. While Traditional Healers are not formally included in the health service structure they are integral to the health system.

Studies undertaken (e.g. Motlomelo et al) indicate that sexual debut is as early as 12 years. Early marriage and early pregnancy are common. The 2009 DHS estimates the Contraceptive Prevalence Rate (CPR) at 57% while the Total Fertility Rate (TFR) is 3.2 per woman.

According to the 2006 census young people (15-24) comprised 23.5%, and Women of Child-Bearing Age (WCBA) 24%, of the total population. The Maternal Mortality Ratio (MMR) has increased from 282 in the 1990s to 939 -1152 per 100,000 LB in 2009 (UN and DHS 2009). A number of risk factors have been identified, key among which HIV/AIDS and unsupervised deliveries. With the estimated 46% of women delivering at home while only 34% attend post-natal care, the result is more increased maternal and child mortality. Out of the total 23,016 deliveries conducted in health facilities there were 49 maternal deaths and 40% of those born were fresh Stillbirths (AJR 2012); the underlying causes were all preventable.

The adult Human Immunodeficiency Virus (HIV) prevalence rate is estimated at 23% (DHS adjusted with SSS 2009); the third highest prevalence in the world. The HIV prevalence is higher in urban (31%) than rural (27.6%) sites but the rate of increase is higher in the rural areas. Young people are worst off with the highest prevalence among 25 to 29 year olds at 39.1%; 30.1% among 20 to 24 year olds; and 14.1 % among the 15 to 19 year olds. The 15 to 29 year old age group represents 25% of the HIV positive population and 10% of new infections. Women are particularly vulnerable representing 57% of all adult infections. The rate among women attending antenatal care was 30% in 2011. The PMTCT and exclusive breastfeeding are each estimated at 68% and 71% respectively (AJR 2012). The facility reports indicate an HIV rate as high as 64% among the women that received HIV testing and Counselling (HTC) and women accounted for 55% of all AIDS admissions. UNAIDS estimates that there are 300,000 adults and 22,000 children living with HIV/AIDS. HIV and AIDS accounted for up to 20-22% of inpatient deaths in 2011 (AJR 2012).
Internationally and regionally Lesotho through the MOH is party to several Declarations and commitments inclusive of the 1994 ICPD Programme of Action, the MDGs, the Maputo Programme of Action (2008) Declaration, the 2009 AU Campaign on Accelerated Reduction of Maternal Mortality (CAMMA), and the Ouagadougou Declaration of 2008. All underline the importance of community participation and linkages of SRH and HIV.

3.0 Specific Objectives

The specific objectives for the Consultancy are as follows:

(a) Map and review all Ministry of health (MOH) SRH and HIV tools and instruments (policies, manuals, registers, IEC materials etc.) to assess the level of integration and bi-directional linkages of SRH and HIV

(b) Identify linkage gaps in all SRH and HIV tools and define specific approaches to address them

(c) Identify tools and instruments that have bi-directional linkages strengths and assess how their development was approached

(d) Establish a list of all policies' timeframes and review dates in order to strategically target the incorporation of bi-directional linkages during the review phase

4.0 Deliverables

(a) An Inception Report
(b) Synthesis Paper (report) on the bi-directional linkages between SRH and HIV as captured in different tools and instruments
(c) An outline and description of key linkages gaps as assessed in all tools and instruments
(d) The SRH and HIV bidirectional linkages strengthening approach and recommendations to upgrade existing and new tools and instruments
(e) A list of all tools and instruments detailing their development and review dates

5.0 Conceptual Framework

The MOH along with the Christian Health Association of Lesotho (CHAL) are the key providers of public health services; the Lesotho Red Cross also contributes. Within the MOH and CHAL there are several documents that are intended for the use of central and district level staff in management as well as in service delivery. Some of these date back to the 1980’s.
With the support of partners (UN, bi-laterals and multilaterals, and international NGOs) several tools (policies, manuals, guidelines, register) have been developed and adopted to facilitate SRH and HIV service delivery. The majority of these were developed through each of the programmes and mainly focused on either of the SRH or HIV; the process did not necessarily consider the need for ensuring linkages and integration. A review will allow for identification of gaps and provide insight into how they may be strengthened, eventually culminating in their update and/or development as well as improved linkages and integration of these programmes.

The African Institute for Development Policy (AFIDEP) conducted a rapid assessment of the status of HIV and SRH linkages and integration, for UNFPA, in May 2011. The purpose of the study was to help the Government of Lesotho (GOL) and key stakeholders in SRH and HIV to identify policy, system, and service delivery gaps in SRH and HIV linkages and integration and recommend ways of effectively addressing the gaps to strengthen the linkages. The methodology followed the tool developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, and Young Positives. The study followed the recommended methodology that includes literature review, and consultation of key stakeholders at all levels. The study found strong support for strengthening the linkages but a strong need to streamline policy and strategic direction as well as strengthen leadership on integration.

Among several efforts, the UNFPA then provided Technical Assistance to the MOH to facilitate implementation of the recommendations. Several challenges were met, among the key of which was the inadequate recognition by the MOH programme leadership to fully appreciate the strategic approaches to linkages and integration. An updated and further review of the tools, emphasizing on gap analysis, will hopefully garner the MOH and its implementing partners to align themselves and endeavor to establish definitive linkages as well integrate SRH and HIV and AIDS activities.

6.0 Methodology

The consultancy was based on desk and literature review on the most relevant data and information on the bi-directional linkages between SRH and HIV. The information on the bi-directional linkages was accessed through an internet search while relevant tools and instruments were provided by the SRH and HIV Programmes.

The analysis was aligned to the levels of service delineating roles of the different levels and assessing whether the tools fulfilled the linkages and integration. The main references for the work were the WHO joint publications with other agencies and Organizations such as IPPF, UNFPA, UNAIDS, UCSF, GNP+, ICW and Young Positives.
7.0 Findings

7.1 Literature Reviews most relevant data and information

7.1.3 Definitions

(a) Linkages: Bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV; integration a subset. The perspective that linkages need to be broad-based addressing not only the health sector and direct impact on health but also structural and social determinants affecting SRH and HIV.

(b) Integration: SRH and HIV services or programmes that can be joined together to ensure and maximize collective outcomes

(c) SRH: includes FP, MNH, STIs, RTIs, promotion of sexual health, prevention and management of GBV, prevention of unsafe abortion, management of post-abortion care

7.1.2 Methodologies

The WHO et al guidelines have outlined a comprehensive methodology for the assessment of the linkages and integration that include desk review, individual and group interviews, key informant interviews, observation of services, focus group discussions, review of clinic records and collection of data, and mystery client surveys. This report is based only on desk review.

7.1.3 Desk Review Documents

The guidelines include a wide spectrum of documents to be reviewed. These include policies, plans, strategic Frameworks, UNAIDS Country reviews, MOH statistics, situation analysis studies, Behaviour Surveillance Surveys, RH and related surveys, HIV and SRH training materials, guidelines service delivery, protocols service delivery, legal tools, and others.

7.1.4 Categorization of approaches/responses

The approaches to linkages and integration include the following:

- Inclusion of HIV/STI prevention in FP/MNCH
- Inclusion of SRH services in HIV related programmes
- SRH and HIV in programmes targeting young people and men
- SRH and HIV services for key vulnerable groups

7.1.5 Approaches to integration
- Integration of HIV/AIDS into FP/SRH settings
  - STI/HIV education, counseling and management
  - VCT/PMTCT
  - ART
- Integrating FP/SRH into HIV/AIDS care, support and treatment programmes
  - FP/SRH
  - HIV/STI prevention in VCT and treatment settings
  - HIV/AIDS and youth SRH services
  - Other key groups (MSM, IDU, CSW)

### 7.2 Gap Analysis Linkages and Integration Lesotho Tools and Instruments

<table>
<thead>
<tr>
<th>Tool</th>
<th>Gaps by Level</th>
<th>District Team</th>
<th>Hospital and Health Center</th>
<th>Community Health Workers</th>
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</thead>
<tbody>
<tr>
<td>Health Sector Policy 2011 (follows that)</td>
<td>Failure to recognize the HIV impact on the broader SRH and not just as an STI; and vice versa. Social determinants and governance not addressed</td>
<td>No measures for the intermediate level to facilitate and ensure integration at service delivery point</td>
<td>The policy measures on management and treatment are vertical and there is no measure for integration or linkages</td>
<td>Tracking and follow up programmatically used differently and separately</td>
</tr>
<tr>
<td>National Reproductive Health Policy 2009</td>
<td>Not address linkages directly but unidirectional approach HIV as part of SRH. Social determinants not addressed</td>
<td>Not addressed</td>
<td>No policy measure for integration; integration more for improving access to communities and interrelationships at an individual level not mentioned</td>
<td>Community Health Worker training and activity emphasis on safe motherhood and referrals as well as PMTCT (unidirectional)</td>
</tr>
<tr>
<td>SRH policy and Implementation strategic framework 2010</td>
<td>Integration recognized but no specific measures to ensure integration</td>
<td>Framework not include active efforts at integration</td>
<td>Integration not mentioned for routine SRH services but for service improvement through integrating SRH to HIV and AIDS</td>
<td>No mention</td>
</tr>
<tr>
<td>Tool</td>
<td>Gaps by Level</td>
<td>District Team</td>
<td>Hospital and Health Center</td>
<td>Community Health Workers</td>
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<tr>
<td>HQ Admin</td>
<td>Outreach activities; ART integration mentioned in relation to FP not in continuum of care starting at PMTCT</td>
<td></td>
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<tr>
<td>HQ PGs</td>
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<tr>
<td>District Team</td>
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<td></td>
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<tr>
<td>Hospital and Health Center</td>
<td>Responsible behavior in relation to all but approach more STI and less SRH except in relation to GBV</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Community Health Workers</td>
<td>Adolescent rights and behavior integrated with emphasis on illnesses and less on SRH</td>
<td></td>
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<tr>
<td>National ADH Policy 2006</td>
<td>Timeframe within the SRH policy of 2006 but not updated concurrently with that in 2010</td>
<td></td>
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<tr>
<td>Roadmap 2007-2015</td>
<td>Linkages delineated in problem and in implementation and integration emphasized Therefore no gaps</td>
<td>Objectives emphasize more on PMTCT and not much on other SRH although indicators include % facilities with comprehensive SRH and HIV</td>
<td>As in DHT; strong emphasis integration of services for youth/adolescents</td>
<td>CHW training on safe delivery and PMTCT therefore emphasis on pregnancy not all facets/services for SRH</td>
</tr>
<tr>
<td>National FP Guidelines July 2010</td>
<td>Comprehensive guiding principles, rights methods, those with special needs, and methods include linking and integrating SRH, STI. HIV and AIDS. Therefore no gap</td>
<td>Clear guidelines linkage and integration; no gaps</td>
<td></td>
<td>Roles CBDs specified in method, service (method provision and information on correct and consistent use) and provider= no gap</td>
</tr>
<tr>
<td>Guidelines Cancer of the Cervix 2009-2012</td>
<td>Association between HIV and Cancer noted and addressed as part of HIV But not distinctly relate to SRH</td>
<td></td>
<td>Screening for all women of child bearing age but linkages SRH and HIV outside cancer not clear</td>
<td>Not addressed</td>
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<tr>
<td>Tool</td>
<td>Gaps by Level</td>
<td>District Team</td>
<td>Hospital and Health Center</td>
<td>Community Health Workers</td>
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<tr>
<td>National HIV and AIDS Policy 2006</td>
<td><strong>HQ Admin HQ PGs</strong> Recognize vulnerability women Linkage HIV prevention and PMTCT and STI= HIV treated more as STI; intention to develop guidelines for special groups/MARPs but no policy measures to that effect except for youth</td>
<td>Life skills in SRH and youth friendly services emphasis on STI and HIV and no clear linkages with SRH</td>
<td>Add GBV, OVCs, migrants, MSM, CSW, prisoners to services delivered</td>
<td>Not clear</td>
</tr>
<tr>
<td>National HIV and AIDS Strategic PLAN 2011/12-2015/16</td>
<td><strong>Inadequate SRH in the context of HIV and emphasis on young people and not WCBA; No clear activities nor guidelines to support integration and no indicator targets in line with this; no clear interventions for MARPs etc.</strong></td>
<td>No guidelines integration nor for special groups</td>
<td>Not clear</td>
<td>Not clear</td>
</tr>
<tr>
<td>MOH Health Sector Policy for HIV prevention 2010</td>
<td><strong>While it recognizes the higher prevalence HIV among women and its heterosexual transmission, includes HIV and GBV, risks for adolescents and migrants as well as rights based approach and gender equality; the strategy to use all entry points health services for prevention of HIV does not specifically mention SRH; the risky behavior and migrants is recognized but there are no measures targetting this risk group as well as MARPs</strong></td>
<td>Services and activities target HIV and not much SRH linkage</td>
<td>Community mobilization for HIV prevention with stronger male involvement concentrates on methods for HIV prevention (HTC, PMTCT, STI) and no linkage to SRH</td>
<td>Not clear</td>
</tr>
<tr>
<td>National Guidelines for</td>
<td><strong>Measures decreasing infections WCBA</strong></td>
<td>Guidelines integrate HIV</td>
<td>As for district</td>
<td>Not clear</td>
</tr>
<tr>
<td>Tool</td>
<td>Gaps by Level</td>
<td>District Team</td>
<td>Hospital and Health Center</td>
<td>Community Health Workers</td>
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<tr>
<td>the PMTCT of HIV Sep 2010</td>
<td>mentioned and include SRH and HIV, integrated ANC for positive women including nutrition and STI as well as TB screening; indicators include % clients partners attend at least 1 ANC session, % receiving FP and disaggregated by HIV status; guidelines drugs include FP methods; PNC include MN status and HIV issues; indicators include HIV and MN health</td>
<td>with SRH status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HTC and Counselling Policy for the Kingdom of Lesotho, Nov 2009</td>
<td>Predates prevention policy. While the data/prevalence is disaggregated by gender and there recognition of the disproportionate impact of HIV on women and the need for promotion of gender equality and women and girls vulnerability, the implementation of routine testing targets pregnant women (PMTCT), FP, STIs, TB; integration is therefore only in the context of pregnancy. Outreach and mobile services are for HTC and no mention of SRH. Vulnerable groups are also targeted in the context of HIV alone</td>
<td>PMTCT integration STI, TB; no other SRH</td>
<td>PMTCT integration with STI and TB but with no other SRH</td>
<td>Outreach HIV and no specific mention SRH</td>
</tr>
<tr>
<td>Lesotho Policy, Strategy, Implementation</td>
<td>Indication of the need to integrate with SRH services for men but</td>
<td>Service delivery VMMC and no guide</td>
<td>Training on VMMC specific communication;</td>
<td>Only for VMMC specific communication</td>
</tr>
<tr>
<td>Tool</td>
<td>Gaps by Level</td>
<td>District Team</td>
<td>Hospital and Health Center</td>
<td>Community Health Workers</td>
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<tr>
<td>Plan, Costing and Budget for Scaling up Safe Facility-Based Voluntary Medical Male Circumcision for HIV Prevention 2012/13-2016/17</td>
<td>focus only on VMMC as HIV prevention</td>
<td>to integration</td>
<td>plans task shifting for VMMC for Nurses and others but not relate to SRH</td>
<td>in the context of HIV prevention</td>
</tr>
<tr>
<td>National Guidelines for HIV and AIDS Care and Treatment (Third Edition) Dec 2010</td>
<td>Emphasis PMTCT, and relations to STI, Cancer Cervix and FP; reference PHC services only but no service linkage nor guide except for STIs and Cancer</td>
<td>ART &amp; PMTCT and guidance STI, OIs and nutrition, otherwise refer other manuals</td>
<td>ART and &amp; PMTCT, and STI, CA Cervix and Ols, otherwise refer manual FP not reinforcing integrated service provision that is recommended</td>
<td>Emphasis on HIV testing and referrals as well as education; there is no linkage even between HIV testing and care; neither SRH</td>
</tr>
<tr>
<td>Ante-natal Care Guidelines in Primary Health Care Settings in Lesotho</td>
<td>The guidelines delineate the linkages with a focus on ANC for HIV Positive women and guide PMTCT as well as management STIs, Ols, IPT and Ols; condoms and prevention of primary infection and secondary HIV as well as STIs; necessity offer HIV screening all visits if not accepted earlier and ART follow up all visits if positive.</td>
<td>The SRH and HIV are linked and integrated in approach providing bi-directional coverage in pregnancy and related HIV issues</td>
<td>The SRH and HIV are linked and integrated in approach providing bi-directional coverage in pregnancy and related HIV issues</td>
<td>VHWs promote ANC and benefits of ANC information dissemination, follow up failure to keep appointments; guide syndromic treatment of STIs.</td>
</tr>
<tr>
<td>VHW Training Manual and Reference Manual, July 2011</td>
<td>Community Based HIV and SRH issues guidance including selected CBDs. Linkage however only in PMTCT and HIV as STI</td>
<td>Definition role VHW in HIV and SRH as promotion and education</td>
<td>Training VHWs to educate and promote SRH and HIV but not integrated and HIV more as an</td>
<td>Education on and Promotion and education key messages ANC and HIV</td>
</tr>
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</table>
8.0  Discussion

8.1  Roles by level of Health Service Delivery

This information was obtained through interaction with the leadership of the 2 programmes as they shared their tools.

(a)  MOH Headquarters

The role of the central MOH is to provide guidance and oversight as well as support services over health services design, implementation including monitoring and evaluation of such services. It is responsible for the development, dissemination and follow-up of policies, plans, manuals, guidelines, protocols and materials for advocacy and IEC/Social mobilization. This is done in collaboration with primarily CHAL and LRC. The input of other partners, including the implementing ones, is also sought, especially for manuals, guidelines and IEC materials. The input of the other partners, however, tends to be more in line with their area of interest.

(b)  Referral Hospital

There were no tools for the referral hospital. The Specialists/experts at this level are however represented in the development of manuals and guidelines.

©  District Team (Management others [DHMT and DHT])

The district team is responsible for providing oversight including technical assistance to the Health Centers (HC) and community level services in support of the Health Center. They are responsible for ensuring policy implementation, planning and that programmes follow the manuals, guidelines and protocols. No specific tools except the Management Manual of 1990s were found for this level. The teams are expected and assumed to apply their knowledge in the management of the district services.

(d) District/Local Hospital and Health Center levels

These levels are responsible for implementation of programmes and should be aligned to the policies as well as follow the guidelines, manuals and protocols.
(e) Community level (Communities and Community Based Health Workers especially VHWs)

Communities benefit from the interventions and their input should be sought in the development of programmes especially within their midst. They should be empowered to participate and be involved in programmes. VHWs are the key link between communities and health facilities. They are responsible for promotion, education and social mobilization. They may be specifically trained to deliver specific services e.g. Community Based Distributors (CBDs) of family Planning methods.

8.2 Gaps in Linkages and integration

(a) MOH Headquarters

Neither the time of development nor the period of validity between overarching documents such as policy and strategic plans coincide or are they similar; neither the guidelines for SRH compared with HIV and vice versa. Sometimes, the periods for documents such as manuals and guidelines overlap with the period for the development of the updated policy. Based on the dates indicated on the documents no attempt has been made to review or develop tools concurrently for SRH and HIV; each of the parties however involves/invites the other when the tools are developed. Synergies are therefore not necessarily considered although one often refers to the existence of the other.

While both the SRH and HIV and AIDS policies refer to the structural and social determinants of health, and the SRH policy in problem analysis includes these factors, the measures for policy implementation for both policies mention little or nothing on the means to addressing them. The especially vulnerable groups are included in the HIV tools but no interventions outside education are specified.

While the Government of Lesotho (GOL) through the MOH is party to several international and regional commitments that include systems for community participation and involvement as well linkages for SRH and HIV, its (MOH) policies and plans however do not systematically operationalize these commitments; they are hardly mentioned in the documents developed post these commitments.


(b) Referral Hospital
Specialist opinion and involvement is included through their participation in the development of the tools, especially the manuals and guidelines (acknowledgements). Given that the documents are developed separate for each programme and that SRH and HIV are also separate specialties the level of integration of the services at this level is a question mark.

© District Teams

There are no specific tools targeting this level and most documents to a large extent only refer to integration but do not have measures/activities towards integration. The district team members are also not included in the development but only in providing feedback (stakeholder forum/feedback). The level of linkages and integration at district level is also a question mark.

(d) District Hospitals and Health Centers

While most of the guidelines indicate the need for integrating SRH and HIV neither the SRH except for FP, STI and in the context of PMTCT, nor the HIV guidelines clearly delineate the steps for assuring linkages and integration. Neither the guidelines for HIV nor SRH guidelines include interventions for special groups except for adolescents/youth.

(e) Communities and Community Based Health Workers

The tools emphasize more on the communities being beneficiaries. The VHWS are to educate and mobilize for the services but without the guidance on linkages and integration. Social determinants for health are not addressed even at the level of communities.

8.0 Conclusions

8.1 The MOH while party to many international commitments that include SRH and HIV linkages and integration has not systematically operationalized these in its policies and plans

8.2 Structural and social determinants of health while recognized are not addressed; the interventions thereof would facilitate attention to the linkages and integration since they would influence both SRH and HIV outcomes. Relevant sectors should be mobilized to participate.

8.3 The development of the policies for each of SRH and HIV and AIDS is separate, so is the programme management and implementation at the central and district level.
It may therefore be difficult to assure integration is in built into the development of the tools for the programmes.

8.4 The importance of linkages and integration are not comparatively addressed across the policies that mention them. Each of the programme policies tend to emphasize on a unidirectional integration and do not include linkages especially linking policy to the different levels of and systems for intervention.

8.5 The support by partners varies between programmes although there are mutually shared ones. The partner involvement is related (KII) to their funding and technical assistance further compounding the inadequate collaboration and bidirectional focus of the 2 programmes.

8.6 Despite international commitments they are not reflected upon in the development of the policies, missing a further avenue for ensuring bi-directional linkages and provision of guidelines that foster integration.

8.7 There is neither a definitive national policy nor strategy for integration, and there is a paucity of clearly defined interventions for integration; service delivery points are therefore devoid of relevant tools to ensure integration in their day to day service delivery.

8.8 The absence of guidance for the DHTs in their oversight function to the programmes coupled with the separation of the management of the programmes further limits opportunities for integration.

8.9 Interventions directed at vulnerable groups, except for adolescents, are not always considered by both the SRH and HIV and AIDS programmes; when considered, as for adolescents/youth, emphasis is more in education especially for STI and unwanted pregnancy. This is one area for which integration may be implemented but not the only one for programme effectiveness and maximum impact.

8.10 The integration of services in the context of PMTCT, ANC, STI and FP is commendable and should provide lessons from which the programmes may learn and further enhance their efforts.

8.11 The needs and interests of the population/communities are not addressed and the inadequacy of the focus on enhancing the participation and involvement of communities may limit the effectiveness as well as minimize impact of the services delivered.

**9.0 Recommendations**

9.1 The MOH should review and update its overall policy and strategic plans in line with the regional and international commitments with due recognition of the social determinants of health, and assure linkages as well as measures for integration of SRH and HIV and AIDS.
9.2 The MOH should concurrently review the policies of the SRH and HIV & AIDS programmes involving all stakeholders (other sectors, units, partners) and together developing a joint SRH and HIV and AIDS policy that gives recognition to the linkages and includes measures for integration.

9.3 The MOH should systematically review the country experience in PMTCT, ANC, and FP whose guidelines integrate SRH and HIV & AIDS to assess the impact in outcomes draw lessons from the approaches that have been implemented to date. The results may also be useful for advocacy and case studies for ensuring linkages and integration of services in SRH and HIV and AIDS.

9.4 Specific tools should be developed for the district level to ensure integration of SRH and HIV and AIDS in their managerial and supervisory role of health services.

9.5 The already linked SRH and HIV responses should be strengthened through appropriate design of infrastructure and SOPs for services, integrating the commodity and supplies procurement as well as security systems (RCHS), quality assurance indicators that are integrated.

9.6 The training of VHWs for SRH and HIV & AIDS education and social mobilization should be integrated to facilitate linkages and enhance community participation in the programmes without “fears” of stigma and other deterrents to accessing services.

9.7 The M&E framework should include indicators of integration of SRH and HIV & AIDS. These should be regularly monitored and evaluated to inform future approaches and improvement of the programmes.

9.8 The MOH should undertake operations research to inform providers and highlight the benefits of integration including in reduction of stigma, cost effectiveness and enhancing access to services.

9.9 The MOH should also advocate for joint funding for the SRH and HIV & AIDS including in security of commodities and supplies.

9.10 The UN agencies that support the MOH ensure the “delivering as one” in their support for SRH and HIV & AIDS; they should also advocate with the donors and implementing partners of the MOH to ensure all their activities enhance integration of these services.
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