Ministry of Health and Child Care - Zimbabwe

Sexual & Reproductive Health and Rights and HIV Linkages

Training Curriculum for Health Service Providers

Facilitator’s Guide
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ACKNOWLEDGMENT

The Ministry of Health and Child Care (MOHCC) would like to thank all persons and stakeholders who, in one way or another, contributed to the development of the training materials (three training modules, reference manual and the corresponding teaching aids) for the integrated SRH and HIV training.

Special acknowledgements go to the members of the National Technical Committee on SRH and HIV linkages, for their ongoing oversight and leadership in the SRH and HIV linkages programme and especially their technical input in the development of the training modules and the reference manual.

The Ministry would like to extend its sincere appreciation to the members of staff and other stakeholders who participated in the pretesting of these training modules. The team included staff members from Ministry of Health and Child Care Head Office, Provincial Medical Directors’ offices and Schools of Nursing; Zimbabwe National Family Planning Council (ZNFPC); National AIDS Council (NAC); Harare City Health Department; SAFAIDS, Seke Home Based Care and Family AIDS Counselling Trust (FACT).

Special mention goes to the consultant, Dr Woldemedhin Haile for his dedication and expertise in the development of the training materials.

Most importantly, special gratitude goes to United Nations Population Fund (UNFPA) and Joint United Nations Programme on HIV/AIDS (UNAIDS) for their guidance and technical direction in the development of the training materials, as well as the European Union for the financial support.

Dr Gibson Mhlanga
Principal Director Preventive Services
Ministry of Health and Child Care

2014
FOREWORD

Over the past decade there has been a growing understanding that sexual and reproductive health and rights (SRHR) and HIV linkages can have a range of social and public health benefits. A number of global and regional instruments and commitments alluding to this include the Programme of Action adopted at the International Conference on Population and Development (ICPD) (1994); Beijing Declaration and Platform of Action of September 1995; UN Millennium Development Goals adopted at the Millennium Summit in September 2000; Declaration of Commitment agreed upon in June 2001 at the UNGASS on HIV and AIDS; The Maputo Plan of Action (MPoA) adopted by AU member states in 2006; and the UN High Level Meeting on HIV and AIDS - Declaration of Commitment of 2012.

The Maputo Plan of Action (MPoA) in particular, seeks to advance the agenda on universal access to sexual and reproductive health services including family planning, as a contribution towards attainment of MDGs 4, 5 and 6. The continental framework strives to strengthen commitment of member states to achieving universal access to SRH services, including family planning, and recognize and support the contribution of these services to HIV prevention. A key strategy for operationalizing the MPoA policy framework is to “…integrate STI/HIV/AIDS, and SRHR programmes and services, including reproductive cancers, to maximize the effectiveness of resource utilization and to attain a synergetic complementary of the two strategies”. This commitment signals an important step in the efforts already underway to strengthen linkages between SRH and HIV programmes and services.

HIV and SRH related conditions share the same target groups as well as root causes. Thus, addressing one cause is likely to benefit the other. Linking and integrating the two programmes minimize missed opportunities by increasing access and coverage of services for all, including the most at risk population groups. This means that those seeking services can get them at either an SRH or HIV service delivery points. In a way this would reduce duplication of efforts, whilst reducing competition for scarce resources.

A rapid assessment conducted in 2010 in Zimbabwe to assess bi-directional linkages between SRH and HIV programmes and services noted that integration was taking place at service delivery level, mostly at the primary health care facilities. This often occurred out of necessity, as clients seeking both services present to the same service provider. The challenge, however, was that the integration tended to be ad hoc, uncoordinated and not guided by policy or guidelines. At the same time, the generally weak levels of coordination mechanisms between SRH and HIV key players led to programmes that were not optimally linked.

The linkages programme has created a greater level of focus for the integration discourse. Findings from the rapid assessment have informed the development of a national operational plan
on linking SRHR and HIV programmes and services. Within the design of the programme is
capacity strengthening of programme managers and service providers across the different sectors
aimed at equipping them with the necessary knowledge and skills required for implementing
integrated SRH and HIV services. The Ministry of Health and Child Care has produced integrated
SRHR and HIV service guidelines to provide national standards for the provision of high quality
services by programme managers and service providers at all levels of health care. However, for
the service guidelines to be operationalised optimally there is need for standardized training for the
different categories of health care providers and their supervisors on how to integrate SRH and HIV
services. This has led to the development of standardized training tools.

The Ministry of Health and Child Care with support from UNFPA and the National Technical
Committee on SRH and HIV linkages has produced tools to support training in SRH and HIV
linkages i.e. three training modules and accompanying teaching aides for: a) managers of service
providers, b) service providers and c) community based workers. In addition, a reference manual
on SRHR and HIV linkages that cuts across all categories of health workers and trainers is part of
this package. The tools have been developed through a highly consultative process. The aim has
been to develop a standardized approach that guides learning and practice on linking and
integrating SRH and HIV programmes and services.

I urge you all to use these tools diligently in advancement of the SRH and HIV linkages agenda, as
we work towards achievement of MDG 4, 5, and 6.

Brigadier General (Dr) Gerald Gwinji
Secretary for Health and Child Care
2014
## ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ASRHR</td>
<td>Adolescent Sexual and Reproductive Health</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral Medicine</td>
</tr>
<tr>
<td>DMO</td>
<td>District Medical Officer</td>
</tr>
<tr>
<td>EID</td>
<td>Early infant diagnosis</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organization</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HAART</td>
<td>Highly Active Antiretroviral Treatment</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing &amp; Counselling</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
</tr>
<tr>
<td>IMNCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>ISP</td>
<td>Integrated Support Program</td>
</tr>
<tr>
<td>SGBV</td>
<td>Sexual &amp; Gender based violence</td>
</tr>
<tr>
<td>MARPS</td>
<td>Most At Risk Populations</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal Newborn &amp; Child Health</td>
</tr>
<tr>
<td>MOHCW</td>
<td>Ministry of Health and Child Welfare</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother to Child Transmission</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Council</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic Infection</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PIHTC</td>
<td>Provider Initiated Testing &amp; Counseling</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMD</td>
<td>Provincial Medical Director</td>
</tr>
<tr>
<td>PNC</td>
<td>Postnatal Care</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>VMMC</td>
<td>Voluntary Medical Male Circumcision</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>ZDHS</td>
<td>Zimbabwe Demographic and Health Survey</td>
</tr>
<tr>
<td>ZNFPC</td>
<td>Zimbabwe National Family Planning Council</td>
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</tbody>
</table>
1. ABOUT THIS GUIDE

This guide will provide a structured approach for facilitators to lead training on sexual and reproductive health and rights (SRHR) and HIV linkages for service providers. It contains the instructions and materials that facilitators will need to help participants develop the accurate knowledge, attitude and skills necessary to effectively provide integrated SRHR and HIV services.

Facilitators should follow the steps in this guide and refer to the accompanying reference manual and SRHR and HIV service guidelines, as needed, when they prepare and facilitate sessions, as these three course materials are very much interlinked. The contents in the facilitator’s guide, including the slides are derived from the reference manual and some examples in the reference manual and service guidelines will be used to simulate the ‘how’ part of SRHR and HIV service integration.

2. TRAINING OVERVIEW

The objectives of this training are:

- To improve the knowledge, attitudes and skills of health service providers on SRHR and HIV linkages
- To improve the practical application of SRHR and HIV service integration at health facility level

This training is divided into six sessions:

- **Session I: Introduction** - Covers participants’ introduction and course overview.
- **Session II: Introduction to Linkages** - Discusses the terms in SRHR and HIV linkages and the rationale for linking SRHR and HIV at policy, system and service delivery levels, including historical perspectives and process that led to linkages. It also highlights the national SRHR and HIV context.
- **Session III: Benefits of Linkages** - Explores the benefits and evidences of the bidirectional linkages between SRHR and HIV policies, programs and services
- **Session IV: Principles of Linkages** - Elaborates the key principles of linkages
- **Session V: Implementing Linkages at Service Delivery Level** - presents what linkages entail at service delivery, including models of SRHR and HIV service integration
- **Session VI: SRHR and HIV Service Integration Guidelines** - Explains the purpose of the service integration guidelines and the application of the minimum package of services in health facilities.
2.1 Intended Audience

The curriculum is designed for integration into the existing SRHR and HIV trainings. Its use is intended for all cadres of health providers at primary, secondary, tertiary and referral levels who are responsible for SRHR and HIV clinical, counseling and health promotion services. This curriculum can be easily adapted for use in onsite or standalone trainings.

The training is appropriate for a group of around 20 to 25 participants. It is assumed that this class size of participants would allow optimal participation. With the proposed training structure and time allocation, a participant size of more than 25 won’t allow optimal participation of participants in the intended participatory exercises and interactive presentations.

2.2 Training Materials

For the training to run smoothly, there are other materials the facilitator will need in addition to the trainer’s guide, including:

- **Reference Manual**: This manual is designed to provide an up-to-date quick reference in SRHR and HIV linkages. It serves as reference source both for the participants and the facilitator. Because the manual contains information that is consistent with the course objectives, it becomes an integral part of all classroom discussions and exercises.

- **Overheads**: Electronic copies of overheads are available to facilitators, and can be used with a computer as a PowerPoint presentation or can be copied onto transparencies for use with overhead projectors. In circumstances where there is lack of facilities to use slides or overheads, the facilitator needs to prepare presentations on flip charts.

2.3 Facilitator Requirements

A team of at least two facilitators is needed to co-facilitate this training that includes a lead facilitator and an assistant. The two facilitators will swap roles between a lead and an assistant for specific session depending on experience and expertise. While the lead facilitator facilitates a session, the assistant can record information on flipcharts, monitor the time, help keep the discussion focused on the session objectives, and moderate small-group work.

Facilitators should be selected for their knowledge, expertise, and training skills. Due to the interactive exercises, experience in participatory training is necessary. Also the ability of facilitators to be interactive, attending, and engaging with high levels of energy is optimal. Moreover, it is preferable to have a health provider do the training, someone that the other health providers respect and will listen to and learn from, but one that does not have the traditional provider bias.
In general, the selection criteria for facilitators should include the following:

- Expertise and experience in SRHR and HIV;
- Experience in integrated service delivery and familiarity in SRHR and HIV linkages;
- Familiarity with adult learning principles, strategies, and techniques;
- Ability to adapt materials to meet the participants’ needs;
- Interest and experience in training other healthcare providers; and
- Ability and willingness to make the time commitment required.

Before conducting this particular training, the facilitators should participate in a training conducted with this curriculum and attend a training of trainers (TOT) course. Without firsthand experience with the curriculum and an understanding of the training methods and tools, facilitators might find the curriculum difficult to use.

2.4 Timeframe and Structure

The curriculum is structured as a one day classroom course. It is also important to assume that the amount of time needed for the course depends on many factors, including the qualification and experience of participants, the number of participants, participants’ needs, etc. Adaptation of the curriculum may be needed to better meet such factors and any time or logistical constraints.

Regardless of how the overall training will be scheduled, it is important to follow the recommended sequence of sessions because the later sessions build on knowledge and attitudes developed in the earlier sessions (Refer to annex 1) for training agenda.

2.5 Training Approach

The training methodologies proposed in this curriculum are grounded in competency-based skills acquisition and participatory learning, stemming from the principles of adult learning. To that end the following methodologies will be used throughout the training:

- Interactive presentations,
- Role plays,
- Brainstorming,
- Group work, and
- Buss groups
2.6 Training Preparation

Facilitators need to be well-prepared for the training. As the facilitator of this course you need to take the following steps to adequately prepare and carry out the course:

- Familiarize yourself with the entire Trainer’s Guide and Reference Manual, reading them thoroughly to get an overall sense of the purpose, content, and approach of the training.

- Attend a training conducted with this curriculum, or co-train with another facilitator who is experienced in using this training curriculum. This will help you to better understand how training methods are used.

- After reading the curriculum, arrange a meeting with the program administrators to:
  - Clarify the purpose of the training and any queries you have;
  - Determine if appropriate participants have been selected;
  - Identify who will assist with the training;
  - Confirm the time committed for the training; and
  - Finalize plans for follow-up and ongoing support to the participants after the training.

- Make sure that there are enough copies of the Reference Manual and SRHR and HIV service integration guidelines for all of the participants.

- Prepare preparation checklist in advance for each session. Before each session, make sure that the necessary materials and methods are ready.

- Prepare warm-ups and wrap-ups.

- Decide on which presentation aid to use for your sessions.

- Ensure availability of a LCD projector since the training relies heavily on this equipment to guide and summarize discussions. If it is not possible to use an LCD projector or a computer, alternatively a flip chart or an overhead projector and transparencies can be used instead.
3. COURSE OUTLINE

The course outline presented here is a model plan of the training to be delivered. It presents topics for presentations and supporting activities needed to accomplish the participants’ learning objectives. For each session there are suggestions regarding appropriate learning activities and materials needed. The facilitator may develop different warm up activities.

The course outline is divided into four sub sections:

**Time:** This section of the outline indicates the sum of the approximate amount of time to be devoted to each learning activity for a given session. Though the facilitator should try to accomplish the session in a given time, it will depend upon the participants as well. However, extra time used in one session will have to make up for in another session.

**Session objectives:** Delineates what participants will be able to learn at the end of each session. During the wrap-up of each session these objectives will be reviewed to provide a framework for assessing how well objectives were achieved and where there might be gaps in the participants’ understanding.

**Process:** Describes the presentation topics and learning activities. The combination of the topics and activities outlines the flow of the training. It also describes the various methods to be used to deliver the content related to each topic.

**Advance Preparation:** Describes the necessary preparations to be made ahead of a session and materials needed to support the learning activities. Some of these materials need to be adapted, developed, or gathered in advance.
SESSION I: INTRODUCTION

**Time:** 40 Minutes

**Session Objectives:**

By the end of this session, participants will be able to:

- Get to know each other and the facilitator/s in charge of facilitating sessions.
- Explain the purpose of the training and reconciled their expectations to the objectives of the training.
- Familiarize themselves with the training packages and course schedule.

**Advance Preparation**

- Prepare materials to distribute
  - Reference manual
  - SRHR and HIV service integration guidelines
  - Note cards
- Make sure laptop and LCD projector are available and assembled well
- Prepare slides/flip chart and markers
  - Power point slide 1
- Prepare ice breaker

**Process:**

**Activity 1: Introduction of facilitators and participants (10 minutes)**

The person/s in charge of facilitating the sessions will introduce himself/herself (e.g., name, professional background, current work, experience in SRHR and HIV linkages, etc.). As the participants have already introduced each other at the beginning of the main course, the introductions can be brief (e.g., name, professional background,
where they work, and what their job is). Even if the introductions are brief, the facilitator should include a quick ice breaker, such as any interesting story or warm up activity about SRHR and HIV linkages.

**Note:** This activity is optional if facilitators in charge of SRHR and HIV linkages training took part in the introductory sessions at the beginning of the main training.

**Activity 2: Course overview (Expectations, training objectives, course package and agenda) (30 minutes)**

1) Using the exercise below (exercise 1.1), explore participant’s expectations and concerns from the SRHR and HIV linkages training.

### Exercise 1.1: Course Expectations and Concerns

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Explore participants’ concerns and expectations from the course and clarify the purpose of training.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials</td>
<td>12 X 15 cm note cards, flipchart or whiteboard and markers.</td>
</tr>
<tr>
<td>Advance Preparation</td>
<td>Prepare enough number of two different colored cards that match the number of participants.</td>
</tr>
<tr>
<td>Time</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Introduction</td>
<td>Explain that this exercise will help them to explore their individual concerns and expectation from the course.</td>
</tr>
<tr>
<td>Activities</td>
<td>Distribute two cards with different colors to each participant. Ask participants to spend 5 minutes thinking about their concerns and expectations from the course and then to write their responses related to their expectation in one of the card and their concern in the other one, a maximum of 1 expectation and 1 concern:</td>
</tr>
</tbody>
</table>

**Expectations:** What do you want to learn or take away with you at the end of the course?

**Concerns:** Do you have any concerns, related to the training, during and after completing the course? If Yes, what are they?

Give participants 5 minutes. While they complete their cards, write each question on a separate piece of paper and tape it to the wall. Then ask participants to post their responses to the wall corresponding to the questions.

After all participants posted their responses, ask a volunteer among participants to read the responses. Ask him/her to read first responses related to expectations followed by concerns. While he/she is reading the responses take time to write the summary of expectations and concerns separately on the flipchart.

Post the summarized responses on the wall then show the power point of the training objectives and lead a short discussion by linking the expectations and concerns mentioned by the participants to the objectives of the training.
2) Following the card game, show the power point of the training objectives (slide # 2: training objectives) and lead a short discussion by linking the expectations and concerns mentioned by the participants to the objectives of the training.

2) Walk participants through the reference manual and SRHR and HIV service integration guidelines and familiarize them with the course schedule.

3) Optional: Set ground rules, and assign a mood monitor and time keeper from participants. This activity is expected to be covered in the main training.

Training Tips:

Point out to the participants that the Reference Manual includes essential ideas from the sessions in greater details. The participants need to take notes only on additional points or issues that are of particular relevance or interest. Explain that the intent is to enhance their participation.
SESSION II: INTRODUCTION TO SRHR AND HIV LINKAGES

Time: 1 hour, 15 minutes

Session Objectives:

By the end of this session, participants will be able to:
- Define key terms in SRHR and HIV linkages
- Explain the rationale for linking SRHR and HIV at policy, system and service delivery levels
- Understand historical perspectives and processes that led to linkages

Advance Preparation

- Prepare materials
  - Power point slide: Session II-introduction to SRHR and HIV linkages
  - Be prepared for the warm up activity (exercise 2.1)
  - Prepare enough flip chart and markers
  - Laptop and LCD projector

Process:

Activity 1: Session Objectives (15 minutes)

1) Start the session with a warm up activity (Exercise 2.1)
Course Exercises 2.1: Warm Up Exercise

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Topic lead-ins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Materials</td>
<td>12cm by 15cm cut cards, markers</td>
</tr>
</tbody>
</table>
| Activities | 1) Ask participants to form a circle.  
2) Distribute a card to each participant. Cards should have one of the following words written on it:  
  - Aggressiveness  
  - Sadness  
  - Happiness  
  - Angriness  
  - Excitement  
  - Boredom  
  - Friendliness  
  - Tiredness  
3) Each participant says “Give me the oranges” in the manner described on their card. The rest of the group has to guess which tone of voice they are using.  
4) Ask participants what they learned from the warm up exercise. |

Debriefing  
The activity will generate fun and laughter but also highlight the importance of tone of voice in communication. In any communication how it is said is as important as what is said.

2) Explain the objectives of the session (Slide 2)

Session Objectives

By the end of this session you should be able to:

- Define key terms in SRHR & HIV linkages
- Explain the rationale for linking SRHR & HIV
- Understand historical perspectives and process that led to linkages
Activity 2: Definition of Key Terms (15 minutes)

3) Ask participants the following two questions:
   i) What is SRHR and HIV linkage?
   ii) How is linkage different from integration?

4) By using power point slide (slide 3-8) discuss the key terms in SRHR and HIV linkages, by linking the key points raised during the question and answer session.

**Definition of Key Terms**

- **INTEGRATION**: Different kinds of SRH and HIV services or operational programs that can be joined together to ensure and perhaps maximize collective outcomes. This would include referrals from one service to another, for example. It is based on the need to offer comprehensive and integrated services.

**Examples of SRH and HIV integrated services**

- **Community level**: Condoms and family planning (FP) pills; IEC on HIV prevention, treatment, care and support and FP

- **Maternal Child Health / FP clinic**: HTC and antenatal care (PMTCT), HTC and postpartum care, STI screening and ARV prophylaxis.

- **HTC Centers**: FP and HTC

- **Comprehensive Care Centers**: TB Screening and ART, FP and ART
Definition of Key Terms

For the **user**, integration means health care that is seamless, smooth and easy to navigate.

Users want a coordinated service which minimizes both the number of stages in an appointment and the number of separate visits required to a health facility.

They want health workers to be aware of their health as a whole (not just one clinical aspect) and for health workers from different levels of a system to communicate well. In short, clients want **continuity of care**.

Definition of Key Terms

For **providers**, integration means that separate technical services (and their management support systems) are provided, managed, financed and evaluated either together, or in a closely co-ordinated way.

A **key feature of integrated services** is that during one session or single visit a client receives more than one service.

An additional service besides the index service for which the client seeks care.

Definition of Key Terms

**LINKAGES:** The bi-directional synergies in policy, programs, services and advocacy between SRHR and HIV. It refers to broader human rights based approach, of which service integration is a subset.
Activity 3: Rationale of SRHR and HIV Linkages (40 minutes)

1) Form three buss groups and ask the groups to discuss the **Rationale of Linkages**. After 5 minutes of discussions ask each group to present their answers for plenary.

2) Use power point slides (slide 9-13) to guide the discussion on the **Rationale of SRHR and HIV Linkages**, including the process that led to linkages.

**Rationale**

- Majority of HIV infections are
  - sexually transmitted, or
  - associated with pregnancy, childbirth and breastfeeding.
- Target groups for HIV and SRH services are generally the same

- Many management and procurement issues are the same

- Sexual and reproductive ill-health and HIV share root causes:
  - Poverty
  - limited access to appropriate information
  - gender inequality
  - cultural norms and social marginalization of the most vulnerable populations
Key Processes that Led to Linkages

- Pioneered by both the May 2004 Glion Call to Action on Family Planning and HIV & AIDS in Women and Children and the New York Call to Commitment (Linking HIV & AIDS and Sexual and Reproductive Health, June 2004)

- In 2006, African Union adopted the ‘Maputo Plan of Action’, calling on countries to ‘strengthen commitment to achieving universal access to Sexual and Reproductive Health Services, including Family Planning’.

- In 2010, the Southern African Development Community recognized strengthening SRHR and HIV linkages as key to achieving its target of a 50 percent reduction in new HIV infections by 2015.

Key Processes that Led to Linkages

- In 2011, UNGASS High-level Meeting: target #10 - Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts.

- The international community agrees that the Millennium Development Goals (MDGs) will not be achieved without ensuring access to SRH services and an effective global response to the HIV epidemic.

- Reinforcing and scaling up linkages between HIV and SRH is critical for the achievement of the health related Millennium Development Goals namely: 4 (Reducing child mortality); 5 (Improving maternal health) and 6 (Reducing new HIV infection)
Local Initiatives to Support Linkages

- Integrated support program (ISP)

- The structure of the MoHCC presents a unique opportunity for integration

- Policy documents such as the Maternal and Neonatal Health Roadmap, the Reproductive Health policy, PMTCT guidelines identify the need for SRH and HIV integration

- Some level of integration especially at the service delivery level

- ZNASPII 2011-2015, guiding principle 4 emphasizes that service integration will be supported as a strategy to improve synergy and complementarity between interventions and optimize use of resources.

3) Use power point slides (slide 15-25) to guide the discussion on the Zimbabwe project on SRHR and HIV linkages
Background

- The EU, as part of its health initiative and portfolio, is supporting, through a sub-regional project, 7 countries in Southern Africa: (Malawi, Botswana, Namibia, Zambia, Lesotho, Swaziland, and Zimbabwe) in overcoming barriers to strengthening linkages between SRH and HIV policies, programs and services.

Aim

- The overall aim of the project is to promote efficient and effective linkages between HIV and SRHR policies and services as part of strengthening health systems.

Objectives

- Advocate for integrated SRHR and HIV program delivery and funding support
- Facilitate bi-directional linkages within SRHR and HIV policies, strategies, guidelines and plans
- Strengthen management capacity to plan, support implement, monitor and evaluate integrated SRHR and HIV prevention, care and support services
- Review SRHR and HIV protocols, manuals and tools to reflect integrated HIV and SRHR programming.
- Strengthen the capacity of managers and service providers to implement integrated SRHR and HIV prevention, care and support services
Project Inception Phase Activities:
January-June 2011

- Rapid Assessment conducted in October – December 2010 and validated by stakeholders

- Wider stakeholder meeting to disseminate findings of the Rapid Needs Assessment (March 2011) - Findings were endorsed. Country priorities were identified.

- SRHR and HIV Linkages Technical Committee and M&E Technical Working Group established and formalised

- Log frame, implementation plan, an advocacy and visibility plan, M&E plan, 2011 annual work plan developed

Rapid Assessment: Methodology

- **Literature Review**: Policies, strategic plans and guidelines - RH policy, MC strategy, ZNASP, BC strategy, ASRH BC strategy, PMTCT strategic plan, ART guidelines, ASRH strategy, HTC Guidelines, National Health Strategy, MNH road map etc, etc

- **Key Informant Interviews**: National level, Provincial, District and Primary Care Level - MOHCW, NAC, ZNFPC, UN Agencies, Development agents, Bilateral agencies, NGOs/CSOs

- **Exit interviews** with clients at health facilities

- **Interviews with community agents** (mainly Village Health Workers, HIV facilitators and CBDs)

- **General observations at facility level** (Government and Mission Hospitals, and Clinics/RHGs)

- Four (+) provinces selected for the field assessment
Rapid Assessment Key Findings: Policy Related Barriers

- Lack of national policy or framework and standard operating procedures to guide SRHR and HIV integration
- Inadequate coordination between SRHR and HIV units at the national level
- Donor specific interests in HIV or SRHR and conditions on use of funds for specific HIV or SRHR interventions
- Inadequate institutional capacity for SRHR and HIV integration

Rapid Assessment Key Findings: System & Service Delivery Related Barriers

- Inadequate capacity among health workers to offer integrated services.
- Inadequate supportive supervision
- There were no mechanisms to track referrals both within the same facilities and to other facilities
- Infrastructural challenges such as lack of enough space to provide integrated services
- Some integration of services at service delivery level was noted but this was not supported by a policy or operational guidelines
Rapid Assessment Key Findings: Barriers at Community Level

- Inadequate capacity by community based agents (CBDs and Village Health Workers) to implement integrated services
- Lack of integrated community based strategy to guide SRHR and HIV integration
- Weak coordination of SRHR and HIV community based programs

Country Priorities

- Set up and formalize the technical committees
- Develop National SRHR and HIV Integration Policy/Guidelines
- Review National HIV and SRHR policies and strategies
- Develop advocacy package for policy makers and undertake advocacy with departmental directors, programme managers and heads on SRHR and HIV integration.
- Adapt existing SRHR and HIV training manuals, protocols, guidelines and procedures
- Revise HIV and SRH M&E tools to ensure collection of relevant integrated SRHR and HIV data
- Train Service Providers and Management on SRHR and HIV Integration
- Recruit an officer in MOHCW to coordinate SRHR and HIV integration work

Proposed Integration Framework

- **Policy level**: Joint Planning, review of strategies and policies, Coordination, SRH and HIV integrated service guidelines and protocols standardization
- **Systems Level** — Pooled funding mechanism, integrated M&E system
- **Service delivery level** — establish centres of excellence, develop models of integration, training of providers
- **Community level** — develop community strategy for integration, demand creation, training of CHWs
3) Use power point slides (slide 27-33) to guide the discussion on the **Overview of SRHR and HIV and AIDS in Zimbabwe**

**HIV & AIDS Context**

- Generalized epidemic with HIV primarily transmitted through heterosexual means.

- Adult HIV prevalence has declined from 18% (2005-06 ZDHS) to 15% (17% urban, 15% rural with provincial differentials) in 2010-11 ZDHS.

- 18% among women and 12% among men. Among women, the prevalence peaks at 29% in the 30-39 age groups; among men, HIV prevalence peaks at 30% in the 45-49 age groups.
HIV & AIDS Context

- Out of 2,700 cohabiting couples tested for HIV in 2010-11 ZDHS 12% of couples were discordant.

- Among MARPs like female sex workers different studies found 3-5 times as high infection rates than among the general population.
HIV & AIDS Context

- Key drivers of the HIV spread:
  - Low and inconsistent levels of condom use,
  - Multiple concurrent partnerships,
  - Age disparity in sexual relationships
  - Low rates of male circumcision.

SRHR Context

- MMR rose from 283/100,000 in 1994 to 960/100,000 live births in 2010 (ZDHS 2010/2011)

- HIV and AIDS is the single highest indirect cause of maternal mortality (ZMPMS 2007)

- ANC coverage 90%. However, only 19% of the women received any antenatal care during their first trimester (ZDHS 2010/11).

- Up to 65% of the pregnant women were delivering at health facilities, and the PNC coverage was 27%. However, 12% of newborns received a postnatal check-up in the first two days after birth (ZDHS 2010/11)

SRH Context

- CPR in married women 59% with 57% using a modern method (2010/11 ZDH)

- Unmet need for FP 13% among married women (13.4% rural, 11.6% urban)-unchanged for the past 20 years (2010/11 ZDH)

- A high rate of teenage pregnancy rate- 24% (2010/11 ZDH)
Activity 4: Session wrap-up (5 minutes)

- Ask if there are any last questions or comments
- Review session objectives
SESSION III: BENEFITS OF SRHR AND HIV LINKAGES

Time: 1 hour, 15 Minutes

Session Objectives:

By the end of this session, participants will be able to:
- List the benefits of the bi-directional linkages between SRHR and HIV policies, programmes and services
- Explain the evidences of benefits

Advance Preparation

- Prepare materials
  - Power point slides: Session III-Benefits of Linkages
  - Prepare exercises 3.1
  - Prepare enough flip chart and markers
  - Laptop and LCD projector

Process:

Activity 1: Introduction and Exercise (50 minutes)

1) Begin by introducing the session objectives (Slides 2)
2) Ask participant to do the following group work (exercise 3.1).

Course Exercise 3.1 Group work

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Help participants identify the benefits of SRHR and HIV linkages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enhance participants understanding of factors that promote</td>
</tr>
<tr>
<td></td>
<td>and hinder linkages</td>
</tr>
<tr>
<td>Time</td>
<td>45 minutes</td>
</tr>
<tr>
<td>Materials</td>
<td>Flip chart and markers</td>
</tr>
<tr>
<td>Activities</td>
<td>Divide participants into three small groups (6-8 groups</td>
</tr>
<tr>
<td></td>
<td>if possible) and instruct them to work on the following topics.</td>
</tr>
<tr>
<td>Group I:</td>
<td>Describe the benefits of linkages</td>
</tr>
<tr>
<td>Group II:</td>
<td>Describe the factors that promote linkages</td>
</tr>
<tr>
<td>Group III</td>
<td>Describe the factors that hinder linkages</td>
</tr>
</tbody>
</table>

Ask each group to assign a chairperson who moderates the discussion and a rapporteur who report on their group findings. Provide each group with flip chart and Markers to present their responses.

Allow 20 minutes for the group to finalize the group work.

Allow each group to present their responses in plenary in 5 minutes, and then allocate 10 minutes for plenary discussion.
2) Summarize the key points of the discussion using power point slide (slides 3).

Activity 2: Evidence of Linkages: Presentation and Discussion (25 minutes)

1) Ask 2 or 3 participants if they have any information about the evidence of linkages.

2) Using power point slide (slides 4-16) discuss the Systematic Review of SRHR and HIV Linkages and other evidences, by linking with the key points raised during the question and answer session.

Evidence of Linkages: Systematic Review of SRH and HIV Linkages

- In order to gain a clearer understanding of the effectiveness, optimal circumstances, and best practices for strengthening SRH and HIV linkages, a systematic review of the literature published between 1990 and 2007 was conducted.

- Key research questions include:
  - What linkages are currently being evaluated?
  - What are the outcomes of these linkages?
  - What types of linkages are most effective and in what context?
  - What are the current research gaps?
  - How should policies and programs be strengthened?
Methods
- Systematic review
  - Comprehensive online search of scientific databases, program websites, and consultation with experts

Results

Citations identified through search strategy (n=50,797)

Citations excluded from review (n=50,570)
  - Did not meet inclusion criteria
  - Interventions with elements 3 of PMTCT (matrix column 3, row 2) were reviewed elsewhere (see full report)

Citations included in review (n=225)

Citations not retained for analysis (n=167)
  - Interventions linking PMTCT prevention, education, and condoms with SRH services (matrix column 1) were reviewed elsewhere (see full report)

Citations included in analysis (n=58)
Key Outcomes

- Despite diverse settings and clients, the majority of studies showed improvements in all outcomes measured, and only a few showed mixed results.

- Many studies reported an increase or improvement in:
  - access to and uptake of services
  - health and behavioral outcomes
  - condom use
  - HIV and sexually transmitted infection knowledge
  - overall quality of service

Key Outcomes continued....

- Linking SRH and HIV was considered beneficial and feasible, especially in:
  - family planning (FP) clinics
  - HIV counseling and testing centers
  - HIV clinics

- Interventions which successfully implemented provider training resulted in improved provider knowledge and attitudes, leading to better SRH and HIV service provision.

- Preliminary analysis of both cost-effectiveness studies suggested net savings from HIV/STI prevention integrated into maternal and child health (MCH) services
Promoting and Inhibiting Factors

Promoting
- Stakeholder involvement
- Capacity building
- Positive staff attitudes and non-stigmatizing services
- Engagement of key populations

Inhibiting
- Lack of sustainable funding and stakeholder commitment
- Staff shortages, high turnover or inadequate training
- Poor program management and supervision
- Inadequate infrastructure, equipment, and commodity supply
- Client barriers to service utilization, including low literacy, lack of male partner involvement, stigma, and lack of women’s empowerment to make SRH decisions

Strengths & Limitations of the Review

Strengths
- Broad scope of review
- Systematic methodology

Limitations
- Difficult to synthesize data due to heterogeneity in:
  - Interventions
  - Populations
  - Research questions/objectives
  - Study designs/rigor
  - Measured outcomes
- May not have captured all promising practices
The INTEGRA Project

- 5 year research project (Jan 2008 – Dec 2012)
- Implemented in three medium and high HIV prevalence countries in Africa: Kenya, Malawi, and Swaziland

The INTEGRA Project

Objectives:
- Determine the benefits of different integrated models to increase range, uptake and quality of selected SRH and HIV services.
- Determine the impact of different integrated services on changes in HIV risk behavior, HIV related stigma and unintended pregnancies.
- Establish the efficiency of using different operational models for delivering integrated services in terms of cost, utilization of existing infrastructure and human resources.
- Increase utilization of research findings by policy and program decision makers through involvement of and dissemination to key stakeholders.
Summary of Key Findings: Cost analysis of integrated services in Kenya and Swaziland

- There is potential for integration to improve efficiency, with variation in unit costs

- Underutilized capacity: a potential for efficiency gains in both SRHR and HIV services, through the better use of infrastructure and human resources

- Substantial variation in workload. While in some facilities staff are likely to be overworked, there are facilities where staff are not working to full capacity.
Summary of Key Findings: Cost analysis of integrated services in Kenya and Swaziland

- Uniform increases in utilization
- Services times fall, but possibly at the expense of quality
- Some suggestion of possible economies of scope and scale
- Limited movement in physical integration on the aggregate level, with differences by facility.

Activity 3: Session Wrap-up (10 minutes)

- Ask if there are any last questions or comments
- Review session objectives
SESSION IV: PRINCIPLES OF SRHR AND HIV LINKAGES

Time: 35 Minutes

Session Objectives:

By the end of this session, participants will be able to:

- Describe the key principles of linkages

Advance Preparation

- Prepare materials
  - Power point slides: Session IV-key principles of linkages
  - Laptop and LCD projector

Process:

Activity 1: Session Objectives (5 minutes)

1) Using power point slide (slide 2) introduce the session objectives.
Activity 2: Presentation: Principles of linkages (20 minutes)

2) Ask participants to cite the key principles that represent the philosophical foundation and commitments upon which linked responses must be built.

3) Through a question and answer approach, use power point slides (slides 3-9) to discuss the key principles of linkages. Ask participants what is being done in Zimbabwe and in the health facilities in terms of addressing each principle, and provide practical examples for each principle.

---

**Principles**

1. Address structural determinants:
   - Root causes of HIV and sexual and reproductive ill-health need to be addressed. This includes action to reduce poverty and gender inequalities, ensure equity of access to key health services and improve access to information and education opportunities.

2. Focus on human rights and gender:
   - Sexual and reproductive rights of all people, including women and men living with HIV, need to be emphasized, as well as the rights of marginalized populations such as people who use drugs, men who have sex with men, sex workers and people with disabilities. Gender sensitive and gender transformative policies and programs to promote gender equality and eliminate gender-based violence are additional requirements.
Principles

3. Promote a coordinated and coherent response

- Promote attention to SRHR priorities within a coordinated and coherent response to HIV that builds upon the principles of one national HIV framework, one broad-based multi-sectoral HIV coordinating body, and one agreed country level monitoring and evaluation system (Three Ones Principle).

4. Meaningfully involve PLHIV:

- Women and men living with HIV need to be fully involved in designing, implementing and evaluating policies and programs and research that affect their lives.

5. Foster community participation:

- Young people, key vulnerable populations, and the community at large are essential partners for an adequate response to the described challenges and for meeting the needs of affected people and communities.
Activity 3: Session Wrap-up (10 minutes)

- Ask if there are any last questions or comments
- Review session objectives
SESSION V: IMPLEMENTING SRHR AND HIV LINKAGES

Time: 45 Minutes

Session Objectives:

By the end of this session, participants will be able to explain:
- What linkages entail at service delivery level
- Models of SRHR and HIV service integration

Advance Preparation

- Prepare materials
  - Power point slides: Session V-Implementing Linkages
  - Prepare enough flip chart and markers
  - Laptop and LCD projector

Process:

Activity 1: Session Objectives (5 minutes)

1) Introduce the objectives of the session (Slide 2)
Activity 2: Brainstorming on SRHR & HIV service integration (15 minutes)

1) Lead a brainstorming session about Linkages at service delivery level. To guide the discussion, ask:
   - Which SRHR and HIV services are you currently integrating at service delivery level?
   - What lessons did you learn from the provision of integrated SRHR & HIV services?

Note the responses for the two questions on the flipchart.

Activity 3: Service Delivery Integration (15 minutes)

1) Using power point slide (slide 3-9) summarize the key points, linking the discussion to the points raised during brainstorming.
Service Delivery Integration Conceptual Framework

Examples of Bi-directional Integration

<table>
<thead>
<tr>
<th>From SRH to</th>
<th>HIV</th>
<th>From HIV to</th>
<th>SRH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning into HIV counseling and testing</td>
<td>HIV counseling and testing into family planning programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning into prevention of mother-to-child transmission</td>
<td>HIV counseling and testing into antenatal care including congenital syphilis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning into HIV treatment, care and support</td>
<td>HIV treatment and care into community based reproductive health interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI management including cervical and other cancer screening into HIV treatment, care and support</td>
<td>HIV treatment and care into post-partum care canters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal care into HIV treatment care and support</td>
<td>Antiretroviral therapy into SRH service delivery programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing violence against women and girls into PMTCT programs</td>
<td>Promotion of male involvement in HIV prevention into SRH services for men</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Models of Integration

- **On-site integrated SRHR-HIV service delivery:**
  - "One-stop shop": Relating to or providing a comprehensive health services at a single location. A one-stop health care. In the one-stop shop model, SRHR-HIV integrated services are usually offered by one service provider in one room during the same visit.
  - "Supermarket approach": In this model, integrated SRHR-HIV services are offered by several service providers, usually located in different rooms during the same visit.

- **Off-site integrated SRHR-HIV services**: are offered outside the facility through facilitated referral.

- **The mixed model approach**: Some services are initiated in one facility, but are provided in another. Or, some services are offered in one facility while others are offered in a different facility.

Missed Opportunities for Integration

- Integration of SRH and HIV services for key populations

- Cervical cancer screening for women in HIV care and treatment clinics

- Lifelong ART for pregnant women

- GBV prevention and counseling in HIV care and treatment clinics
Providers Perspectives

Positive
- Availability of multiple services increases client and therefore provider satisfaction
- Promotes accountability and responsibility because up to you to offer all services to client
- Allows some providers practice skills which they could not practice when they provided un-integrated specialized service
- Can promote collaboration between colleagues

Negative
- Poor understanding of precisely what integration means
- Concern that most staff either not trained or are lagging behind in skills
- Increased workload, more frequent experience of ‘burn out’
- Staff not clear of support/supervision
- Pre-existing deficiencies (lack of rooms, staff, drugs/equipment)
- Weak clinical information system

Key Steps to Delivering Integrated SRHR and HIV Services
- Making sure that integration does not overburden existing services in a way that compromises service quality, by ensuring that integration actually improves healthcare provision
- Managing any potential increased workload for staff who take on additional or ‘task-shifting’ responsibilities
- Allowing for increased costs initially when setting up integrated services and training staff
- Combating stigma and discrimination from and towards healthcare providers
Activity 4: Session Wrap-up (10 minutes)

- Ask if there are any last questions or comments
- Ask participants to indicate how they plan to manage patient flow at a health facility in order to enhance provision of integrated SRHR and HIV services
- Ask participants to indicate how they plan to meet the SRHR and HIV service needs of vulnerable and key populations
- Review session objectives
SESSION VI: THE SRHR AND HIV SERVICE INTEGRATION GUIDELINES

Time: 2 hours

Session Objectives:

By the end of this session, participants will be able to:
- Understand the purpose of the service integration guidelines
- Apply the minimum package of services in everyday work

Advance Preparation

- Prepare materials
  - SRHR & HIV service integration guidelines
  - Flipchart and markers
  - End of course evaluation form (Appendix 2)
  - Laptop and LCD projector

Process:

Activity 1: Session objectives (5 minutes)

1) Introduce the objectives of the session (Slide 2)
Activity 2: Objectives and basic assumptions of the guidelines (10 minutes)

1) Using slides 3-8 discuss the objectives, intentions and basic assumptions of the guidelines.

Objectives of the Guidelines

- **Promote efficient and effective linkages** between SRH and HIV policies and services as part of strengthening the health systems;

- **Provide national standards** for the provision of high quality integrated SRH and HIV services for all groups of people in society based on principles and values of equity, human rights, gender equality and socio-cultural sensitivity; and

- **Address policy, systemic and service gaps and barriers** to SRH and HIV linkages
Intended Users

- The guidelines build on current experiences of integration. Integration is already happening, especially at the primary health care level.

- The guidelines will be used by:
  - SRH and HIV service providers at all levels of health care,
  - Health program managers at all levels, and
  - Policy makers in health

How to Use the Guidelines

- The health providers will use the minimum packages for integrated SRHR-HIV services as reference in their everyday practice.
  - The minimum packages will be summarized in a form of job aid for ease of use by providers.

- Health program managers and policy makers will refer to the basic health system and policy requirements identified in the guideline in order to create an enabling policy and system that support the smooth implementation of integrated service delivery at facility and community levels.

Minimum Package: Basic Considerations

- Bi-directional integration: Integrating HIV services into SRHR services and vice versa

- Prioritization: In reality not all SRHR services need to be integrated with HIV services and vice versa. Minimum packages of integrated services have been identified based on experience and programming realities for which integrations is likely to lead to important public health benefits.

- Feasibility: The integrated services need to be delivered effectively, safely, and in cost effective manner. Services should be acceptable to the client and feasible to the health system, especially to the provider.
Minimum Package: Basic Considerations

- **Modes of service delivery**: The mode of delivery of priority integrated services will take either:
  - on site-one stop
  - on site-supermarket
  - off site through referral or
  - mixed approaches depending on availability of services and feasibility at each level of care.

- **Existing service guidelines and protocols**: Integration processes are informed by existing service guidelines and protocols related to both SRHR and HIV services so as to avoid duplication and confusion of users.

Minimum Package: Basic Considerations

- **Policy and Strategy**: The Guideline is informed by National SRHR and HIV strategies and policies, international policy frameworks and commitments.

- **Health Systems Strengthening**: Integrated service packages were developed within the broad framework of strengthening the overall primary health care system.

  - It takes into consideration the six interlinked building blocks for health systems as defined by WHO

Activity 3: Minimum Package of Services (1 hour, 30 minutes)

1) Using slides 9-12 and the SRHR and HIV service integration guidelines discuss the minimum packages of services at Rural/urban clinics; Rural hospital; and at Secondary, Tertiary and Referral levels (15 minutes).
Flow Charts for Minimum Package

Minimum Package of Services at Rural/Urban Clinics

- At this level, all health services are provided as a **one stop or supermarket approach** as most facilities are run by one or two nurses.

- SRHR and HIV services are integrated in the overall health delivery system.

- As services are already integrated, for the sake of standardization the minimum packages are proposed based on client’s reason for visit- **index visit** (refer to page 27-29 of the guidelines).

- The minimum package of services are organized based on the types of SRHR and HIV services provided at this level of care.
Minimum Package of Services at Rural Hospital

- In Rural hospitals all health services are integrated by “supermarket approach”.

- SRHR and HIV services are integrated in the overall health delivery system.

- The reason for visit: Index visit is taken as an entry point for other SRHR and HIV services and information provision.

- The minimum package of services are organized based on the types of SRHR and HIV services provided at this level of care

Minimum Package of Services at Secondary, Tertiary & Referral Levels

- SRHR and HIV services are mainly provided by different providers.

- The provincial (tertiary) and referral hospitals, in addition, manage complicated SRHR and HIV related cases referred from district hospitals.

- The minimum level of services to be incorporated either related to SRHR or HIV depending on the reason for visit: Index visit. It includes only services to be incorporated in addition to the main reason for visit.

- The minimum package of services are organized based on the types of SRHR and HIV services provided at this level of care

2) Divide participants into three groups. Ask them to discuss and role play how they envisage service integration by applying the minimum package in a real situation as outlined in course exercise 6.1 (1 hour, 30 minutes minutes).
Course Exercise 6.1 Group work

| Purpose                           | Help participants internalize the minimum package at each level of care  
|                                  | Identify issues that need clarification in the implementation of minimum package.  
| Time                             | 1 hour, 30 minutes  
| Materials                        | Flip chart and markers  
| Activities                       | Divide participants depending on the level of care they are currently working.  

**Group I: Rural/urban clinic**

**Group II: Rural Hospital**

**Group III: Secondary, Tertiary and Referral levels**

Ask each group to look at the minimum package for the level of care they are assigned to work and identify one type of integrated service from the minimum packages outlined in the service integration guidelines. Instruct them to discuss and role play how they envisage to practically implement service integration by applying it in a real situation.

Allow 30 minutes for the group to finalize the role play.

Allow each group to present their role play in plenary in 10 minutes, and then allocate 10 minutes for plenary discussion. During plenary lead the discussion by posing questions to the group and other participants: Ask them the strengths and limitations observed; how practical are the proposed minimum packages? Any emerging practical issues from the role play?

**Activity 4: Session Wrap-up (10 minutes)**

- Ask if there are any last questions or comments
- Review session objectives

**Activity 6: End of course evaluation (15 minutes)**

1) Distribute end of course evaluation form (Appendix 2) to participants and collect after 15-20 minutes. Remind participants when 10 minutes are left. Explain to participants the aim of the evaluation and make sure to tell them that the form is anonymous.
## Appendix 1: Training Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30-08:45</td>
<td>Opening remark and participants introduction</td>
<td>MOHCC</td>
</tr>
<tr>
<td>08:45-09:15</td>
<td>Expectations, training objectives, course package and agenda</td>
<td>Facilitator</td>
</tr>
<tr>
<td>09:15-09:55</td>
<td>Introduction to linkages</td>
<td>“</td>
</tr>
<tr>
<td>09:55-10:30</td>
<td>Benefits of linkages</td>
<td>“</td>
</tr>
<tr>
<td>10:30-10:50</td>
<td>TEA BREAK</td>
<td>“</td>
</tr>
<tr>
<td>10:50-11:20</td>
<td>Principles of linkages</td>
<td>“</td>
</tr>
<tr>
<td>11:20-12:30</td>
<td>Implementing linkages</td>
<td>“</td>
</tr>
<tr>
<td>12:30-02:00</td>
<td>LUNCH BREAK</td>
<td>“</td>
</tr>
<tr>
<td>02:00-03:30</td>
<td>The SRHR &amp; HIV service integration guidelines</td>
<td>“</td>
</tr>
<tr>
<td>03:30-03:50</td>
<td>TEA BREAK</td>
<td>“</td>
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<tr>
<td>03:50-04:40</td>
<td>The SRHR &amp; HIV service integration guidelines continues</td>
<td>“</td>
</tr>
<tr>
<td>04:30-05:00</td>
<td>Course evaluation and closure</td>
<td>MOHCC</td>
</tr>
</tbody>
</table>
Appendix 2: End of Course Evaluation Form

Please answer all sections of this evaluation form, using the reverse side for comments, if needed. Your responses will assist the training organizers in determining what modifications, if any, should be made to this training.

I. Overall Evaluation

Select the choice that best reflects your overall evaluation of this training:

_____ Very good _____ Good _____ Fair _____ Poor _____ Very poor

II. Achievement of Session Objectives

For each objective (below), please circle the number that reflects the degree to which you feel that objective was achieved (or the task described in the objective was mastered):

5 = totally achieved
4 = mostly achieved
3 = somewhat achieved
2 = hardly achieved
1 = not at all achieved

For any objectives given a rating of 1, 2, or 3, please indicate in the comments/Suggestions column why you feel that it was somewhat, hardly, or not at all achieved, and please offer any suggestions you might have to improve it.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Score</th>
<th>Comment/suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Introduction to linkages</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>2) Benefits of linkages</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>3) Key principles of linkages</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>4) Implementing linkages</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>5) Service integration guidelines</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
</tbody>
</table>
III. Other Aspects of the Training

Please indicate on a scale of 1 to 5 to what degree you agree with the following statements (1 = do not agree at all, 2 = hardly agree, 3 = somewhat agree, 4 = mostly agree, 5 = totally agree).

1. The training was well organized (overall assessment of logistical arrangements and facilitations).
   
   1  2  3  4  5

2. The facilitators were well prepared and assisted the participants at every stage.
   
   1  2  3  4  5

3. I was able to participate as much as I wanted to.
   
   1  2  3  4  5

4. There was a good balance between presentations and participatory exercises.
   
   1  2  3  4  5

5. I was able to benefit from the experience of my colleagues during the training.
   
   1  2  3  4  5

IV. General comments

1. What else should be done to improve the training?
   
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

2. What other opinion, comments or suggestions do you have about the training?
   
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
Appendix 3: Pre and Post Course Knowledge Assessment

Circle the correct answer(s)

1. Integration is the bi-directional synergies in policy, programs, services and advocacy between SRH and HIV.
   
   a) True
   b) False

2. The rationale for SRH and HIV linkages includes which of the following?
   
   a) Sexual and reproductive ill-health and HIV share root causes, including poverty, limited access to appropriate information, gender inequality, and cultural norms
   b) The risk of HIV transmission and acquisition can be increased due to the presence of certain STIs
   c) Target groups for HIV and SRH services are generally the same
   d) All
   e) None

3. The leading indirect cause of maternal death in Zimbabwe is:
   
   a) Abortion
   b) Obstructed labor
   c) Sepsis
   d) HIV and AIDS

4. Key local responses to SRH and HIV linkages include the following
   
   a) The structure of MOHCC
   b) Rapid assessment of SRH and HIV integration and linkages
   c) Integrated support program
   d) All
   e) b & c only

5. In general it was envisaged that HIV-related stigma and discrimination can be reduced through integration of SRH and HIV services
   
   a) True
   b) False

6. Some studies showed that the following factors promote successful integration of SRH and HIV services
   
   a) Positive staff attitudes and non-stigmatizing services
   b) Training of health care providers and managers
   c) Engagement of key populations
d) All of the above  
e) a & b only

7. Currently there is adequate evidence to demonstrate the benefits of SRH and HIV linkages
   a) True
   b) False

8. Recognizing the centrality of sexuality and community participation are the key foundations for linked SRH and HIV services
   a) True
   b) False

9. In the Zimbabwean context all SRH services need to be integrated with HIV services and vice versa.
   a) True
   b) False

10. SRH and HIV integrated services should always be offered by one service provider in one room during the same visit.
    a) True
    b) False