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______________________________

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

This reference manual is designed to provide an up-to-date quick reference on sexual and reproductive health and rights (SRHR) and HIV linkages during the training of health care providers and managers in SRHR and HIV linkages and integration. It serves as a reference source for both the participants and the trainers. The manual contains information that is consistent with the course objectives and, therefore, it becomes an integral part of the classroom discussions and exercises.

The manual is designed for use by health care providers and managers at all levels of health care system in Zimbabwe, who are responsible for managing and providing SRHR and HIV clinical, counselling and health promotion services.

This reference manual is comprised of 5 sections:

1. **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 the process that led to linkages. It also highlights the SRHR and HIV context in Zimbabwe as well as the linkages programme.

2. **Benefits of Linkages**: This section explores the benefits and evidences of the bi-directional linkages between SRHR and HIV policies, programmes and services.

3. **Principles of Linkages**: Elaborates the key philosophical foundations of SRHR and HIV linkages.

4. **Implementing Linkages at Policy, System and Service Delivery Levels**: Presents what linkages entail at policy, system and service delivery levels, including models of SRHR and HIV service integration.

5. **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.
1. INTRODUCTION TO SRHR AND HIV LINKAGES

This section sets the scene for subsequent sections in this document by explaining key terms and concepts in SRHR and HIV linkages, including the rationale for linking SRHR and HIV at policy, system and service delivery levels, and historical perspectives and process that led to linkages. The highlights on linkages project and SRHR and HIV situation in Zimbabwe presented at the end of this section introduces the context of SRHR and HIV linkages in the country.

1.1 Definition of Key Terms

Understanding the meanings of key terms used in SRHR and HIV linkages is an essential starting point to understanding SRHR and HIV linkages.

(i) Integration and Linkages

INTEGRATION: Different kinds of SRHR and HIV services or operational programmes 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.\(^1\)

SRHR and HIV integration refers to the delivery of reproductive health and HIV services within the same setting, during the same hours, and, preferably, under the same roof, or as part of a facilitated referral within the same facility or to off-site facilities. Thus, clients or patients typically receive both SRHR and HIV services in one visit.

Examples of SRHR and HIV integrated services provided at various units or levels of care:

- **Community level**: Condoms and family planning (FP) pills; IEC on HIV prevention, treatment, care and support and FP
- **Maternal and Child Health / FP clinic**: HTC and antenatal care; HTC and postpartum care; STI screening and ARV prophylaxis.
- **HIV Testing and Counselling (HTC) Centers**: FP and HTC
- **Comprehensive Care Centers / OI/ART Centres**: TB Screening and ART; FP and ART

NB: A key feature of integrated services is that during one session or single visit, a client receives more than one service (i.e. an additional service besides the index service for which the client seeks care).

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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.

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.

**LINKAGES**: The bi-directional synergies in policy, programmes, services and advocacy between SRHR and HIV. It refers to broader human rights based approach, of which service integration is a subset.

At the macro level of senior managers and policy-makers, integration happens when decisions on policies, financing, regulation or delivery are not inappropriately compartmentalized. This means bringing together different technical programmes, but also considering the whole network of public, private and voluntary health services, rather than looking at the public sector in isolation. For an effective integration of services at the facility level to happen, there is need to create an enabling environment that fosters HIV and SRHR bi-directional linkages at the policy, systems and service-delivery levels.

**Figure 1: Linkages and Integration**

The idea of integrated health services is not new. It was the basis for the focus on primary health care in the 1980s. It is the most logical way to organize a health system – indeed the only way that does not

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2 OP. Cit. 1
compromise universal access to a broad range of services. The current challenge is to be specific about what integrated services look like – what are the key functions which need to be delivered?

The term “integrated health services” has several usages and can refer to a number of different health service issues. For further details, please refer to WHO technical brief No. 1, 2008.

(ii) **Bi-directionality:** Both linking sexual and reproductive health and rights (SRHR) with HIV-related policies and programmes and linking HIV with SRHR-related policies and programmes. It implies that linkages work in both directions, such as from SRHR to HIV and vice versa. It is about linking SRHR with policies, programmes and services of HIV and likewise HIV with policies, programmes and services of SRHR.

**Figure 2: Examples of bi-directionality of linkages**

![Diagram showing bi-directionality of linkages]

Integration of HIV services into SRHR services  
Integration of SRHR services into HIV services

(iii) **Dual protection:** A strategy that prevents both unintended pregnancy and sexually transmitted infections (STIs), including HIV, through the use of condoms alone, or combined with other FP methods (dual method use).³

(iv) **HIV and AIDS programmes and policies:** Include the complete spectrum of prevention, treatment, care and support activities, as well as the broad guidance which establishes appropriate and timely implementation and development of HIV policy. Core programmes and policies relate to HIV and AIDS include HIV counselling and testing, prophylaxis and treatment for people living with HIV opportunistic infections (OIs) and antiretroviral therapy (ART), home-based care and psycho-social support, prevention for and by people living with HIV, HIV

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prevention for the general population, male and female condom provision, prevention of mother-to-child transmission (PMTCT) of HIV, and specific services for key populations.4

(v) **Key populations:** Populations for which HIV risk and vulnerability converge. Key populations are distinct from vulnerable populations that are subject to societal pressures or social circumstances, which may make them more vulnerable to exposure to infections, including HIV. They are both key to the epidemic’s dynamics and key to the response, implying that HIV epidemics can be limited by concentrating prevention efforts among key populations and they can play a key role in responding to HIV. Key populations vary in different places depending on the context and nature of the local epidemic, but in most places, they include sex workers (SWs) and their clients.

(vi) **Prevention for and by people living with HIV:** This is a set of actions that help people living with HIV (PLHIV) to live longer and healthier lives. It encompasses a set of strategies that help PLHIV to: protect their own sexual and reproductive health and avoid other STIs; delay HIV disease progression; and promote shared responsibility to reduce the risk of HIV transmission. People living with HIV and those who are HIV negative both play an equal role in preventing new HIV infections. Key approaches for prevention for and by people living with HIV include individual health promotion (positive living, good nutrition), access to HIV and sexual and reproductive health services, community participation, advocacy and policy change.5

(vii) **Risk and vulnerability:** Risk is defined as the probability or likelihood that a person may become infected with HIV. Certain behaviours create, increase, and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown, multiple sexual partnerships involving unprotected sex, and injecting drug use with contaminated needles and syringes. Vulnerability results from a range of factors outside the control of the individual that reduce the ability of individuals and communities to avoid HIV risk. These factors may include: (1) lack of knowledge and skills required to protect oneself and others; (2) factors pertaining to the quality and coverage of services (e.g. inaccessibility of services due to distance, cost or other factors); and (3) societal factors such as human rights violations, or social and cultural norms. These norms can include practices, beliefs and laws that stigmatize and disempower certain populations, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.6

(viii) **Sexual and reproductive health programmes and policies:** Includes, but is not restricted to: services for family planning; infertility services; maternal and newborn health; prevention of

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5 Op. Cit. 4

unsafe abortion and post abortion care; prevention of mother-to-child transmission of HIV; sexually transmitted infections, including infection from HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; promotion of sexual health, including sexuality counselling, and prevention and management of gender based violence.\textsuperscript{7}

\begin{quote}
Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes.

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.\textsuperscript{8}
\end{quote}

\subsection*{1.2 Rationale}

The world is moving towards 2015 when progress towards attaining the MDGs will be ultimately judged. Increasingly these goals are recognized to be intertwined, though progress towards the goals is still insufficiently capitalizing on opportunities to strengthen a united response. The evidence\textsuperscript{9} that, in Sub-Saharan Africa, HIV was the leading cause of death in women of reproductive age, and in particular that HIV contributes significantly to maternal mortality, reverberated throughout the reproductive health and HIV communities. It was a wakeup call that the health MDGs 4 (child health), 5 (Improving maternal health), and 6 (Halt the spread of HIV and other diseases), are interconnected. Clearly, universal access to reproductive health services and to HIV prevention, treatment, care and support are joint goals. And together, they will contribute to and cannot be achieved without attaining MDG 3 – gender equality and empowerment of women.

Reinforcing and scaling up linkages between HIV and SRHR is critical for the achievement of the health related Millennium Development Goals namely: MDG 4 (Reduce child mortality); MDG 5 (Improve maternal health) and MDG 6 (Combat HIV/AIDS, Malaria and other diseases).

\textsuperscript{7} Op. Cit. 4
\textsuperscript{8} International Conference on Population and Development -- Cairo 1994; Programme of Action, para 7.2
**Figure 3** below shows that most countries in East and Southern Africa (ESA), including Zimbabwe, are off target towards reaching the MDGs. The high HIV prevalence in these ESA countries coincides with the low progress towards MDGs.

**Figure 3: HIV prevalence and MDG 5**

The majority of HIV infections are sexually transmitted or are associated with pregnancy, child birth and breast feeding. The risk of HIV transmission and acquisition can be further increased due to the presence of certain STIs. Target groups for HIV and SRHR services are generally the same and many management and procurement issues are the same.

In addition, sexual and reproductive ill-health and HIV share root causes, including poverty, limited access to appropriate information, gender inequality, cultural norms and social marginalization of the most vulnerable populations. The international community agrees that the Millennium Development Goals will not be achieved without ensuring universal access to SRH services and an effective global response to the HIV epidemic.\(^\text{10}\)

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\(^{10}\) Op. Cit. 4
Following are examples of key data:

- Globally, the two top causes of death in women of reproductive age are HIV and complications related to pregnancy and childbearing, which account for 19% and 15% of all deaths in women aged 15-49 years, respectively. The growing burden of HIV infection in young sexually active women, and the maternal health problems that they face, have been described as two intersecting epidemics.\textsuperscript{11} The 2010-11 Zimbabwe Demographic and Health Survey (ZDHS), shows that the maternal mortality ratio rose from 283 per 100 000 live births in 1994 to 555 per 100 000 live births in 2005/6 and to 960 in 2010/11. The Maternal and Peri-natal Mortality Study of 2007 showed that HIV and AIDS related deaths accounted for 25% of all maternal deaths. Stronger linkages between efforts on HIV and SRHR policies, programmes and services are therefore critical in achieving MDG 4, 5 and 6. The rationale for such linkages is sound as over 90% of HIV infections in Zimbabwe are spread through sexual contact and the remainder is linked to pregnancy, childbirth and breastfeeding (mother to child transmission).

- More than 340 million people per year have a curable sexually transmitted infection, which can significantly increase the risk of HIV transmission.\textsuperscript{12}

- In sub-Saharan Africa, 63% of women have an unmet need for effective contraception and consequently a high proportion of unintended pregnancies.\textsuperscript{13} Many of these women do not know their HIV status, or are living with HIV, and have limited access to information and services. The unmet need for family planning in Zimbabwe is 13% among married women, which has remained unchanged for the past 20 years (ZDHS 2010-11).

1.3 Historical perspectives and process that led to linkages

The International Conference on Population and Development (ICPD) held in September 1994 established the effective prevention and treatment of sexually transmitted infections, including HIV, as an integral component of reproductive health services.

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), the fundamental linkages were articulated and human rights were enshrined as the cornerstone of this joint response. Other international commitments followed:

- UNAIDS policy position paper ‘Intensifying HIV prevention’ (June, 2005)
- UNGASS World Summit Outcome (September, 2005)
- UNGASS Political Declaration on HIV/AIDS (June, 2006)
- 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

\textsuperscript{11} The Lancet, Volume 375, Issue 9730, Pages 1948 - 1949, 5 June 2010  
\textsuperscript{12} UNAIDS Report on the Global AIDS Epidemic, 2006  
\textsuperscript{13} UNFPA and the Guttmacher Institute, Adding it up: The benefits of Investing in Reproductive Health Care, 2003
Family Planning.” Fifty two African countries adopted the “Maputo Action Plan”, and recommitted themselves to the goal of universal access to sexual & reproductive health & rights (SRHR). One of the key strategies of the Maputo Action Plan is to integrate SRHR programmes and STI/HIV/AIDS programmes to maximize the effectiveness of resource utilization. It is within this context that the EU and UNFPA supported project has been designed with the aim of supporting seven countries in Southern Africa, including Zimbabwe, in overcoming barriers to strengthening linkages between SRHR and HIV policies, programmes and services.

- Reproductive Health Matters (May, 2007) Ensuring Sexual and Reproductive Health for PLHIV.
- GNP+ (December, 2007) Global Consultation on Sexual and Reproductive Health and Rights of PLHIV.
- 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.
- 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…

Upholding human rights is intrinsic to the linkages agenda, in particular the human rights of people living with HIV, key populations, and women and girls. SRHR and HIV related stigma and discrimination against vulnerable people such as young persons – in particular young women and girls – and marginalized groups prevent them from attaining basic rights and health.

Despite the promise of mutual gains, a linked response has not been the norm. HIV and SRHR programming still remains largely vertical and has not, until recently, begun to be linked. Several factors have contributed to this situation, including:

- At the outset of the HIV epidemic, the need to establish an emergency response to deal with the magnitude and severity of the impact in developing countries;
- The historical roots of the HIV epidemic lead to the assumption that the “traditional” clients of SRHR services differ from the “most at risk” clients attending HIV services;
- The emergence of divergent donor funding streams that prioritize one area as opposed to another, instead of focusing on overall people-centered benefits and health systems strengthening;
- The creation of HIV units that were not linked to sexual and reproductive health units and largely neglected the sexual and reproductive needs of people living with HIV;
- The perception that HIV prevention and HIV treatment and care require two very separate responses, which has led to the SRHR community largely neglecting ARV delivery;
- The perceptions held by many sexual and reproductive health providers that HIV requires specialized training and specific skills that were outside the scope and remit of sexual and reproductive health.
Despite the current financial crisis and donor fatigue, there are a number of significant global and local health initiatives to support national processes – including:

- The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR-2) Strategy,
- The US Government Global Health Initiative,
- The Global Fund to fight AIDS, TB and Malaria,
- The International Health Partnership,
- The UN Health 4 partnership,
- The UN Secretary General Global Strategy for Women’s and Children’s Health,
- The World Bank Health Systems Strengthening Platform,
- Integrated Support Programme (ISP) in Zimbabwe,
- The structure of the MoHCC presents a unique opportunity for integration. The AIDS and TB and RH units both fall under the MoHCC as well as the National Aids Council and ZNFPC. Both AIDS and TB and RH units report to the Principal Director Preventive Services. This provides the Director with an opportunity to provide strategic leadership and coordination for SRHR and HIV integration,
- Policy documents such as the Maternal and Neonatal Health Roadmap, the Reproductive Health policy, PMTCT guidelines among others, identify the need for SRHR and HIV integration, hence presenting an entry point for advocating for integration, and
- Some level of integration especially at the service delivery level identified in the rapid assessment provide a learning opportunity from which SRHR and HIV integration can be scaled up nationally, etc.
- Zimbabwe National AIDS Strategic Plan (ZNASP II) 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.

These initiatives recognize the importance of supporting the linkages agenda and contributing to health systems strengthening.

1.3.1 Zimbabwe Project on SRHR and HIV Linkages

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

**The specific objectives of the project**

- Advocate for integrated SRHR and HIV programme delivery and funding support
- Facilitate bi-directional linkages within SRHR and HIV policies, strategies, guidelines and plans
- Strengthen management capacity to plan, 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

The project inception phase activities between January and June 2011 included the following:

- Rapid assessment conducted in October – December 2010 and the findings were validated by key stakeholders
- Wider stakeholder meeting to disseminate findings of the rapid needs assessment was held in March 2011. The meeting endorsed the findings of the rapid assessment and country priorities were identified
- SRHR and HIV Linkages Technical Committee and M&E Technical Working Group were established and formalized
- Log frame, implementation plan, an advocacy and visibility plan, M&E plan, 2011 annual work plan were developed

The Rapid Assessment on SRH and HIV linkages and Integration

The following methodologies were used to conduct the rapid assessment:

- **Desk Reviews**: Documents on SRHR and HIV policies, strategic and guidelines were reviewed, including – reproductive health (RH) policy, male circumcision strategy, Zimbabwean National AIDS Strategic Plan (ZNASP), behavior change strategy, adolescent sexual & reproductive health (ASRH) strategy, PMTCT strategic plan, ART guidelines, HTC guidelines, National Health Strategy, MNH road map, etc.
- **Key Informant Interviews**: These were conducted at National, Provincial, District and Primary Care Levels with representatives from MOHCC, NAC, ZNFPC, UN Agencies, Development agents, Bilateral agencies, NGOs / CSOs
- **Exit interviews** were conducted with clients at health facilities
- **Interviews with community agents** were held mainly with Village Health Workers, HIV facilitators and CBDs
- **General observations** were done at the facilities that were visited (Government and Mission Hospitals, and Clinics/RHCs)
- Four (4) provinces selected for the field assessment and 143 interviews were conducted,
The box below summarizes some of the barriers identified in the rapid assessment.

**Rapid Assessment Key Findings: Barriers to SRHR and HIV integration in Zimbabwe**

**Policy related barriers:**
- Lack of national policy or framework and standard operating procedures to guide SRHR and HIV integration
- Inadequate coordination between SRH 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

**System and 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

**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 programmes

**Opportunities Identified**

Despite all the above barriers, the assessment identified several opportunities and entry points that can be explored for SRH and HIV integration in Zimbabwe. The opportunities include:

- Global focus and attention for SRHR and HIV integration as good practice.
- Renewed global focus on maternal and neonatal health with a view towards attainment of MDG 4, 5 and 6.
Many national SRHR and HIV strategic documents were under review. This presented an opportunity to ensure that SRHR and HIV linkages agenda was addressed.

The structure of the MOHCC presents a unique opportunity for linkages. The AIDS and TB and RH units both fall under the MOHCC as well as the National AIDS Council and the Zimbabwe National Family Planning Council. Both RH and AIDS and TB Units report to the Principal Director Preventive Services. This provides the Director with an opportunity to provide technical leadership and coordination for SRH and HIV linkages.

Some level of integration especially at service delivery level was identified. This already forms a learning ground from which SRH and HIV integration can be scaled up nationally. Some policies such as the Maternal and Neonatal Health Road Map also strongly call for SRHR and HIV integration. These form clear entry points for SRHR and HIV linkages.

The strong civil society organizations, if well coordinated, present an opportunity for SRHR and HIV linkages.

Integrated reporting structure for health workers at the provincial level.

Existing community structures such as village health workers, community based distributors, home based care providers and behaviour change facilitators were identified during the assessment as an important resource for promoting integration at the community level, with adequate capacity building.

**Country Priorities**

The following are country priorities identified by all stakeholders based on the key findings of the rapid assessment:

- Recruit an officer in MOHCC to coordinate SRHR and HIV integration work
- 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 monitoring and evaluation (M and E) tools to ensure collection of relevant integrated SRHR and HIV data
- Train service providers and management on SRHR and HIV linkages

**National Linkages Framework:**

- **Policy level** – At this level there should be joint planning, review of strategies and policies, coordination, development of standardized SRH and HIV integrated service guidelines and protocols
- **Systems Level** – Pooled funding mechanism, integrated M and E system
- **Service delivery level** – Develop models of integration, training of providers, establish centers of excellence
- **Community level** – Develop community strategy for integration, demand creation, training of CHWs

**The progress of the project**

- Project coordinator was recruited in August 2011.
- An 18 member National Technical Committee on HIV and SRHR linkages chaired by the MOHCC Principal Director Preventive Services was constituted and formalized.
- Three sub-committees/working groups were formed and these report quarterly to the technical committee (M and E Technical Working Group, Advocacy, Visibility and Publicity subcommittee and the Service Guidelines and Training Subcommittee.
- Advocacy package was developed with materials for the different targets that include policy makers, service providers, media personnel, community based service providers and members of the civil society.
- Sensitization and advocacy sessions were commenced and will continue to be conducted
- A compendium of indicators to monitor the integration process was developed. An indicator definition guide was also developed. Five indicators were identified.
- SRHR and HIV service integration guidelines were developed, validated and pretested with the target groups.
- Three training modules for managers, service providers and community based workers were developed and pilot tested.

**1.4 Overview of SRHR and HIV and AIDS in Zimbabwe**

**1.4.1 Overview of the HIV and AIDS Situation and Response Analysis**

Zimbabwe has a generalized epidemic with HIV primarily transmitted through heterosexual means. Adult HIV prevalence has declined from 18% (2005-06 ZDHS) to 14.67% (17% urban, 15% rural with provincial differentials) in the 2010-11 ZDHS. The prevalence is 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. Out of 2,700 cohabiting couples tested for HIV in the 2010-11 ZDHS, 12% of couples were discordant. Among key populations like female sex workers different studies found 3-5 times as high infection rates than among the general population.

Figure 4 below shows that the estimated number of new HIV infections in adults (age 15 to 49 years) peaked in 1992. The number of new adult infections declined from 1993 through 2008. Thereafter, the new adult infections shows slight increase. The new infections were estimated to increase to 66,156 (55,801 – 79,132) in 2009.
Globally, Zimbabwe remains among the countries with high HIV infection rates; it carries the third largest HIV burden in Southern Africa and has one of the highest rates of premature adult mortality, largely due to HIV-related illnesses. The key drivers of the HIV spread include low and inconsistent levels of condom use, multiple concurrent partnerships, age disparity in sexual relationships and low rates of male circumcision.

Availability and accessibility of ART has drastically decreased the HIV-related mortality. However, AIDS is still a leading cause of mortality in Zimbabwe. It is estimated that in 2010 alone 59,318 adults and 11,981 children died of HIV-related illnesses. AIDS related deaths have left in their wake large numbers of orphans and vulnerable children: it is estimated that 25% of all children in Zimbabwe have lost one or both parents to AIDS. Zimbabwe is however committed to achieving the vision of zero new HIV infections, zero discrimination, zero AIDS-related deaths.
The key principle of the country’s response hinges on one multi-sectoral action framework, one national coordinating authority and one monitoring and evaluation system guiding and consolidating HIV-related action at all levels across sectors. Particular attention is paid on ensuring genuine participation in the responses of public sector and civil society, including people living with HIV and in supporting partnership and coordination mechanisms at the national and decentralized levels.

The National AIDS Trust Fund (NATF) collected and disbursed, in line with the Zimbabwe National AIDS strategic plan priorities, USD5.7 million in 2009 and USD15.9 in 2010 and the incremental trend has continued to 2013. The NAC and partners have succeeded in attracting a significant amount of external and internal resources. Bilateral and multilateral agencies contributed a total of USD38 million in 2009 alone.

The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) has contributed and committed about USD158.7 million towards the HIV response (rounds I, V and VIII funding) during the ZNASP I implementation. A consortium of bilateral development partners have supported the national HIV response through the Expanded Support Program (ESP), which has contributed a total of USD66 million over 2007-10. Following its closure in 2012, the ESP was replaced by the Integrated Support Program (ISP) which focuses on provision of integrated HIV, SRH and GBV services. The ISP has special component that, in addition, focuses on mobilizing demand for uptake of the integrated HIV, SRH and GBV services.

Universal access to HIV services is achieved through sustained scale up in availability, accessibility and quality prevention, treatment, care and support services delivered at all levels by public, private and civil society providers. Efforts are made to create an enabling environment for more effective and efficient responses, in particular in strengthening the national regulatory frameworks and practices and effective functioning of mechanisms to ensure protection and fulfillment of human rights and gender equality.

In scaling up the HIV services, the country aims at achieving equitable access to products and services through:

- Interventions that address the key drivers of the HIV epidemic
- Meeting the needs and ensuring participation of the most vulnerable and most affected populations
- Integrated provision of services, with strong service linkages and operational referral mechanisms, for optimized expenditure, increased service coverage and improved prevention, treatment and care outcomes.
1.4.2 Overview of SRHR Situation and Response Analysis

The Zimbabwe Demographic and Health Survey (ZDHS) of 2010-11 reported the maternal mortality ratio (MMR) at 960 per 100,000 live births, which is higher than that measured in the 2005-06 ZDHS (612 maternal deaths per 100,000 live births). The high MMR in 2010-11 could be partly attributed to the impact of HIV and AIDS but, with the widespread use of Highly Active Antiretroviral Treatment (HAART), this effect would be expected to have decreased. According to 2007 Maternal and Perinatal Mortality Study HIV and AIDS is the leading indirect cause of maternal death, attributable to the high prevalence of HIV infection, the low percentage of women whose status is known during pregnancy, and the lack of access by women to ARVs.

The 2010-11 ZDHS reported ANC coverage of 90%. However, only 19% of the women received any antenatal care during their first trimester. Up to 65% of the pregnant women were delivering at health facilities, and the postnatal coverage was 27%. However 12% of newborns received a postnatal check-up in the first two days after birth.

Knowledge of contraception is nearly universal in Zimbabwe with 98% percent of women and 99% of men report knowing about a contraceptive method (ZDHS 2010-11). Contraceptive prevalence rate among married women of reproductive age (15-49 years) was 59% with 57% using a modern method. The most popular contraceptive method is the pill, in use by 41% of married women. Government-sponsored facilities remain the chief providers of contraceptive methods in Zimbabwe with 73% of users of modern contraceptive methods obtaining them from the public sector. The unmet need for family planning was 13% among married women of reproductive age (13.4% rural, 11.6% urban), which has remained unchanged for the past 20 years. The unmet FP need is highest (26.2%) in Matabeleland South, with little variation in the other provinces. If all married women with an unmet need for family planning were to use a contraceptive method, the prevalence rate in Zimbabwe would increase from 59 to 74% (ZDHS 2010-11).

A high rate of teenage pregnancy was recorded in 2010-11 ZDHS, at about 24%. Rural teenagers, those with less education, and those in the lowest wealth quintile tend to start childbearing earlier than other teenagers.

The ASRHR strategy 2010-2015 was developed to guide the MOHCC’s efforts in providing quality, affordable and appropriate sexual and reproductive health services to young people of Zimbabwe. It also provides guidelines to relevant parastatals, policy makers, various line ministries, non-governmental organizations and communities. This entails defining the key ASRH problems, key strategies to be adopted to address the identified ASRHR problems and providing framework for standardized and well-coordinated approach for ASRHR programming during the period 2010 - 2015. The strategy seeks to adopt a preventive, promotive, curative and counseling service approach for young people (10-24 years), in line with the relevant national policies and strategies.

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14 Unmet need for family planning is defined as the percentage of women who do not want to become pregnant but are not using contraception.
The Zimbabwe maternal and neonatal health road map 2007-2015 outlines the national framework for planned activities and aimed at improving maternal and new born health services at institutional and program levels. It is meant to provide an increased and long term investment to reduce maternal and neonatal mortality and morbidity, and to provide guidance to all strategic partners for a more coordinated multi sectoral and national response.
2. BENEFITS OF LINKAGES

Bi-directional linkages between SRHR and HIV related policies and programs can lead to a number of important public health, socio-economic, and individual benefits. The movement to link SRHR and HIV had its impetus from both sides and is characterized by shared and separate motivations. Overall it was envisaged that linkages would yield the following mutually beneficial results:15

2.1 Evidence of Benefits

While there was general acceptance that linkages between SRHR and HIV related policies and programs were in the right direction, many national governments and donors wanted robust evidence to support their increased investment in integrated service delivery. However, scant research had been undertaken to document the benefits of this approach despite the integration of SRHR and HIV services in many settings for a considerable period of time, although not on a national scale.

Linking SRHR and HIV is a broad-scope area, embracing legal and policy areas such as age of consent to services, criminalization, and national SRHR and HIV strategies; addressing systems concerns ranging from partnerships, financing, capacity building, coordination mechanisms, and commodity security; and providing delivery of the full range of SRHR services (maternal health, Family Planning, STI and Gender Based Violence (GBV) prevention and management and other reproductive health concerns) and of HIV

15 Op. Cit. 4
services (prevention, treatment, care, and support). The clients of these services are also diverse, including women of reproductive age and their partners, young people, people living with HIV, and key populations. Hence, amassing an evidence base for this entire field is daunting. There have been discrete studies assessing certain aspects of linkages, which differ in their methodologies and robustness. Only one systematic review using the Cochrane style review has been undertaken in 2008, and even that study had methodological limitations and pointed to significant research gaps. A systematic review of the literature was conducted using standard Cochrane\textsuperscript{16} review methodology.

2.1.1 Systematic Review of SRHR and HIV Linkages\textsuperscript{17}

In order to gain an understanding of the effectiveness, optimal circumstances, best practices, and potential trends for strengthening SRHR and HIV integrated services, a systematic review of the literature published between 1990 and 2007 was conducted in 2008. The following questions guided the systematic review:

- 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?

In order to capture the most recent innovative linkages initiatives, this systematic review was not limited to peer-reviewed studies, but also included “promising practices” (‘grey’ or non-peer-reviewed literature). A total of 58 studies (35 peer-reviewed studies and 23 promising practices) met the inclusion criteria for further analysis. The search strategy identified over 50,000 citations. Of these, 58 were included in the final analysis.

\textsuperscript{16} Cochrane Reviews are systematic reviews of primary research in human health care and health policy, and are internationally recognized as the highest standard in evidence-based health care. For this particular review the methodology included a comprehensive online search of scientific databases, program websites, and consultation with experts to identify studies.

Figure 6: Matrix of study results categorized by type of linkage

This matrix was created to help classify the different types of SRHR and HIV interventions. Under HIV interventions, included were [PINK COLUMN]. Under SRHR interventions, included were [GREEN ROWS].

The numbers in each box represent the number of studies identified for each type of linkage. Several studies included multiple linkages, so the numbers reported here exceed the total number of studies included in the review. The studies integrating HIV prevention, education and condoms with SRHR services (column one) were not included in the final analysis as they have been reviewed elsewhere.

For this analysis, the first column of the matrix was excluded, because it has been reviewed elsewhere. You’ll also see the shaded box in the center, which includes element 3 of comprehensive PMTCT linked with maternal and child health. This box was excluded since the topics of antiretroviral drug treatment or prophylaxis, safer deliveries and infant feeding counseling have been covered in other Cochrane reviews.
Key outcomes of the review include the following:

**Key Findings**

- 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, including HIV testing
  - health and behavioral outcomes
  - condom use
  - HIV and sexually transmitted infection knowledge
  - overall quality of service
- Linking SRHR 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 SRHR 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.

Factors promoting and inhibiting successful integration as reported by the studies were extracted.

<table>
<thead>
<tr>
<th>Promoting Factors</th>
<th>Inhibiting Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholder involvement</td>
<td>Lack of sustainable funding and stakeholder commitment</td>
</tr>
<tr>
<td>Capacity building</td>
<td>Staff shortages, high turnover or inadequate training</td>
</tr>
<tr>
<td>Positive staff attitudes and non-stigmatizing services</td>
<td>Poor programme management and supervision</td>
</tr>
<tr>
<td>Engagement of key populations</td>
<td>Inadequate infrastructure, equipment, and commodity supply</td>
</tr>
<tr>
<td></td>
<td>Client barriers to service utilization, including low literacy, lack of male partner involvement, stigma, and lack of women’s empowerment to make SRHR decisions</td>
</tr>
</tbody>
</table>
Several gaps in the existing evidence were identified in the review:

- Inadequately studied interventions
  - Linked services targeting men and boys
  - Gender-based violence prevention and management
  - Stigma and discrimination
  - Comprehensive SRHR services for people living with HIV, including addressing unintended pregnancies and planning for safe pregnancies, if desired
- Infrequently used study designs & research questions
  - Research questions that specifically address SRHR and HIV service integration
  - Study designs that compare integrated services to the same services offered separately
- Insufficiently reported outcomes
  - Health
  - Stigma reduction
  - Cost-effectiveness
  - Trends in access to services

Strengths and limitation of the review:

The strengths of this review include its broad scope – the review attempted to cover the entire field of sexual and reproductive health and HIV. The other strength was the systematic methodology based on Cochrane methods. However, because this review was so broad, it was difficult to synthesize data due to the enormous heterogeneity in the types of studies included. In addition, because promising practices are unpublished reports, the search strategy may not have captured all of them.

Linkages Research Agenda

The systemic review recommends areas warranting further action and rigorous operational research. These include:

- Which integration models are optimal in particular settings
- Impact of linkages (e.g. on unmet need for family planning, HIV incidence, stigma & discrimination, etc.)
- Cost-effectiveness of combining HIV and SRHR interventions
- Efficiency gains from integration beyond the service level (in management systems etc.) and economic gains to HIV service users
- What are the incentives for service providers in linking services
- Best models for implementing integration in a way that does not overload some service providers
- Optimizing reach of services in challenging circumstances, including in humanitarian responses, settings with diverse cultural practices, and for survivors of sexual violence.
2.1.2 The INTEGRA Project

INTEGRA was a 5 year research project funded by the Bill and Melinda Gates Foundation (Jan 2008 – Dec 2012). It is managed by the International Planned Parenthood Federation (IPPF) in partnership with the London School of Hygiene and Tropical Medicine (LSHTM) and Population Council. It is implemented in three medium and high HIV prevalence countries in Africa: Kenya, Malawi, and Swaziland.

Project Goal: To strengthen the evidence of the benefits and costs of a range of models for delivering integrated HIV and SRHR services in high and medium HIV prevalence settings.

Figure 3: Models under evaluation
Objectives:

- Determine the benefits of different integrated models to increase range, uptake and quality of selected SRHR 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.

Research questions:

1) What are the relative benefits of different models of integrated SRHR and HIV services over separately provided services? Does integration lead to:

- increases in the numbers of clients using services;
- changes in the profile of clients attending services;
- increases in the range of services accessed by clients;
- improvements in the quality of services?

2) In the target populations, what is the impact of integrated services on:

- HIV related risk behavior;
- HIV related stigma;
- Unintended pregnancy?

3) What is the cost, feasibility and cost-effectiveness of providing selected integrated services:

- What is the cost of integrating HIV and/or SRHR services with existing services? (patients and providers)
- Economies of scope. Does integration result in a more optimal utilization of existing infrastructure and human resources?

Summary of Key Preliminary Findings and Recommendations

Summary of Key Findings

Cost analysis of integrated HIV and Sexual Reproductive Health Services in Kenya and Swaziland: London dissemination meeting July 2013

There is potential for integration to improve efficiency, with variation in unit costs. Although most clinics are moderately efficient, and some some clinics with very high costs. In absolute terms there

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18 Learn more at: www.integrainitiative.org
is potential for efficiency gains in both SRHR and HIV services, through the better use of infrastructure and human resources

- Under-utilized capacity
- 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. This may in some cases be due to low demand for SRH and HIV services. If staffing clinically required, provider induced demand may be an effective way of increasing demand amongst health service users
- Staff workload may be higher with more integration (but not significant/ or controlled)
- Voluntary Testing and Counselling suggests that stand-alone may be less efficient (but this needs to be weighed with other factors).
- Limited movement in physical integration on the aggregate level, with differences by facility. Most change in physical integration happened at the health center level. Initial range of services provided by staff may enable integration, but staff workload does not appear to be a factor. Integration in the MCH unit showed the least increase, and only was possible when one of the elements of physical integration was in place.
- Uniform increases in utilization, HTC increases associated with new service provision (and integration)
- Services times fall, but possibly at the expense of quality
- No association between technical efficiency and integration
- Some suggestion of possible economies of scope and scale; association at best weak and hard to establish due to multiple drivers of costs; and limited movement over time in integration

**Summary Conclusion and Recommendations:**

- Inefficiency due to un-integrated SRH and HIV services is clear: There is room for efficiency improvement from integrating SHR and HIV services
- In practice organizational change is difficult to achieve at scale
- Efficiency gain is highly setting specific: different facilities will integrate in different ways. Need to match demand for services and resources at the facility level
- Follow-up work required to further explore how facility, contextual and patient factors impact the ability to improve efficiency through integration
- Readiness assessment should precede integration policy
- The risks of integration are clear: Adding new services may increase utilization, but with possible over-work and quality concerns
- Need to determine resourcing (not just investment, but recurrent)
- Putting in place monitoring system is important, such as simple workload indicators to track the effectiveness of integrated service provision
3. **KEY PRINCIPLES OF LINKAGES**

In order to build a common understanding between the SRHR and HIV communities of linked SRHR and HIV responses, and to ensure they are underpinned by a human rights approach, broad principles for joint action have been articulated. One of the stumbling blocks in linking these fields has been different perceptions and familiarity with principles that are fundamental to each other’s work. The following principles were articulated in 2009 by the SRHR and the HIV communities and represent consensus on the key philosophical foundations and commitments upon which linked responses must be built.

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 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.

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.

6. **Reduce stigma and discrimination:** Ensure legal and policy measures are in place to protect PLHIV and vulnerable populations from discrimination.

7. **Recognize the centrality of sexuality:** Sexuality is an essential element in human life and in the individual, family and community well-being.

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19 Op. Cit. 4
4. IMPLEMENTING LINKAGES

Implementing the linkages agenda requires a paradigm shift in the way in which all stakeholders from both the SRHR community and those in the HIV field work in unison. Yet, the two fields have often been forced into territorialism and an unhealthy competition for scarce resources rather than actively encouraged to act on any of the natural synergies. Fully realizing the anticipated benefits inherent in linking the HIV and SRHR responses requires a change in a stereotypical ‘business as usual’ approach, for example:

- National governments often appear to have strong National AIDS Councils and Country Coordinating Mechanisms for managing Global Fund to Fight AIDS, Tuberculosis and Malaria grants that do not adequately support many of the initiatives within other priority sectors, including SRHR;
- Donors who continue to support separate and unlinked responses, and impose conditions, are partly responsible for the creation of a dual track system in many countries in which the HIV portfolio is often not sufficiently linked to the SRHR portfolio, especially to maternal and child health responses; and
- The imperative of addressing the SRHR needs of people living with HIV and key populations is particularly challenging in many concentrated and low level epidemics since current laws, policies and health systems are not sufficiently supportive.

Linking sexual and reproductive health and HIV policies and practices presents an unparalleled opportunity for all relevant stakeholders, national policy makers; the donor community; national program managers (SRHR and HIV); politicians; researchers and civil society to address a range of challenges that will strengthen unified program responses.

Leadership for and about linkages is not the sole mandate of the SRHR movement. The HIV community needs to embrace and guide this agenda and increasingly networks of people living with HIV have begun to help lead this ‘linkages’ agenda and to proactively shape the content to respond to their rights and SRHR needs. Similarly, different sectors – education, the world of work, the private sector - need to meaningfully engage on relevant aspects of SRHR and HIV linkages.

The ‘why’ and the ‘what’ of linkages are clear and largely agreed. However, despite these established connections, for those on the front line of health care planning and delivery some of the key policy and service level challenges include:20

- 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
- Reorganizing/reorienting service provision processes, e.g. patient flow

- Combating stigma and discrimination from and towards healthcare providers, which has the potential to undermine the effectiveness of integrated services no matter how efficient they are in other respects
- Adapting services to attract and involve men, who tend to see sexual and reproductive health, and especially family planning, as ‘women’s business’ [e.g. SRHR information and services integrated with male circumcision for combination HIV prevention services]
- Reaching those who are most vulnerable but least likely to access services, such as young people and those from key populations
- Providing the special training and ongoing support required by staff to meet the complex sexual and reproductive health needs of HIV-positive people effectively
- Motivating donors to move from supporting parallel to integrated services, and sustaining support for integrated policies and services.

4.1. Service delivery integration

Integrating SRHR and HIV services recognizes the importance of empowering people to make informed choices about their sexual and reproductive health, and the vital role that sexuality plays in people’s lives.

The moral and programmatic imperative of bringing the HIV and SRHR responses into closer unison is clear. The 2005 Sexual and Reproductive Health and HIV/AIDS: A framework for priority linkages highlights four strategic programmatic interventions:

a) Learn HIV status and access services;

The moral and programmatic imperative of bringing the HIV and SRHR responses into closer unison is clear. The 2005 Sexual and Reproductive Health and HIV/AIDS: A framework for priority linkages highlights four strategic programmatic interventions:

b) Promote safer and healthier sex;

c) Optimize the connection between HIV and STI services; and

d) Integrate HIV with maternal and infant health.

Figure 4: Conceptual framework

21 Op. Cit. 4
Innovative in-country work on integration has exceeded the scope of the framework as many traditional SRHR facilities are increasingly providing ART delivery programs as part of their services. Many traditional HIV service providers have begun to address the SRHR needs of their HIV positive clients. Similarly, other sectors such as the ‘world of work’, and the private sector, are increasingly providing integrated services. There is also momentum to provide linked responses in humanitarian crises and conflict settings.

The table below gives some illustrative examples of various kinds of bi-directional integration that is currently being implemented in programs around the world:

**Table 1: Examples of bi-directional integration**

<table>
<thead>
<tr>
<th>From SRHR to HIV</th>
<th>From HIV to SRHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning into HIV counseling and testing</td>
<td>HIV counseling and testing into family planning programs</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>
</tr>
<tr>
<td>Family planning into HIV treatment, care and support</td>
<td>HIV treatment and care into community based reproductive health interventions</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>
</tr>
<tr>
<td>Antenatal care into HIV treatment care and support</td>
<td>Antiretroviral therapy into SRHR service delivery programs</td>
</tr>
<tr>
<td>Preventing violence against women and girls into PMTCT programs</td>
<td>Promotion of male involvement in HIV prevention into SRHR services for men</td>
</tr>
</tbody>
</table>

This conceptual framework demonstrates the following key points:

- This is just a starting point, a sampling of what is possible in a certain context. For example, sometimes STIs are considered HIV services, not SRHR services.
- The categories aren’t rigid. Bi-directionality is key: SRHR interventions into HIV service delivery settings, and HIV interventions into SRHR service delivery settings.
- Not just around prevention—treatment too. SRHR settings are increasingly delivering treatment services as well.
- While all of the linkages look like services (integration) there are structural and policies concerns embedded within each one.
Examples of Successful Integration in the Different Countries

Case Study 1: Gateways to Integration: Voluntary HIV testing and – an entry point for comprehensive sexual and reproductive health services.

All services under one roof

Haiti has one of the oldest AIDS epidemics and one of the highest rates of HIV infection in the world outside of sub-Saharan Africa. As a pioneer of integrated sexual and reproductive health and HIV services, GHESKIO has valuable lessons to share from its experience.

GHESKIO’s decision to offer sexual and reproductive health services integrated with its existing HIV program, all under one roof, was motivated partly by the following factors:

- The great majority of HIV infections in Haiti are contracted sexually
- Without intervention, about a third of infants born to women living with HIV become HIV-positive themselves, and, in Haiti, AIDS is responsible for 20% of infant death
- Although improving, stigma and lack of necessary professional skills result in many PLHIV being denied access to sexual and reproductive health care in other health facilities
- People do not have the time or money to go from one place to another to meet their different health needs.

GHESKIO has played a major role in influencing policy and practice in the Haitian national health system. This is particularly apparent in the way it has developed its model of integrated services targeting the endemic and most common diseases, such as tuberculosis, HIV, STIs, diarrheal diseases and malaria. Integrating sexual and reproductive health services into the voluntary counseling and testing network – to prevent unintended pregnancies and prevent mother-to-child transmission of HIV – has significantly increased access to services. This model of service provision was used in 22 public and private health centers and hospitals nationwide. As the country rebuilds following the devastating earthquake, such an integrated service delivery model can provide a platform for replication and scale-up.
Case study 2: Gateways to Integration: Providing ART in a sexual and reproductive health setting—A model of integrated services

The International Planned Parenthood Federation’s affiliate in Kenya, the Family Health Options Kenya (FHOK) has a clinic in Nakuru which provides a good example of the Association’s work in practice. As well as its original function offering family planning services, the clinic offers general outpatient services. Clients can attend for any reason, but every opportunity is taken to raise the topic of sexual and reproductive health and to advocate for voluntary counseling and testing. More than 300 people a month seek HIV counseling and testing, and in 2004 nearly 1,000 clients sought treatment for HIV-related opportunistic infections, which is offered as part of general outpatient services. Currently:

- All FHOK clinics provide voluntary counseling and testing for HIV
- All clinics offer programs which aim to prevent mother-to-child transmission of HIV as part of their maternal health services
- Five of the nine clinics provide antiretroviral therapy to people living with HIV.

Case study 3: Gateways to Integration: Investing in youth—Reaching those most vulnerable to HIV

The Institute for Students’ Health (ISH), Serbia, caters for a population of 110,000 students plus university staff. It also offers nondiscriminatory SRH and HIV services for key populations such as men who have sex with men, sex workers and people who use drugs. The Institute has been prepared to push out the boundaries to create a model of care that meets the needs of its target populations in a more convenient and user-friendly manner while offering health professionals more effective and satisfying ways of working. As a pioneer of integrated SRH and HIV services in Serbia the Institute found that:

- Between 2006 and 2008, 3,000 young people a year accessed a number of HIV prevention services—including voluntary counseling and testing—at the ISH Centre in Belgrade.
- From 2006 to 2008 the number of people who use drugs accessing services at the Centre quadrupled.
- The ISH Centre became the preferred voluntary counseling and testing center in Belgrade for men who have sex with men.

For further details please see Gateways to Integration\textsuperscript{22} series:

\textsuperscript{22} Gateways to Integration case studies from Haiti, Kenya and Serbia. WHO, UNFPA, UNAIDS, IPPF, 2008-2009.
4.1.1 Models of integration:

Determining the optimal model for integrating services depends on a variety of factors. To date, successful methods of service integration have captured the ground realities faced by a variety of service providers. From delivering all SRHR and HIV services by one provider to providing selected high quality health and other services through innovative partnerships. The success of many integrated SRHR and HIV services rests on the quality and effectiveness of referrals. Facilitated referrals need to be strengthened to ensure that many of the opportunistic illnesses related to HIV are addressed, including tuberculosis, malaria and hepatitis; and SRHR concerns such as infertility and cervical cancer are made priorities in HIV services.

MODELS OF INTEGRATED SRHR and HIV SERVICE DELIVERY

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

2) Off-site integrated SRHRR and HIV services: are offered outside the facility through facilitated referral.

3) 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.

What determines service delivery approach within a model?

- Infrastructure – multiple and well equipped consultation rooms
- Health care worker attitudes – refusal to provide HIV related services, poor communication
- Territorialism - stubborn refusal to change practices
- Patient load in relation to health care worker availability
- Capacity of health care workers to provide all services
- Meeting the sexual and reproductive health needs of a diverse group of people: The sexual and reproductive health desires of people living with HIV are as varied as the epidemic itself. The issues facing young people living with HIV as they embark on new relationships (repeated
Disclosure; potential sexual rejection because of HIV status, etc.) are very different to the issues facing an HIV-positive couple who may wish to conceive (healthcare provider attitudes; accessibility of appropriate services). Addressing the SRHR needs of people living with HIV would mean addressing issues as diverse as the fertility choices of women living with HIV to addressing the sexual health priorities of sex workers.

Missed Opportunities:

- Integration of SRHR and HIV services for key populations
- Cervical cancer screening for women in HIV care and treatment clinics
- Family planning in HIV care and treatment clinics
- Lifelong ART for pregnant women
- Gender based violence prevention and counseling in HIV care and treatment clinics

Opportunities for improving integrated models

- Decentralization of integrated SRHR and HIV services to primary health care level
- Shifting some tasks of Integrated SRHR and HIV services to lower/community cadres to reduce patient load
- Simplification of diagnostics - point of care CD4, hemoglobin meters, HIV rapid tests, etc.
- Simple electronic patient monitoring system for HIV can also integrate SRHR data
- Funding commitments from donors that encourage SRHR and HIV integration

Remember:

- Various models for integrated SRHR and HIV service delivery exist - fewer providing full range
- Models should include all groups targeted for SRHR services, including key populations
- Important beyond the model is the approach to service delivery of the integrated services-driven by client/patient-centered care
- Improved linkages between SRHR and HIV services at all levels should be starting point
- More research evidence needed to inform what model works in different settings

4.2 Strengthening systems

Linking SRHR and HIV requires that the supportive systems on which health and other services depend on are addressed. The overall weakness of health systems is responsible for many of the gaps that impede the full enjoyment of the right to health, including to SRHR and to HIV prevention, treatment, care and
support. Systems need to be assessed to determine the extent to which they support effective SRHR and HIV integration and linkages.

4.2.1 Imperative linkages mechanisms and systems:

While there are a number of wider health systems considerations, in the context of SRHR and HIV linkages, the following systems should be assessed and strengthened:

- **Partnerships** – for situation analysis, planning, budgeting, resource mobilization, advocacy, implementation, monitoring and evaluation by development partners including civil society (networks of people living with HIV, key populations, women’s organizations, young people, etc.)

- **Coordination mechanisms** – for SRHR and HIV joint planning, management and administration of linked advocacy and policies, and integrated services

- **Human resources and capacity building** – joint SRHR and HIV capacity building, including in-service training of health service providers, managers and trainers; increase knowledge, skills and understanding of how to eliminate stigma and discrimination and gender inequality

- **Logistics and supplies systems** – for ensuring SRHR and HIV commodities security, preferably combined systems, including but not limited to condoms for dual protection, lubricants, full range of contraceptives, STI drugs, post-exposure prophylaxis kits, delivery kits, ‘dignity’ kits for humanitarian settings, HIV test kits, post-rape kits, antiretroviral drugs, drugs for opportunistic infections, anti-malarials, iron/folate, safe injecting equipment, etc.

- **Laboratories** – for the combined needs of SRHR and HIV including hemoglobin concentration, blood grouping and typing, STI diagnosis, (including RPR /VDRL for syphilis), HIV diagnosis (including rapid tests), CD4 count, HIV viral load, liver function tests, urinalysis, pregnancy testing, diagnosis of cervical and other cancers etc.

4.2.2 Addressing stigma and discrimination through capacity building of front line service providers:

Reducing stigma and discrimination about HIV and SRHR means facing and talking openly about issues that include sexuality, drug use, sex work, sexual violence, poverty and gender inequality. As the triple combination of ignorance, prejudice and fear creates a fertile breeding ground for HIV’s continued spread; so openness, acceptance and services provide an opportunity for redress. Despite the growing global rhetoric, stigma and discrimination still hinder access to health services for people who are HIV-positive, young people, and key populations, such as sex workers, etc. Health workers need resources, information, skills and sensitivity training related to the specific needs of the diverse range of clients, including the importance of confidentiality. Therefore linking SRHR and HIV responses could act as a modality of HIV related stigma reduction.

23 Apart from offering life-saving sexual and reproductive services in an emergency, UNFPA provides ‘dignity kits’. They include a variety of things from soap, toothbrushes, underwear, and sanitary pads for menstruating women. Without such supplies, women may be unable to gather food for their families, or simply participate in everyday activities.
4.3 Policy

Health service integration alone will not be sufficient to attain even the health MDGs, as the structural determinants of HIV and SRHR must be addressed. Gender inequality, poverty, stigma and discrimination and low levels of education, will continue to impede the gains on both the SRHR and HIV fronts. Linkages support the fundamental principle of national ownership that enables governments, in partnership with civil society, to examine their human rights laws and policies. These include those related to criminalization of HIV exposure and transmission; criminalization of practices/behaviors associated with key populations; access to SRHR and HIV services including counseling and testing, rights-based family planning; gender-based violence; marriage, divorce and child custody, including, early and forced marriage; women's property and inheritance; female genital mutilation; and other punitive laws and policies that affect human rights.

Members of marginalized groups are often at particular risk of HIV infection and, once they become HIV positive, have an especially difficult time getting the support they need. Legal systems should provide special protection for key populations, people living with HIV, and marginalized groups, as well as access to quality legal services so that human rights violations can be appropriately addressed. These legal services and measures include programs to reduce stigma and discrimination; human rights capacity building of key service providers; campaigns to raise awareness of human rights; and legal audits and reform programs.

In the SRHR and HIV service integration guidelines the WHO health system strengthening framework was used to guide addressing the system and policy related issues related to linkages. It helps for creating common understanding of what a health system is and what constitutes health systems strengthening, and summarizes the points raised under section 4.1 and 4.2. above, related to system and policy aspects of linkages.

The Six Building Blocks of a Health System:

- **Good health services** are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.

- A well-performing **health workforce** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).

- A well-functioning **health information system** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.

- A well-functioning health system ensures equitable access to **essential medical products, vaccines and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.

- A good **health financing system** raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.

- **Leadership and governance** involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.
5. THE SRHR AND HIV SERVICE INTEGRATION GUIDELINES

5.1 Purpose

For integrated SRHR and HIV services to be operationalized systematically, they need to be reinforced by national policy frameworks and service guidelines that can effectively support the SRHR and HIV linkages at the system, service-delivery and community levels. In view of this, the MOHCC with support from development partners developed the guidelines.

The development of the guidelines followed an inclusive and participatory process. With an overall technical guidance of the technical committee on SRHR and HIV linkages the following key steps were followed to develop the guidelines:

- **Desk review of relevant documents**: National guidelines, standard service packages, protocols, policies, strategies on the various components of SRHR and HIV; Global guidelines and frameworks related to SRHR and HIV linkages and health systems strengthening; Documents from other countries in the region and globally; Existing service guidelines and protocols, that have integrated aspects of SRHR and HIV.

- **Discussions and interviews with key stakeholders**: One on one interviews and discussions were held with selected key stakeholders, service providers and managers, including SRHR and HIV linkage technical committee members and MOHCC (HIV and TB, and RH departments).

- **Service integration matrix**: A comprehensive SRHR and HIV service integration matrix was developed to identify the full scope of activities for integration at service delivery level after identifying the essential packages of SRH and HIV in the country). This matrix guided identifying and defining the minimum SRHR and HIV integrated elements of services for the different levels of care that are likely to lead to important public health benefits.

- **Stakeholders Consultative Workshops**: After drafting the guidelines a consultative workshop was organized to gather feedback from key stakeholders.

- **Pretesting**: The final draft guidelines were pretested in selected facilities (61 facilities, including referral, provincial, district and rural hospitals and clinics) and by community health workers, including village health workers, CBDs, behavior change facilitators and secondary care givers.

The objectives of developing the guidelines were to:

a) promote efficient and effective linkages between SRHR and HIV policies and services as part of strengthening the health systems;

b) provide national standards for the provision of high quality integrated SRHR 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

c) Address policy, systemic and service gaps and barriers to SRHR and HIV linkages
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 SRHR and HIV service providers at all levels of health care, health program managers at all levels and policy makers in health in their respective mandate to ensure integrated SRHR and HIV services are provided effectively. The health providers will use the minimum packages for integrated SRHR and HIV services as reference in their everyday practice. The minimum packages will be summarized in a form of job aids for ease of use by providers. Health programme managers and policy makers will refer to the basic health system and policy requirements identified in the guidelines in order to create an enabling policy and system that support the smooth implementation of integrated service delivery at facility and community levels.

5.2 Minimum Package of Services by Level of Care

The minimum packages were developed with the aim of standardizing the provision of integrated services and outlining the basic/priority elements of integrated SRHR and HIV services.

The minimum packages were developed based on the following Basic Considerations:

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

ii. **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. The national and local epidemiological and socio cultural factors as well as the organization and use of health services were taken into consideration.

iii. **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.

iv. **Modes of service delivery**: The mode of delivery of priority integrated services will take either a (a) on site-one stop (b) on site-supermarket approach (c) off site through referral or (d) mixed approaches depending on availability of services and feasibility at each level of care. Where feasible reorganization of services is necessary to foster on site one stop or supermarket approach.

v. **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.

vi. **Policy and Strategy**: These Guidelines are informed by National SRHR and HIV strategies and policies, international policy frameworks and commitments.

vii. **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:

   a. **Service delivery**: packages; delivery models; infrastructure and logistics; management; safety & quality; demand for care
b. **Health workforce**: national workforce policies and investment plans; advocacy; norms, standards and data

c. **Health Information**: facility and population based information & surveillance systems; global standards, tools

d. **Medical products, vaccines & technologies**: norms, standards, policies; reliable procurement; equitable access; quality

e. **Financing**: national health financing policies; tools and data on health expenditures; costing

f. **Leadership and governance**: health sector policies; harmonization and alignment; oversight and regulation

5.2.1 **Minimum Package of Services at Community Level**

The community based health care providers include VHWs, CBDs, HIV and AIDS related service providers and other specific health service providers such as secondary care givers, behavioral change facilitators. These various groups predominantly provide health promotion services and some preventive services at household level. Some provide limited curative services for minor ailments.

The basic assumption at this level of care is that all providers are expected to provide integrated SRHR and HIV services/information to clients and community at all times. Messages on HIV need to include information on SRHR and vice versa.

For detailed description of minimum packages at this level of care please refer to the SRHR and HIV service integration guidelines on pages 23-26.

**Key Requirements for SRHR & HIV Integration at Community Level**

- Trained CHW with skills to offer both SRHR and HIV information and services
- Job aids that guide integrated approach, such as flow charts, cue cards, etc.
- Information pack/client materials
- Basic supplies that support the provision of SRHR and HIV services: Condoms, condoms demonstration models, contraceptives, lubricants
- Tools for documenting the provision of integrated services (For example registers)
- Strong referral linkages and referral tools, where required, to ensure that clients are followed up if they receive services referred for
- Community based health care strategy that promotes integrated SRHR and HIV service delivery approach
- Supportive Ministry of Health policies, strategy, guidelines and leadership
- Effective facility-community linkages and sustained community mobilization
- Multidisciplinary coordination and supervision teams
5.2.2 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.

Sexual and reproductive health services being provided in rural clinics include:

- Family planning information, counselling and services;
- ANC;
- Labor and safe delivery;
- Newborn care
- PNC;
- Prevention and management of STIs/RTIs, including HIV and AIDS;
- Information and screening or referral for screening and management of cancers of the reproductive system (cervical, breast and prostate cancers); and
- Addressing SRHR needs of men and promotion of male involvement in SRHR

The HIV services at rural clinics entails:

- HIV counselling and testing;
- PMTCT (HTC, prophylaxis for mother and baby, information and counseling on infant feeding, collection of DBS at 6 weeks, referral for CD4 and ART);
- HIV prevention information and education;
- Condom promotion and distribution;
- Injection safety and infection prevention; and
- TB screening and management; and Psychosocial support

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

5.2.3 Minimum Package of Services at Rural Hospital

In Rural hospitals all health services are integrated by what is called the “supermarket approach”. SRHR and HIV services are integrated in the overall health delivery system.

Sexual and reproductive health services being provided in rural hospitals include:

- Family Planning information, counseling and services;
- ANC;
- Safe delivery;
- Newborn care
- PNC;
- Prevention and management of STIs/RTIs;
• Information and referral for screening and management of cancers of the reproductive tract (cervical, breast and prostate cancers);
• Adolescent sexual and reproductive health at a separate youth corner; and
• Promoting SRHR needs of men and male involvement in SRHR

The HIV services at rural hospitals entails:

• HIV counseling and testing;
• PMTCT (HTC, Long life ART for HIV positive pregnant, lactating mother irregardless of the CD4 count, prophylaxis for baby, information and counseling on infant feeding, collection of DBS at 6 weeks; ART provision as outreach; husband who is also HIV positive and with a CD4 count below 500 he is started on ART;
• HIV prevention information and education;
• Condom promotion and distribution;
• Injection safety and infection prevention;
• OI management;
• ART initiation as outreach site for district hospital;
• TB screening and management; and
• Psychosocial support

In addition the hospitals have diagnostic facilities such as HIV rapid test, CD4 count, syphilis screening test and hemoglobin.

Services are presented in an unpacked form assuming that clients usually visit facilities seeking help for a specific SRHR or HIV related care. The reason for visit is taken as an entry point for other SRHR and HIV services and information provision.

For the descriptions of minimum packages at this level of care, please refer to page 30-34 of the guidelines.

5.2.4 Minimum Package of Services at Secondary, Tertiary and Referral Levels

At these levels of health care 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 following SRHR services are provided at these levels:

• Family planning information, counseling and services;
• ANC;
• Safe, assisted delivery;
• Newborn care;
• PNC;
• Adolescent Sexual and Reproductive Health;
• Prevention of unsafe abortion and post abortion care;
- Prevention and management of STIs/RTIs;
- Screening and management of cancers of the reproductive tract (cervical, breast and prostate cancers); Treatment and management of subfertility;
- Comprehensive post rape care; and
- Promotion of SRHR needs of men and male involvement in SRHR

The HIV services at these levels include:

- HIV counseling and testing;
- PMTCT;
- HIV prevention information and education;
- Condom promotion and distribution;
- Injection safety and infection prevention;
- Blood safety;
- OI&ART for both pediatric and adult cases;
- TB screening and management; and
- Psychosocial support

For details of minimum packages at this level of care, please refer to page35-41 of the guidelines.

5.3 Operationalization of the Minimum Package of Integrated Services

5.3.1 Institutional Arrangement and Management

The structure of MoHCC presents an opportunity to integrate SRHR and HIV as the RH and HIV units both report to the Principal Director Preventive Services, who reports directly to the Permanent Secretary for Health and Child Care. Moreover, the National SRHR and HIV linkages coordinator position was created in MoHCC reporting to the Principal Director Preventive Services.

The successful implementation of the minimum package of integrated services will require involvement of all relevant stakeholders including, all levels of the health care delivery system, ranging from National, Provincial, District to the Community; civil society organizations; the private-for-profit sector and the development partners.

The MoHCC will lead the implementation of the minimum package of SRHR and HIV integrated services through the office of Principal Director Preventive Services and the national technical committee on linking HIV and SRHR programmes and services. The general roles and responsibilities of MoHCC will include the following:

- Provide informed and transformative leadership to make the guidelines a high priority at National, Provincial, District and Community levels and maximize strategic opportunities for collective action.
- Ensure that the MoHCC has a comprehensive and costed action plan to operationalize the minimum packages of integrated services
- Ensure joint planning, budgeting and implementation of activities by RH and AIDS and TB units at National, Provincial and District levels
- Obtain commitment and encourage financial support from the various departmental / divisional directors who will collaborate directly in planning, budgeting and implementing comprehensive SRHR and HIV services, including the Ministry of Finance
- Ensure strong communication and collaboration between all relevant units of the SRHR and HIV services.
- Comprehensive documentation of progress, lessons learned and good practices for continuous adaptation to the local context, evidence-based advocacy and cost-effectiveness documentation.
- Ensure that investments are made in scaling up services, in creating demand for services, and in removing barriers to access and sustained use.
- Ensure resource allocation for integration and allowing for increased costs initially when setting up integrated services and training staff.
- Ensure that the necessary financial and human resources are put in place to support integrated approach.
- Confirm and maintain national level agreement with all relevant stakeholders to introduce the package of reconfigured services within existing service delivery policies and procedures. Fathom cooperation possibilities with civil society and the private sector for service coverage at national scale, reaching most at risk and key populations.
- Seek commitment from policy makers and other relevant stakeholders to revise policies, if necessary, during and after the minimum package’s introduction.
- Create communication channels and regular opportunities for program management and policy makers to discuss the implementation, address challenges, barriers and bottlenecks and recommend improvements to implementation as they emerge through the documentation mechanism
- Ensure that integration of services is in the national plan (health sector and NAC plans) and has a budget line attached to it and responsible bodies and units for activities are identified in the plan.
- Consider approaches to reduce inequities in health care access by removing financial barriers especially the poor, the young, the marginalized people.
- Provide technical assistance to implementing districts so that they can incorporate the funding needed for rolling-out an integrated model into their annual district health plans.
- Ensure that the package is implemented and develop a performance-based accountability framework.
- Strengthen strategic alliances to improve the sustainability of the integrated model.
- Engage with community stakeholders to plan, mobilize resources, monitor and evaluate community-based services and activities. Raise awareness of services in higher-tiered facilities.
- Strengthen linkages between community-based and facility-based services to further reach and impact of services.
- Identify opportunities for cooperation with additional programmes (including vertical ones) to promote linkages and integrated services with evidence-based advocacy.
5.3.2 Action Plan

An important first step in the operationalization of the minimum package of integrated services is to develop a prioritized action plan that outlines the road map with measurable outputs and included budget needs to fulfill the specific and basic health system requirements identified, which also includes the following additional policy, health system and community related actions. For these cooperation with private not-for profit service providers and the private sector will be fathomed.

Policy/Advocacy:

- Developing management strategies that cover integration and that enhance coordination and involve target audiences and stakeholders in policy and program design and show the benefits expected for providers and decision makers at different levels.
- Developing an advocacy and communication strategy on linkages targeting policy makers, health professionals and community leaders and community members.
- Developing a strategy for evidence based advocacy with donors on SRHR and HIV linkages and integration for motivating donors to move from parallel to integrated services, and sustaining support for integrated policies and services. This could be done through the existing donor coordination forums.
- Orienting policy makers, program managers, experts and health care workers in key public sectors, private sector, NGOs, CBOs, FBOs in the principles, benefits, and mechanisms of SRHR and HIV linkages at policy, system and service delivery levels.
- Gaining policy-level support for delivery of integrated SRHR and HIV services through an minimum package by highlighting the benefits and challenges of this approach compared with existing service delivery approaches for SRHR and HIV services. Utilization of existing or the development of new policy briefs may assist in this process.
- Ensuring inclusion of SRHR and HIV linkages and integration in new policies, strategies and guidelines related to SRHR and HIV.
- Advocacy and empowerment measures for key target groups including advocacy for removal of legal barriers for their SRHR access and connection to SGBV campaigns.

Health System:

- Conducting assessments to identify the health facilities (government, private, NGO facilities) needs related to infrastructure, human resource/technical capacity, finance and logistics to implement integrated SRHR and HIV services.
- Reviewing the existing capacity building and training programs in SRHR and HIV in relation to linkages. This will be the basis to develop or adapt existing curricula for pre-service and in-service trainings.
- Updating existing health care workers’ curriculums, training plans and training materials to foster integrated training on HIV and SRHR linked services.
• Undertaking a review of existing commodity procurement and supply logistics for each minimum package and ensuring that all necessary equipment and supplies can be routinely made available at the relevant service delivery points, and clearly define logistic management responsibilities if different units are involved.

• Estimating existing costs of delivery of SRHR and HIV services using standard costing procedures that can be used to determine marginal costs and cost savings of providing services through a minimum package compared to existing service delivery approaches.

• Disseminating new/revised service delivery checklists, job aids, integrated supportive supervision materials to all health service managers and providers and ensure understanding of and commitment to the integrated approach to SRHR and HIV services delivery.

• Managing the increased workload for staff who take on new responsibilities and orienting staff and supervisors on all revised responsibilities.

• Increasing demand for services through district-wide behavior change communication (BCC) activities.

• Establish medium and long term measures and goals for adolescents and youth friendliness of SRHR services.

• Clarify referral systems, especially the opportunities of documentation and supervision and the cooperation possibilities.

Community:

• Mapping community based health care providers with the potential for an expanded role in advocating, offering, and monitoring integrated package of SRHR and HIV information and services.

• Developing a community strategy for ensuring integration of SRHR and HIV services at community level, which should entail broad stakeholder cooperation and existing good practices.

• Supporting community based health care providers through training, supportive supervisions and other capacity development activities to deliver integrated HIV and SRHR services and information.

5.3.3. Monitoring & Evaluation

Important steps have been taken in terms of developing indicators for tracking integrated SRHR and HIV services at different levels and service points, such as Policy Level, Service Delivery Level, Maternal and Child Health and HIV, Family Planning and HIV, Commodities and logistics and Behavior Change and Communication.
As a next step, the following key measures need to be considered to effectively monitor and evaluate the operationalization of the minimum packages of integrated SRHR and HIV services:

- Review and revise HMIS to collect and record data on integrated HIV and SRHR services; particularly mechanisms to monitor referral system. The Ministry is currently in the process of launching this through the DHIS2.
- Establish a systematic mechanism for documenting and monitoring the introduction of the integrated packages for programme learning purposes including take-up of specific services at different levels of facilities (to measure referral-effectiveness). The ministry established centers of excellence that will be used as the learning sites. Baseline of the three centers was conducted.
- Ensure that the monitoring plan of the national health/HIV plan includes scaling up of integrated services and indicators as well as baseline measures.
- Develop a quality assurance plan to monitor implementation of new services package
- Develop/adapt integrated HIV and SRHR services supportive supervision tool/checklists
- Conduct assessment of the efficiency gains and impact of integrated approach on quality of services and factors that influence acceptability and utilization of integrated services
- Map the most underserved areas and target groups and monitor their access to services.
5.3.4 Supportive Supervision

The column at the right end of the minimum package describes the specific health system requirements to fulfill implementation of the proposed minimum packages. The health managers and policy makers at all levels have the responsibility to fulfill the provision of these requirements.

As outlined in the M&E action plan a supportive supervision tool/checklist should be developed to assist managers at district, provincial and national levels when conducting supportive supervision at community and facility level. The general checklists shown in annex 1 & 2 can be used in the interim until the detailed tools are in place.
REFERENCES
1. International Conference on Population and Development -- Cairo 1994; Program of Action, para 7.2
4. MOHCW, NAC, UNFPA, UNAIDS, EU (March 2011) Zimbabwe National Rapid Assessment on SRHR and HIV Integration and Linkages.
**ANNEXES**

**Annex 1: General Supportive Supervision Checklist on SRHR and HIV Linkages: At Community Level**

Name of the CHW:  
Designation of CHW:  
District/Province:  
Name of Supervisor:  
Date of supervision: ........../......./........

<table>
<thead>
<tr>
<th>Observation</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>CHW trained in SRHR and HIV integration</td>
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<td>Availability of job aids to guide integrated approach</td>
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<tr>
<td>Job aids in use</td>
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<tr>
<td>CHW provides integrated services as per the proposed minimum package</td>
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<tr>
<td>Availability of information pack/client materials</td>
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<tr>
<td>Information pack/client material in use</td>
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<tr>
<td>Availability of integrated data collection and reporting tools</td>
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<tr>
<td>CHW record and report using integrated data collection and reporting tools</td>
<td></td>
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<tr>
<td>Availability of referral linkages and referral tools to ensure that clients are followed up if they receive services referred for</td>
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<tr>
<td>Availability of the required SRHR and HIV products and technologies like male and female condoms, condoms demonstration models, contraceptives, lubricants</td>
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</table>

General comments and suggestions:

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# Annex 2: General Supportive Supervision Checklist on SRHR and HIV Linkages: At Health Facility Level

Name of the health facility: 

Name of the provider: 

District/Province: 

Name of Supervisor: 

Date of supervision: ......../......../........ 

Time Supervision: 

<table>
<thead>
<tr>
<th>Observation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care worker trained in SRHR and HIV integration</td>
<td></td>
<td></td>
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<tr>
<td>Availability of job aids to guide integrated approach</td>
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<td>Job aids in use</td>
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<td>Health care worker record and report using integrated data collection and reporting tools</td>
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<tr>
<td>Availability of referral linkages and referral tools to ensure that clients are followed up if they receive services referred for</td>
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<tr>
<td>Availability of adequate space for privacy &amp; confidentiality</td>
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<tr>
<td>Availability of the required SRHR and HIV medicines, commodities, and equipment</td>
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</table>

General comments and suggestions:

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