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Final Draft

Facility assessments of the status of Sexual and Reproductive Health(SRH)/Human immunodeficiency (HIV)/ Tuberculosis (TB) and Sexual and Gender-based violence (SGBV) integration and implementation in 10 health facilities in Alfred Nzo, OR Tambo and UThukela Districts, South Africa

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
APP	Annual Performance Plan
ART	Antiretroviral Treatment
AYFS	Adolescent Youth Friendly Services
CHC	Community Health Centre
CHW	Community Health Worker
CMS	Council for Medical Schemes
CRA	Comparative Risk Assessment
CSIR	Council for Scientific and Industrial Research
CTOP	Choice of Termination of Pregnancy
DHIS	District Health Information System
DORA	Division of Revenue Act
ESMOE	Essential Steps in Managing Obstetric Emergencies
CBO	Community-Based Organisation
HAART	Highly Active Antiretroviral Therapy
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
ICSM	Integrated Clinical Services Management
IMCI	Integrated Management of Childhood Illness
MDR	Multi Drug Resistance
MMR	Maternal Mortality Rate
MRC	Medical Research Council
NCD	Non-Communicable Disease
NDP	National Development Plan
NDOH	National Department of Health
NGO	Non-Governmental Organisation
NHA	National Health Act
NHC	National Health Council
NHI	National Health Insurance

NHRC	National Health Research Committee
NICD	National Institute for Communicable Diseases
OHSC	Office of Health Standards Compliance
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PPIP	Perinatal Problem Identification Programme
SANAC	South African National AIDS Council
SDA	Service Delivery Agreement
SRH	Sexual and Reproductive Health
STATSSA	Statistics South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNFPA	Unite Nation Agency Population Fund
UNICEF	United Nations Children's Fund
WBOT	Ward Based Outreach Teams
WHO	World Health Organisation
YFS	Youth Friendly Services

Executive summary

Background

The National Department of Health (NDOH) with the support of the United Nation Population Fund (UNFPA) commissioned the assessments of the status of Sexual and Reproductive Health(SRH)/Human immunodeficiency (HIV)/ Tuberculosis (TB) and Sexual and Gender-based violence (SGBV) integration and implementation in 10 health facilities in Alfred Nzo, OR Tambo and UThukela Districts, South Africa. This assessment was conducted by Optidel-Global Public Health and Environment between the August and October, 2017.

The objectives of assessment are:

- To establish the national status of SRHR/HIV linkages at policy and systems level
- To collect baseline data through HMIS on defined SRHR/HIV integration indicators at 10 health facility level
- To conduct rapid assessment of the status of SRHR/HIV integration in the 10 selected health facilities
- To conduct assessment of health facility readiness to integrate SRHR and HIV services in 10 health facilities
- To conduct an assessment of uptake and possible barriers to Family Planning services at the selected health facilities

Methodology

This assessment followed a cross-sectional, descriptive and multiple-site design which involved desk review of policy, strategies and relevant documents, secondary analysis of routine data, site visit and stakeholder interviews involving service providers, service users and partners. Purposive sampling of 10 facilities identified by NDOH was used.

Selected districts and facilities are Alfred Nzo and OR Tambo (Eastern Cape)- Ndela, Amadiba, Libode, Ntaphane and Tombo Clinics, and from UThukela (KwaZulu-Natal) are Injisuthi, Ntabamhlophe, Wembezi, AE Havilland, Ncibidwane Clinics.

Findings and Recommendations

In the light of the findings in this report, the following key recommendations are proposed, these recommendations are practicable and is sensitive enough to strengthen integration at the 10 facilities assess when implemented:

1) Department of Health (DOH) with the support of partners should develop a minimum package of services that can strengthen integration at facility level. This package can be complemented by designing some Job aids that can practically guide integration at the three existing service streams or entry points (Maternal, Child and Newborn, Minor Ailments or Chronic). This minimum package of services should take into cognizance the low integration of SGBV, prevention and management of post abortion services, psychosocial support, AYFS and key population

2) The DOH and partners should innovatively look into and address the inadequate training issues that came out strongly from the study, this approach should not just lead to organisation of training workshops but should look at a way of strengthening in-service

training, mentorship and supportive supervision to address this training gap. The content and guide of this capacity building support should address facility specific factors that affects integration

3) The facility managers and team of the 10 assessed facilities should re-evaluate the patient flow process in order to optimise the opportunities and mitigate the weaknesses of their facilities to provide integrated services. This approach should aim at reduction of waiting time, improved quality of service and staff efficiency. It is also critical to do this in order to mitigate the infrastructural challenges and for the facility team to own the product of the re-evaluation. As described in chapter 9 of this report many pathways can be followed and it should be generic to facilities. This can be supported but not led by partners.

4) As part of the facility re-evaluation process, there is a need for the team to identify opportunities that exist for integration at all entry points of the facility. A simple template sample like Annexure 1 can be used and built upon to facilitate this process. The process will also be helped by the Ten steps towards strengthening integration listed in chapter 9

5) Stakeholders should continue to emphasise that integration should not be viewed as a consulting room process. It must start from the point of entry into facilities and all through the patient flow in order to be able to optimise the opportunity that exists at every service point. Successful referrals and linkages should also be emphasised. Examples of good practises that came out of the validation workshop and can be considered by the facility team includes:

    a. Pregnancy test being done at the vital sign service point for eligible women of reproductive age group.
    b. Provision of the chosen family planning method at a service point before the consultation room, some facilities recognised the vital sign point as an appropriate point, also because this point is manned by appropriate cadre of staff that can provide the service.
    c. Proactively screening for Cervical Cancer can through the use of eligibility criteria can also be done for appropriate referral for pap smear before reaching the consulting room

6) Use the opportunity of the re-evaluation process described above to encourage team building among the staff members with the aim of supporting any service point that will need help at any time due to high patient load; for example, only the PN in chronic team should not be left to attend to patients till 17h00, while the ANC PN had finished seeing patients since 13h00.

7) Establish a sensitive communication strategy as part of the process of introducing the new approach. The platform of health education delivery at the facility level should be used to educate patients on the benefit of integrating SRH and HIV services.

1. Introduction:

1.1. Global overview

Globally significant progress has been made in reducing both the spread of HIV and the number of maternal deaths. Despite these impressive gains, HIV infection and maternal mortality are still two primary causes of death in women of reproductive age worldwide. Nine countries in the Southern African region have the highest HIV prevalence in the world (Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland and Zimbabwe) with HIV resulting in the single sharpest reversal in human development in the region. The region also continues to experience high rates of preventable maternal mortality, teenage pregnancy and gender based violence.

1.2. South Africa Context

South Africa has a complex burden of disease referred to as a quadruple burden of disease consisting of communicable diseases, non-communicable diseases, perinatal and maternal conditions and injury related disorders. In addition to having the largest number of people living with HIV estimated at 7 million, it has the largest number of people on ART in the world; almost at 4 million. South Africa continues to exhibit high levels of new infections in comparison with other countries the world over. According to Statistics South Africa, in 2017 it is estimated that 12.6% of the population, that is 7.06 million people are HIV positive. Of particular concern is the high rate of infection among girls and young women aged 15-24. Although HIV prevalence is declining in this vulnerable group, the pace of decline has been slower than anticipated. The HIV prevalence among females aged 15-19 in 2012 was nearly eight times higher than males 15-19 (0.7% vs 5.6%). Furthermore, it was estimated that 1,744 new HIV infections occur among women and girls aged 15-24 years every week (HSRC: 2012).

The results of the Medical Research Councils' South Africa Demographic and Health Survey, 2016 shows that the age-specific fertility rate for teenagers was 71 births per 1,000 women aged 15-19 with little change since 1998 despite the availability of better and more effective contraceptive methods. 58,3% of women use some form of contraceptive and the overall use of modern contraception remains relatively high. However, 18% of women continue to have an unmet family planning need. Furthermore, the use of male condoms for contraception has increased and now accounts for 15% of the modern contraceptive methods used by women (SADHS: 2016).

1.3. Interactions between SRH and HIV

The interactions between SRH and HIV are now widely recognized (WHO/UNFPA 2005). The majority of HIV infections are sexually transmitted. A smaller number of infections are associated with pregnancy, childbirth, breastfeeding (perinatal transmission) and other behaviours such as injection drug use. Sexually transmitted infections increase the risk of HIV acquisition and transmission. An effective response to the HIV/AIDS pandemic cannot be achieved without addressing the social and structural drivers such as poverty, migration, gender inequality and gender-based violence that underpin and fuel the pandemic. These drivers facilitate new infections, deter individuals from undergoing HIV testing, inhibit retention in care and treatment, and contribute to internal and external stigma. In recent years, there has been strong international consensus on the benefits of providing integrated SRH, HIV, TB and SGBV[1] services, particularly as a strategy to increase the effectiveness of the HIV response.

[1] Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV

1.4. Integration of SRH, HIV, TB and SGBV

The importance of linking sexual and reproductive health (SRH) and HIV response has been increasingly gaining momentum. SRH services can provide a platform for reaching individuals, especially women and children with HIV prevention, care and treatment interventions. At the same time, HIV services can provide an effective entry point for key SRH services such as family planning, cervical cancer screening, Gender Based Violence care and antenatal care. Emerging evidence demonstrates that integrating comprehensive SRH and HIV services provides an opportunity to increase access to and uptake of quality maternal and reproductive health services and improves programme efficiencies and effectiveness.

Evidence from a number of countries suggest that through rapid scale up of specific interventions that integrate sexual and reproductive health (SRH), TB and HIV services it is possible to:

- Promote health, wellbeing and rights of women and children
- Reduce maternal morbidity and mortality
- Prevent new HIV infections
- Eliminate AIDS related deaths

1.5. Scope of the rapid assessment

UNFPA in collaboration with Department of Health commissioned this rapid assessment and project roll out. The assignment is aimed at conducting a rapid assessment on the status of SRH/HIV/TB and SGBV integration and implementation in three districts of OR Tambo and Alfred Nzo (Eastern Cape) and UThukela (Kwa-Zulu Natal), covering ten health facilities in the three districts. Objectives of activities are specified below:

a) To establish the national status of SRHR/HIV linkages at policy and systems level
b) To collect baseline data through HMIS on defined SRHR/HIV integration indicators at 10 health facility level
c) To conduct rapid assessment of the status of SRHR/HIV integration in the 10 selected health facilities
d) To conduct assessment of health facility readiness to integrate SRHR and HIV services in 10 health facilities
e) To conduct an assessment of uptake and possible barriers to Family Planning services at the selected health facilities

violate a number of universal human rights protected by international instruments and conventions. The nature and extent of specific types of GBV vary across cultures, countries, and regions, ranging from sexual violence (Inter-Agency Standing Committee (IASC): 2005).

2. Methodology

This assessment followed a cross-sectional, descriptive and multiple-site design which involved desk review of policy, strategies and relevant documents, secondary analysis of routine data, site visit and stakeholder interviews involving service providers, service users and partners.

2.1. Sampling

Purposive Sampling of ten Clinics identified by the Easter Cape and Kwazulu-Natal Department of Health (DOH) for intervention focus was used. These ten clinics were drawn from three districts of OR Tambo -3 clinic and Alfred Nzo -2 clinics (Eastern Cape) and UThukela -5 clinics (Kwa-Zulu Natal) as shown below:

Table 2.1: District and facility covered by the assessment

Alfred Nzo & OR Tambo (Eastern Cape)	UThukela (Kwazulu Natal)
Ndela PHC - Alfred Nzo	Injisuthi Clinic
Amadiba clinic -Alfred Nzo	Ntabamhlophe Clinic
Libode Clinic- OR Tambo	Wembezi Clinic
Ntaphane Clinic OR Tambo	AE Havilland Clinic
Tombo Clinic OR Tambo	Ncibidwane Clinic

2.2. Data collection

Data collection tools were adapted from the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages following the user guide, the tools were field tested at Nellmapius clinic, Pretoria. The table below shows the tools and its description:

Table 2.2: Tools and description

Tools	Method	Respondent/source	Data type
Policy level	Semi-Structured survey	Policy makers: NDOH Staff	- Policy adequacy on integration - Integrated Planning and Budgeting - Capacity and support structure - Implementation plan content
Systems tools	Semi-Structured survey	Provincial/ District level staff	- Strategy for integration - Operational plan content - Monitoring and supervision - Support from partners - Monitoring and Evaluation
Service delivery level tool	Semi-Structured survey	Service providers	- Services provided; - Patient flow/process mapping - Access to the facility - Monitoring and Evaluation - Referral and Linkages System - Human Resource Capacity - Skills Audit

Waiting time assessment checklist	Observation based on a checklist	Service providers and beneficiaries or clients of the service provider	- Time log of processes involving clients for waiting time estimation
Client Exit Interview	Semi-structured interview	Selected clients accessing different services in line with entry point	- Client profile - Access to services - Frequency of visits - Referrals received and implemented/represented - Strengths and weakness of SRH/HIV services
DHIS data	Extracted data from the DHIS	DHIS Data	- Indicators that relates to integration

2.3. Data analysis

The assessment data were collected from the field and transcribed into excel spreadsheet and validation was done daily by the field team. Descriptive analysis was done including frequencies and summary statistics. Graphs and tables were created for each thematic area to describe the study findings. These summary statistics corroborated the fieldwork observations from the review team members.

The following data from fieldwork were analysed:

- 19 National policy/strategy/legal framework documents
- 7 Policy level questionnaires
- 15 System level questionnaires
- 40 Service provider questionnaires
- 200 Service user/clients questionnaires

2.4. Reporting

The fieldwork team members convened following the fieldwork period for a reporting meeting. All the data were further analysed and key findings collated. The report was structured to address the key questions to be answered as stated in the TOR

2.5. Limitations of the Review

- The inclusion of only ten facilities through purposive sampling, did not allow for fully representative sampling
- Sampling of Clients that consented for exit interviews was conveniently done
- Because of the distances of some facilities from the point of departure the service users were already at the facilities before the team arrived in some cases, hence, the possibility of inaccuracy of the arrival time in the waiting time estimation
- The field team acknowledge the possibility of recall bias in patients responding to the interview questionnaire, especially when follow up questions were made. However, for interviews with service providers, system and policy documentary evidence was requested to verify responses provided.
- Finally, due to time constraints and the need to develop tools, train the fieldwork team, plan logistics for fieldwork, conduct fieldwork and analyse data and produce the report within a short timeframe, there is a possibility that some information might have been missed. Every effort was made to mitigate this including the use of the validation meetings with the districts.

Nonetheless the constraints and challenges highlighted did not affect the findings and recommendations of the assessment, which are believed to be reflective of the current status of the SRH/HIV/TB and SGBV integration and implementation in 10 health facilities in Alfred Nzo, OR Tambo and UThukela Districts.

3. Districts and facility profiles

The rapid assessment took place in ten (10) facilities from three districts: UThukela District of Kwa-Zulu Natal, Alfred Nzo and OR Tambo districts of Eastern Cape. The following information profiles the districts.

3.1. Some Key Indicators

The following are some key indicators that are relevant to the provision of the SRH, HIV and TB services. These indicators were taken out of the DHIS to show the performance of the services at district levels.

Table 3.1: Important TB, SRH and HIV indicators (Source ETR, DHIS)

Districts	Incidence of TB (all types), 2015 (Cases per 100 000 population)	Delivery in facility under 18 years rate, 2015/16 (%)	Cervical cancer screening coverage[2], 2015/16 (Percentage of women 30+ /10)	Male condom distribution coverage by district, 2015/16	HIV testing coverage (including antenatal care)[3], 2015/16 (%)	Couple year protection rate[4], 2015/16
Alfred Nzo	491	12.1	27.5	27.6	30.4	29.8
OR Tambo (NHI)	571	11.1	59.2	72.5	41.5	58.7
UThukela	533	8.7	82.7	61.6	26.3	53.6
SA Average	520	7.1	56.6	44.4	34.5	48.2

The incidence of Tuberculosis (TB) in OR Tambo and UThukela districts is above the South Africa average that of Alfred Nzo is just below the country average. This indicates an ongoing transmission of new TB infection in the districts.

All the districts have a higher delivery in facility under 18 years' rate than the national average. This indicates that there is an ongoing unprotected sexual activities among under 18 age group leading to teenage pregnancy. This indicates failure of uptake of Family Planning. This is risky sexual exposure that can lead to HIV infection and increase the number of adolescent girls dropping out of school. This indicator can be a pointer to the performance of HIV prevention and some SRH services like Family Planning.

Cervical cancer screening coverage is an indication of how many Pap smears are periodically carried out among eligible female adult population. UThukela district has a high cervical cancer screening coverage (82.7%) followed by OR Tambo (59.2%). Alfred Nzo (27.5%) has the lowest coverage among the three districts. This indicator is important to observe at the facility level in determining the level of integration at the service points.

[2] The indicator 'cervical cancer screening coverage' measures the annual number of cervical smears taken in women 30 years and older as a proportion of the female population 30 years and older, factored for one smear every 10 years

[3] HIV testing coverage measures all people aged from 15 to 49 years who were tested for HIV during the year as a proportion of the total population in this age group

[4] The couple year protection rate (CYPR) indicator measures the proportion of women aged from 15 to 49 years who are protected against unplanned pregnancies for a year using modern contraceptive methods, including sterilisation

The male condom distribution coverage is above the national average in UThukela and OR Tambo districts while that of Alfred Nzo is below the national average. Condom use is part of the comprehensive HIV prevention and family planning package and it is critical for preventing the spread of HIV and unplanned pregnancy.

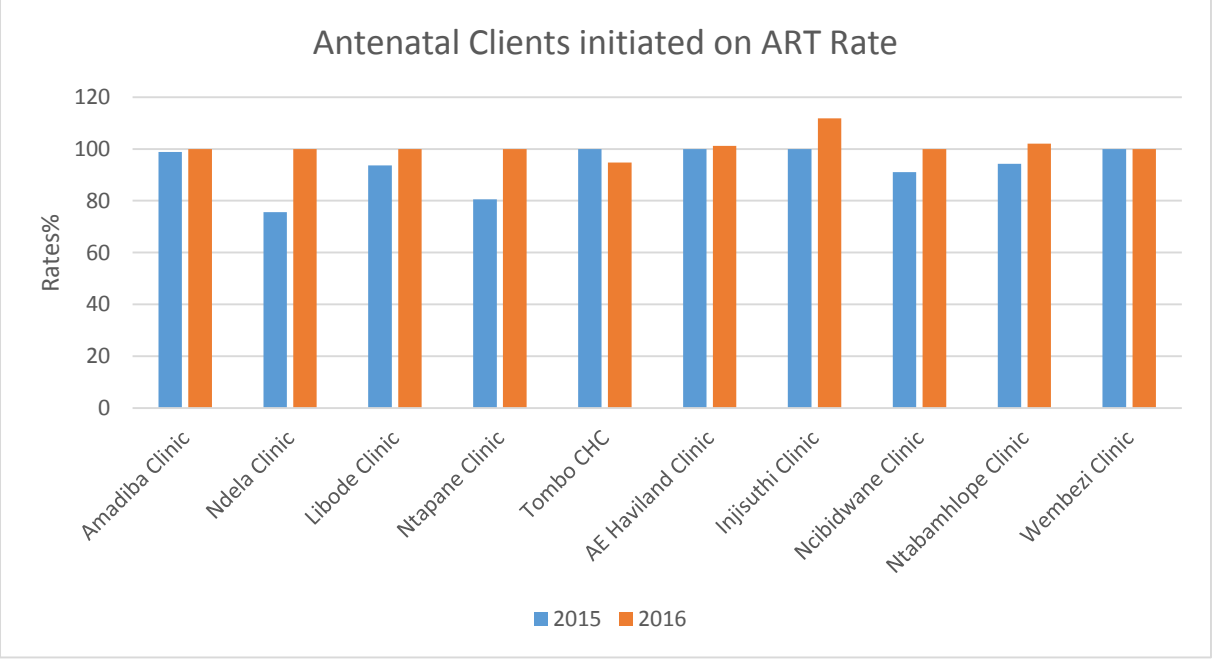
UThukela and Alfred Nzo HIV testing coverage is below the national average while that of Alfred Nzo is above this. HIV testing is the gateway to the HIV services and low coverage implies that many people within the districts have not been offered an opportunity to know their HIV status.

The couple year protection rate is an indication of the proportion of the women 15-49 years that are protected against unplanned pregnancy using modern contraception. This indicator is important to the prevention of unplanned pregnancy, STIs and HIV prevention especially when the dual protection is practiced.

All the indicators above showed a snapshot of a measure performance of the programme in participating districts. These indicators are not directly focusing on integration of services, but optimum performance of these indicators cannot be achieved without integrating the services at the PHC levels.

Figure 3.1 below shows the Antenatal Clients initiated on ART rate, it shows that there is a marked improvement of All the facilities except Tombo is at 100%, There is also a marked improvement in 2016, this improvement is attributed to the change in the national policy, this national policy has facilitated the uptake of the ART services within the ANC services and the indicator being part of National Indicator Dataset (NIDS) also serves as an enabling factor for recording and reporting of the service provision.

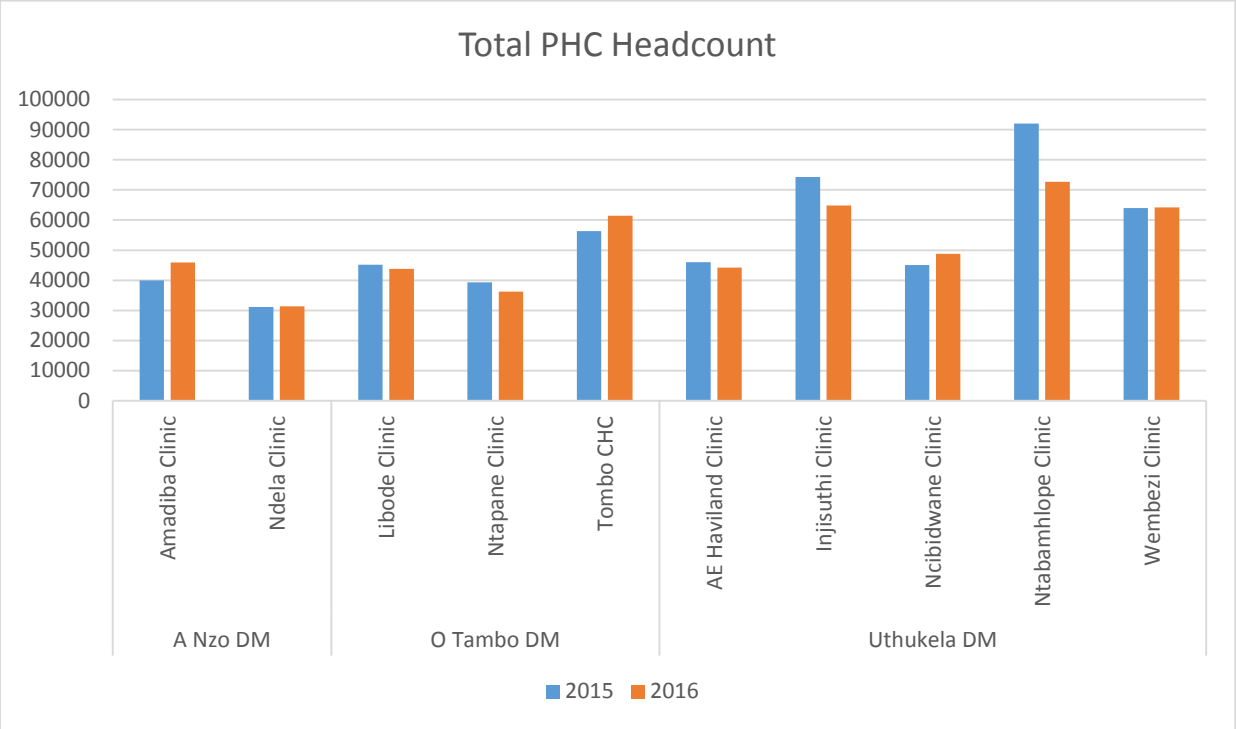
Figure 3.1: Antenatal clients initiated on ART Rate (source DHIS)



The Figure 3.2 below indicates the total PHC headcount of the ten facilities that participated in the rapid assessment. Generally, UThukela facilities have higher PHC Headcount than the Alfred Nzo and OR Tambo facilities. Ntabamphlope Clinic has the highest headcount of the ten facilities surveyed while Ndela clinic has the lowest headcount. There is a marked drop in the total headcount between

2015 and 2016 in Injisuthi and Ncibidwane clinic. Ncibidwane recorded the highest drop of about 20,000; this could be due to many reasons and data related issues should be considered in investigating the cause.

Figure 3.2: Total annual PHC Headcount (Source DHIS)



3.2. Facility Profile

Table 3.2 below illustrates the facility profile as provided by the management. The average waiting time in the last three quarters were provided for each facility, in order to contextualise this; the last column captures the waiting time that was observed from sampled clients on the day of implementation of the survey. There is a wide disparity between the observed waiting time and the management reported waiting time. The survey waiting time indicated that clinics with the lowest headcounts are not necessarily the ones with the lowest waiting time.

All facilities are CCMDD points and reported to be operating ICDM and AYFS. All facilities in KZN have an Ideal clinic status and except for AE Havilland clinic, they open 24hrs and 7days a week.

Table 3.2: Facility profile

	Facilities	Ideal Clinic facility	CCMDD point	ICDM	AYFS	Operating Hours (e.g. 24Hrs, 5 days)	Average Headcount (last 3 months)	Average Waiting time last 3 qtrs	Survey waiting time
KZN: UThukela	Ntabamhlophe clinic	yes	yes	yes	yes	24hrs/7days	6 274	35min	3h20
	Wembezi Clinic	yes	yes	yes	yes	24hrs/7days	6 219	30min	2h10
	AE Havilland clinic	yes	yes	yes	yes	7hrs/ 7days	3 517	30min	1h50
	Ncibidwane Clinic	yes	yes	yes	yes	24hrs/7days	2 106	30min	1h20
	Injisuthi Clinic	yes	yes	yes	yes	24hrs/7days	4 762	30min	3h19

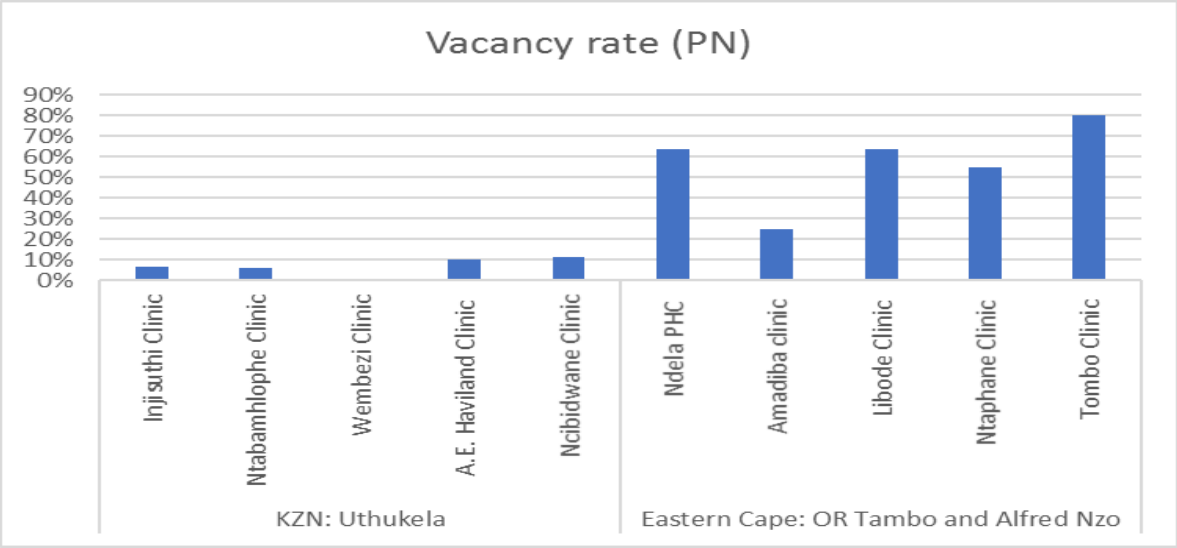
Eastern Cape: OR Tambo and Alfred Nzo	Ndela PHC	yes	yes	yes	yes	8 hrs/ 5 days	2627	3-4hrs	4h40
	Amadiba clinic	no	yes	yes	yes	8 hrs/ 5 days	3582	2hrs	1h20
	Libode Clinic	Yes	yes	yes	yes	8 hrs/ 5 days	2506	1h 45	3h05
	Ntaphane Clinic	no	yes	yes	yes	8hrs/ 5 days	2752	2h 45	1h30
	Tombo Clinic	no	yes	yes	yes	24hrs /7days	3603	2hrs	1h30

Table 3.3 below illustrates the HR capacity using the Professional Nurses (PN) as proxy. The vacancy rate shown in figure 3.3 below displayed a great disparity in human resource capacity between the Eastern Cape and KZN facilities, facilities in Eastern cape have a disproportionately high vacancy rates, this is reported to be as high as 80% in Tombo Clinic. Tombo clinic is also an outlier with a disproportionately high approved number of PN (40). The higher actual numbers of PN in KZN can be explained by the fact that almost all the facilities in KZN operate a 24hr service as against shorter hours of services of clinics in Eastern Cape and very low vacancy rates.

Table 3.3: HR capacity

		Number of PN (including OM) as per approved Organogram (Establishment)	Actual Number of PN (including OM) appointed	Number of Vacancy
KZN: UThukela	Injisuthi Clinic	15	14	1
	Ntabamhlophe Clinic	17	16	1
	Wembezi Clinic	13	13	0
	A.E. Haviland Clinic	10	9	1
	Ncibidwane Clinic	9	8	1
Eastern Cape: OR Tambo and Alfred Nzo	Ndela PHC	11	4	7
	Amadiba clinic	8	6	2
	Libode Clinic	11	4	7
	Ntaphane Clinic	11	5	6
	Tombo Clinic	40	8	32

Figure 3.3: Vacancy Rate in assessed facilities



There seems to be no correlation between the survey waiting time and the headcounts, the vacancy rates and the opening hour. It can be deduced that other processes like patient flow and infrastructure might likely be playing some roles in the amount of time patients spend in facilities

This profiling of the facilities and districts above will help in the contextualisation of the findings and provide a better understanding of the level of integration of each facilities.

4. Findings: Policy level

A desk review of relevant legal frameworks, policies and guidelines was conducted, 19 documents were consulted and contents were reviewed specifically to see possible reference to linkages and integration of SRH, HIV, TB, SGBV and AYFS. Selected policy makers from NDoH SRH, HIV, TB/HIV Units were interviewed using the policy level tools. The following findings were made.

4.1. Relevant Legal framework

Table 4.1: Relevant legal framework

Document	Does this document facilitate linkages and/or integration SRH/HIV/TB/SGBV and AYFS
1. Constitution of the Republic of South Africa Act, 1996 (Act 108 of 1996)	Pertinent sections provide for the rights of access to health care services, including reproductive health and emergency medical treatment.
2. Children's Act, 2005 (Act No. 38 of 2005)	The Act gives effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children, to define parental responsibilities and rights, to make further provision regarding children's court
3. Choice on Termination of Pregnancy Act, 196 (Act No. 92 of 1996)	Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.
4. National Health Act, 2003 (Act No. 61 of 2003)	Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services

4.2. Political level

Table 4.2: National Plans and Strategic documents and contents on linkages and facilitation

Document	• Does this document facilitate linkages and/or integration SRH/HIV/TB/SGBV and AYFS
5. National Development Plan 2030 vision	• The National Development Plan (NDP) sets out nine (9) long-term health goals for South Africa. Five of these goals relate to improving the health and well-being of the population, and the other four deals with aspects of health systems strengthening
6. South Africa's National Strategic Plan For HIV, TB and STIs 2017-2022	• This lays out the strategic approach to breaking the cycle of HIV transmission. It drives a major national push to scale up comprehensive sexuality education and linkage to Sexual and Reproductive Health Services • As part of the goals it identifies a comprehensive package of services for the general population, that will then be supplemented and customised to the age and population served from a gender lens • As an enabler, it emphasises among others that Community Healthcare workers and caregivers should be trained to undertake household wellness assessments and to make referrals to integrated HIV/TB/STI/SRHR and GBV services • It emphasises the comprehensive SRH services (including: cervical cancer screening, Pap smears, access to emergency and STI management, contraception, choice of termination of pregnancy) • It is multi-sectoral and provides a platform for a true national approach

4.3. NDoH level: Policy, Strategy and Implementation plan

Table 4.3: NDoH Policy and Strategic document

Document	Does this document facilitate linkages and/or integration SRH/HIV/TB/SGBV and AYFS
SRH/AYFS	
7. NDoH Strategic Plan 2014- 2019	• It aims at preventing disease and reducing its burden, and promote health through a multi stakeholder National Health Commission • The HIV/TB/Maternal and Child health structure is under the same branch and it proffers an opportunity for integrated policy development and planning
8. National Contraception Clinical Guidelines, 2012	• Implicit in the guidelines is the concept that method provision includes contraceptive and fertility information and counselling, offered as part of a comprehensive HIV and sexual and reproductive health care package. • Well integrated with HIV, Adolescent and youth health with special considerations for service delivery for key and vulnerable population (adolescents, migrants, sex workers, LGBTI, men)
9. Maternal, Newborn, Child, Adolescent and Women's Health and Nutrition Strategic Plan 2017/18 – 2021/22	• This is an integrated plan for reducing maternal and child mortality priority health interventions identified integrates HIV services, PMTCT among other causes of maternal and child mortality • There is also a linkage with adolescent and young women's health through inclusion of priority interventions decrease new HIV infections in girls and young women
10. Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011–2021 and beyond	• Provides for the delivery of integrated sexual and reproductive health services as part of the primary health care approach within a district health system.
11. Guidelines for Maternity Care in South Africa, 4th Edition 2015.	• This guideline promotes the "know your status" and "plan your pregnancy" messages in communities and in the health sector; and ensure non-judgemental approaches. • Ensure every maternity health facility is able to screen for HIV infection and perform early initiation of HAART; and to recognise and treat co-infections, especially respiratory infections. • It also promotes integrated TB Screening as appropriate
12. Adolescent and Youth Health Policy 2017-2021	• It aims to promote the health and wellbeing of young people, aged 10-24 years • It comprehensively integrates HIV, TB and Violence one of objective is to provide comprehensive, integrated sexual and reproductive health and right services, integrated with HIV and TB
13. Breast Cancer Prevention and Control Policy, June 2017.	• The policy recommends that prevention of cancer, should be integrated with prevention of chronic diseases and other related areas of health care (such as reproductive health, hepatitis B immunization, HIV/AIDS…) • Givesspecial considerations to high risk groups such as women living with HIV, sex workers, adolescents and migrants
14. The national policy on cervical cancer screening	• The cervical cancer screening policy is in congruence with the Clinical Guideline on the management of HIV and AIDS that women should have three cervical smears done at 10-yearly intervals starting at the age of 30 years. If HIV status is known and is positive, screening should begin at age 25 and as long as is normal should be repeated 3 yearly.
HIV/TB & AYFS	
15. Health Sector HIV Prevention, 2016.	• A combination prevention[5] approach to achieve universal access to HIV prevention, treatment, care, and support for both the general and the key populations (KPs) in line with the National Strategic Plan on HIV, STIs, and TB, 2012–2016 (NSP) • Well focused on gender issues, key populations etc.
16. Adherence Guidelines For HIV, TB and Non—Communicable Diseases, Feb 2016.	• This is a policy and service delivery guideline for linkage to care, adherence to treatment and retention in care

[5] Combination prevention refers to the strategic simultaneous use of different classes of prevention interventions (biomedical, behavioural and structural) that operate on multiple levels (individual, couple, community and societal) to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritising partnerships and engagement of affected communities

	• It covers special sessions on pregnant women, PMTCT, Adolescent and children. It was also developed with sensitivity to gender issues
17. National HIVTesting Services: Policy and Guidelines 2015	• The policy addresses priority population (Key population, women and children etc.) • Design to cover different entry points where HIV testing should be offered • Indicators covers integration with STI, ANC and TB
18. National Department of Health (NDoH) clinical guidelines for management of HIV and AIDS	• This covers the importance of TB screening and where relevant Family Planning, and STI and other STI management • It recommends more frequent cervical cancer screening, namely on diagnosis and three-yearly thereafter if normal in agreement with the cervical cancer policy
19. National consolidated guideline for the Prevention of Mother-To-Child Transmission of HIV (PMTCT) And The Management of HIV in Children, Adolescents and Adults	• Captures standardize baseline monitoring for pregnant women and breastfeeding which includes, TB screening, Family Planning, annual cervical cancer screening (pap smear) for all HIV-positive women and STI treatment and psychosocial support

4.4. Political level

South Africa is one of the few countries in the world that have an integrated National Strategic Plan for HIV, STI and TB. The existence of an integrated Strategic plan since 2012 and also the implementation of joint review of HIV, STI, TB and PMTCT programmes in 2013 is commendable. The assessment confirmed that there is a strong political will to integrate services and national strategies also supports this.

Although, the country does not have a single policy or guideline to operationalise bi-directional linkages of HIV and SRH, all national policies are developed in an integrated manner with input from all relevant clusters under the HIV, TB, Maternal, Child and Women's Health Branch of the National Department of Health (NDoH), a policy maker mentioned that *"No document will be approved by the Deputy Director-General without consultation and cross-referencing the relevant existing policies from the relevant clusters in the Branch"*.

4.5. National Strategy

The integrated National Strategic Plan HIV, TB and STIs 2017-2022 emphasizes the provision of a comprehensive package of services for the general population, that will then be supplemented and customised to the age and population served. In addition to the policies and strategies that are integrated, the content of the training materials derived from these policies and strategies must be integrated. The country also has a rights based approach to Sexual and Reproductive Health and is backed up by the document *Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011–2021 and beyond.* This document provides for the delivery of integrated sexual and reproductive health services as part of the primary health care approach within a district health system.

4.6. Funding and Budgeting

HIV programme is funded through the Division of Revenue Act (DORA)- Conditional Grant; many donors also fund HIV in South Africa. SRH is funded mainly by the Equitable share and according to the policy makers, not many donors have funds for the SRH programme. At the National level budgeting is done by individual clusters but areas of joint interest such as condom provision which is jointly relevant to the SRH and HIV programs is procured using the HIV conditional grant. This shows that there is an opportunity for funding integrated services if appropriately presented.

4.7. Policy level overview

Overall, the assessment revealed that South Africa has a strong political will and support for the integration of SRH and HIV. There is a supportive national Constitution and relevant legal frameworks

that facilitate the linkage. Many policies show cross-referencing of relevant information to ensure linkages, however, some of the policymakers admit that there are possibilities that the frontline health workers will have difficulties in making references to these many documents in the process of consultation. Funding from government and donors are usually vertical and allocated specifically to tasks and it does not give any room to SRH and HIV linkages in most cases. According to a policy-maker "integration is stronger at smaller facility level than district and national level because of the human resources challenges". Staff shortages at facility level favours integration by default.

5. Findings: Systems level

The findings below are synthesis of key stakeholders' interviews that were conducted at the provincial and district levels focusing on the existence of systems to support effective linkages of SRH and HIV. In total 15 key stakeholders were interviewed across the Provincial and the district level. These stakeholders were drawn from programs and services such as AYFS, SRH, and TB/HIV and HIV units.

5.1. Partnership

There are few partners supporting the SRH programme at all levels when compared to HIV and TB programme. Respondents consistently mentioned UNFPA across the national, provincial, district and facility levels as a key partner in SRH and HIV integration. Partners that focus on SRH in Eastern Cape includes Health Focus, Beyond Zero, Lovelife, Uthombo Wempilo, Soul City and Dumbigo, while Kwa-Zulu Natal SRH partners include CHIVA, Right to Care, MATCH and HST.

The role of Civil Society Organisations (CSO) in SRH programming is not prominent, despite the high level of CSO support received by HIV programme, SRH could not tap into this resource because the funding is focused on HIV and no other services.

Adolescent and Youth Friendly Services (AYFS) is a relatively new area of support with focal persons at the national and provincial levels but with little staff strengths at the district and service delivery level. Some facilities have a partner funded vertically implemented AYFS programme. In KZN; UNFPA, CHIVA and Lovelife are important partners in AYFS programme and it was reported that there is a good linkage of the programme with TB-HIV Care Association and HST which are HIV focused NGOs. KZN also indicated good networking arrangement with National Association of PLWHIV (NAPWA) through their youth HIV support groups.

According to the respondents, generally Partners provide support in conducting situational analysis, programme planning, Implementation, training, and monitoring and evaluation (M&E) of the programme. Partners are reported to play less role in budgeting despite making resources available to support the programme. Partner's coordination seems not systematically structured. For example, a provincial level participant that some partners that were not formally known by provincial level authorities were working at the district level in Eastern Cape.

5.2. Planning, Management and Administration

This section deals with the ways planning and management is administered at the provincial level, it looks at the opportunities that can facilitate integration of services at the lower levels, these include the development of provincial strategic plan, business plan and supervision.

In the Eastern Cape there is joint planning of HIV and SRH programme to develop Strategic Plan and Business Plan for the Conditional Grant. There is also joint development of the implementation and monitoring plan for the 32 indicators for provincial performance monitoring. This planning is only for alignment and oversight and does not lead to integrated budgeting. Supervision is not integrated.

Structurally SRH services fall under the Health Programmes, while the HIV and TB falls under the HAST programme.

In Kwa-Zulu Natal there is joint sitting of the HIV, SRH and TB to plan and develop Strategic Plan, this joint planning also involves the M&E units. AYFS unit does not fall under this Strategic Planning unit, hence, plans are separate. Programme management and implementation of the HIV, SRH, TB, AYFS are separated. Supervision of the programs at lower levels is also done separately and there is no cross-programme or integrated supervision. The general perception is that even though there is a joint planning this is not carried over to programme management and supervision.

Generally: Issue of shortage of staff was expressed as one of the factors limiting integration. While integration is done by default due to lack of enough staff, concerns were raised on the staff being overwhelmed and 'push number' without focusing on quality of services. These opinion was expressed at the two provinces. On the issue of training a provincial respondent said *"How can I be in a two days HIV training when I have my own programme issues to attend to?"*. This underscores the fact that while efforts are being made to develop integrated training material at the policy level, there seems to be a real issue of how to draw staff support to train in other programmes e.g. how will AYFS programme manager be able to train on Youths related needs captured in the condom training manual. According to the respondents, there are no indicators at the provincial level that monitor integration UNFPA carried out capacity building of staff on SRH and HIV integration.

Many other reasons were raised with regards to integration at the provincial and district levels:

"For integration to happen, I need to know SRH activities as well" –Provincial level

Other respondents said:

- "*I need to understand Youth Issues and how it relates to my programme for integration to occur"*-Provincial level
- "*AYFS is an orphan with no one accepting full responsibility at the lower levels, I don't blame anyone because staff at facility level are overwhelmed"*-Provincial level
- *"Some policies from NDoH are integrated and we adapt them as province, but when it gets to the facility it lacks implementation because of lack of staff"*-Provincial level
- *"Integration makes things worse at our level, it is more work and it affects quality"*-a PHC Supervisor
- *"SRH is still a new issue in the community, not prominent because it lacks adequate funding"*-Provincial level
- *"There is minimal integration when it suits especially HIV, they have more funding and they need nothing from us"*-Provincial level

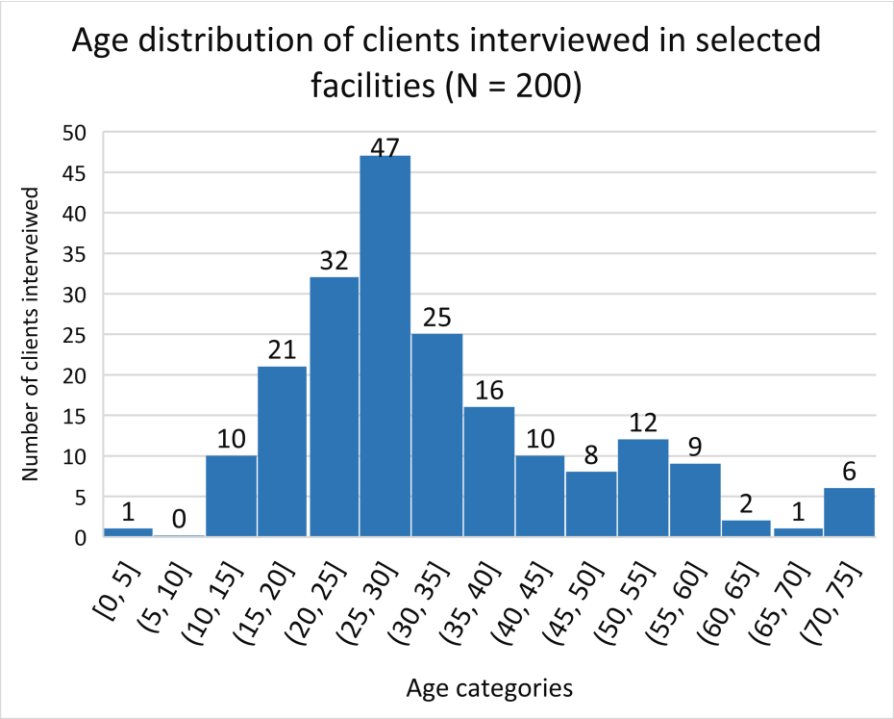
Overall, the responses raised the issues around staffing, Equitable funding for SRH, willingness to understand other programmes to identify integration opportunities and the perceived effect of integration on policy. There is a general agreement that integration will help to address patients' issues holistically.

6. Findings: Service user perspectives

6.1. Service users profile

The purpose of the client exit interviews was to capture the perception of service users or clients on services received at the facilities. Overall, 200clients (20 from each facility) were interviewed from the 10 facilities covered in this assessment, female clients constitute 88% while male constitute 12%. The average age of clients is 33.2 years. Figure 6.1 below shows the age distribution of the clients interviewed.

Figure 6.1: Age distribution of clients interviewed in selected facilities

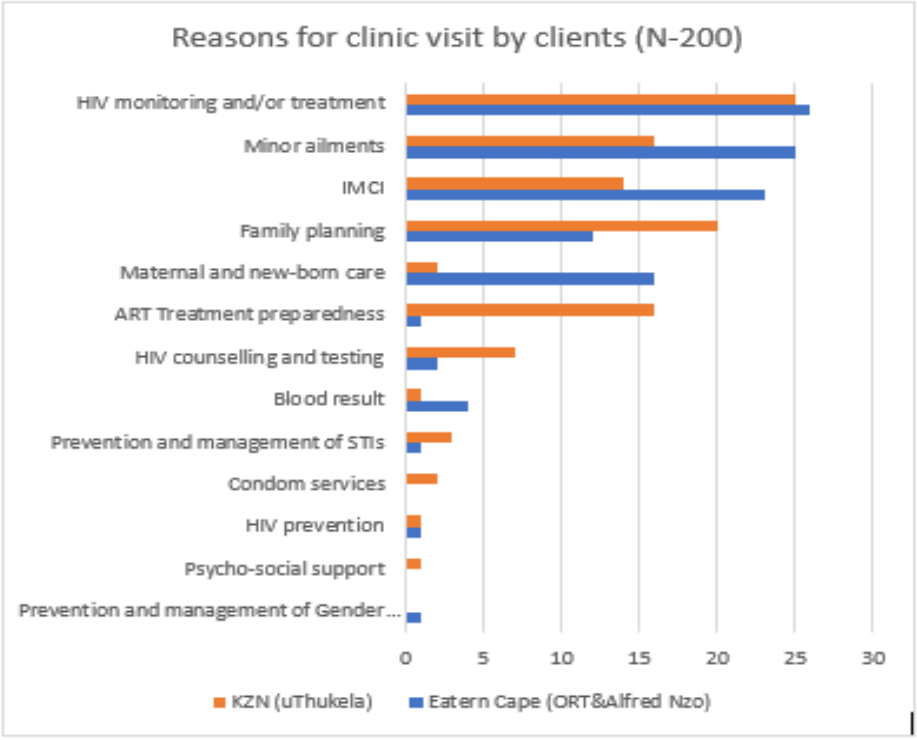


The figure above illustrated that more clients in the age category of 15 to 40 years participated in the survey. One client was indicated to be within the 0-5year bracket, this client was erroneously coded and it was adjusted for in the analysis.

6.2. Reasons for seeking clinic services

The figure 6.2 below shows the reasons why service users were at the facilities assessed on the day of interview.

Figure 6.2: Reasons for coming to the health facility



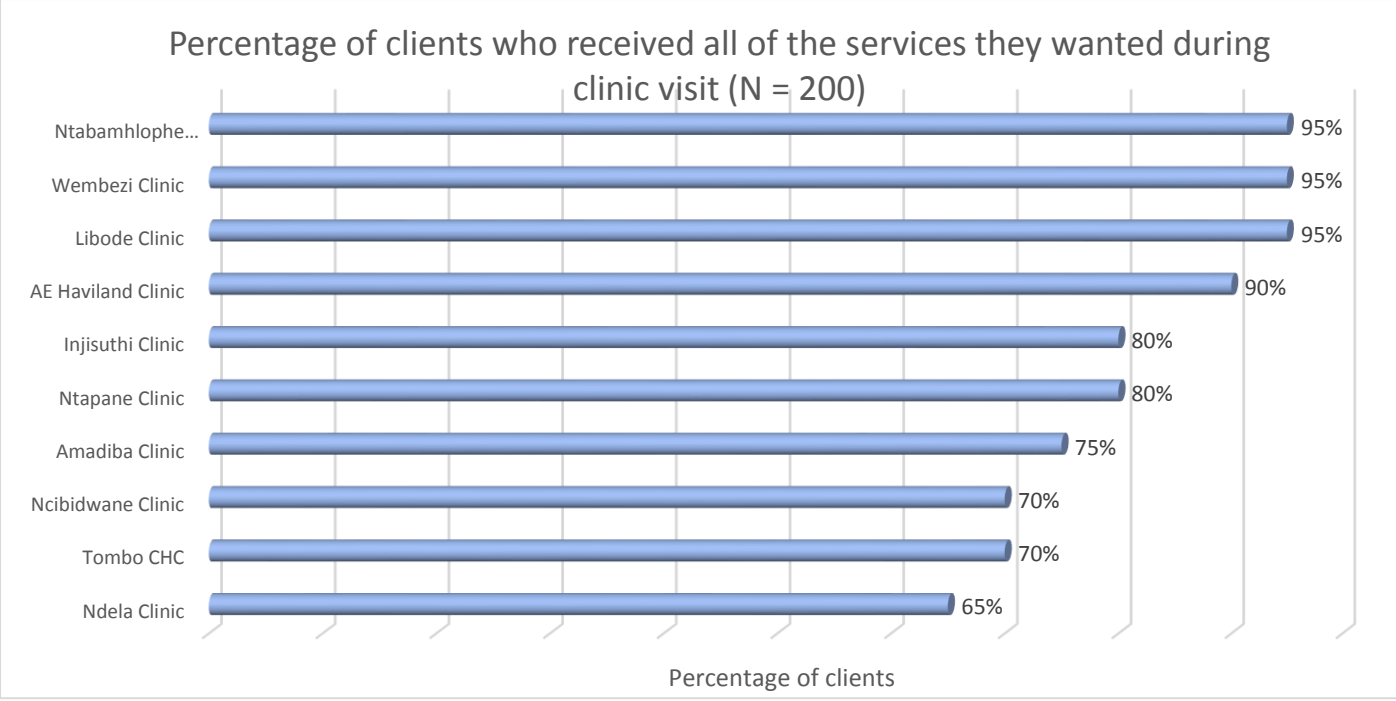
In UThukela district, the most common reasons why clients visited the clinics are for HIV monitoring and/ or treatment, FP, ART treatment preparedness, minor ailments and IMCI in decreasing order. SGBV, Psychosocial and HIV Prevention services (this includes post exposure prophylaxis ,HIV education and other activities apart from condom services that is separated in this graph) were the least sought services in this district

In Eastern Cape (OR Tambo and Alfred Nzo) the most common reasons why clients visited the clinics are for HIV monitoring and/ or treatment, minor ailments, IMCI, Maternal and Newborn, and FP in decreasing order. No clients interviewed indicated coming for condom services (This might have been indicated under HIV Prevention services as well). SGBV, HIV Prevention services and STIs management were also among the least sought services among the participating service users at the visited facilities.

6.3. What proportion received sought service?

When asked if the service users received the services that they came for, 95% of clients from Ntabamhlophe (UThukela), Wembezi (UThukela), and Libode Clinic (OR Tambo) indicated that they received the services that they came for. On the contrary, a lower proportion of clients from Ncibidwane Clinic-UThukela (70%), Tombo Clinic -OR Tambo (70%) and Ndela PHC- Alfred Nzo (65%) indicated they did not. Figure 3

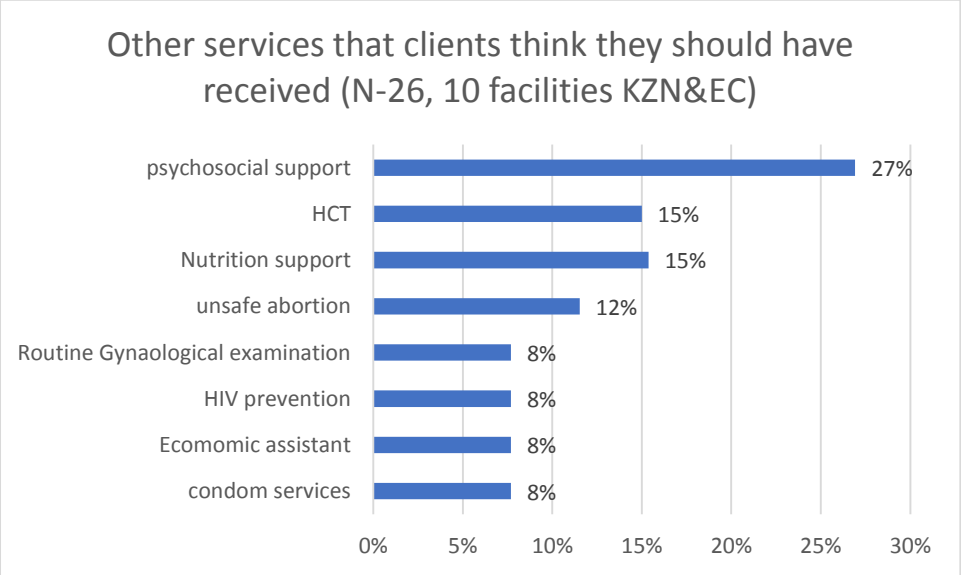
Figure 6.3: Proportion of service providers that received all the services they wanted.



6.4. What other services would you have liked to get from this facility today?

It is ironical that services that were least mentioned as the reasons for coming (Figure 6.2) to the clinic like psychosocial support, HCT, Nutrition support and abortion services as other services that the clients thought they should have received according to Figure 6.4 below.

Figure 6.4: Other services that clients would like to received



6.5. Why do you think you did not receive the service?

Overall, the response of clients to why they thought they did not receive the services they came for is captured under these thematic areas:

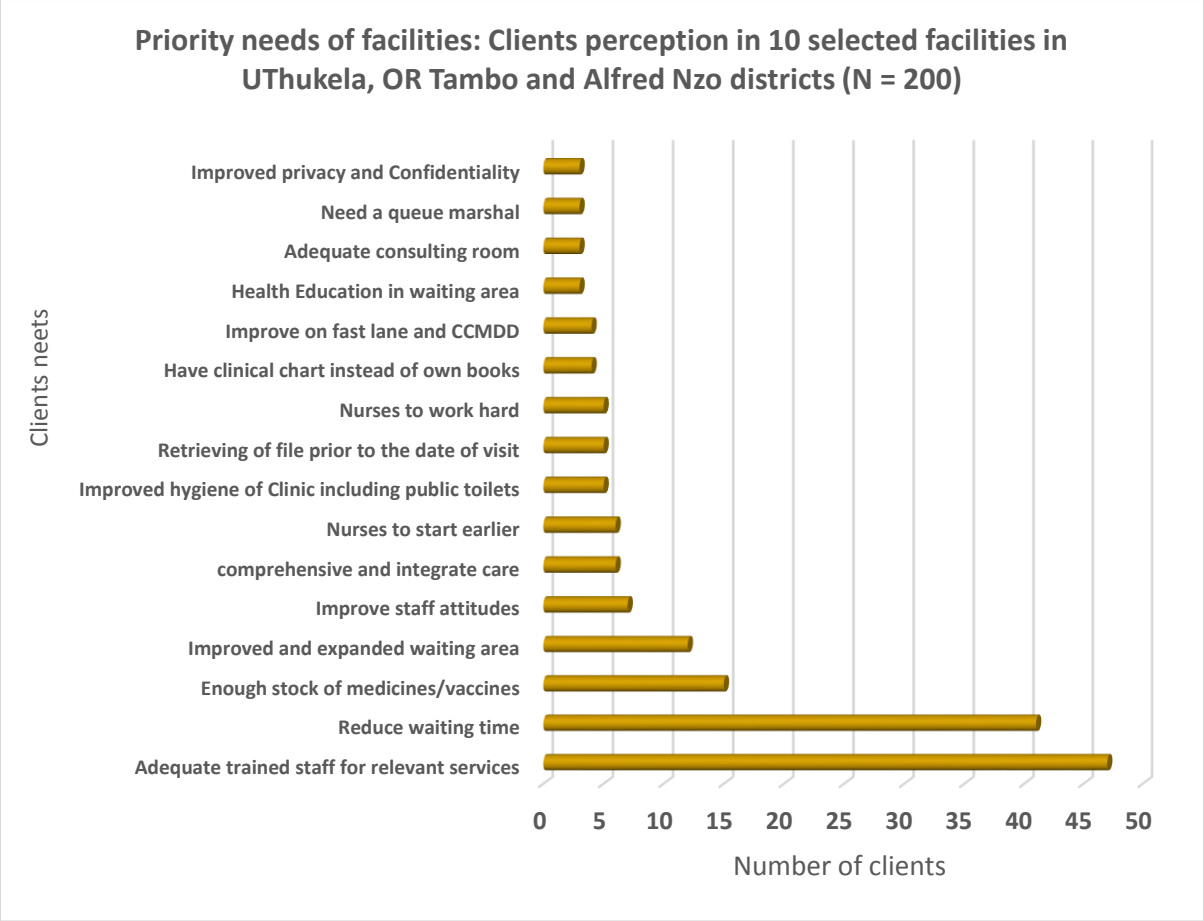
Table 6.1: Why clients thought they did not receive the service

Thematic area	Responses
Staffing	*"No social worker on site", "Nurse too busy", "Nurse seems to be tired", "Nurse do not have time for questions"*
Equipment/ infrastructure	*"No enough room for Nurses,"* "Shortage of equipment"
HCWs attitude	*"Unfriendly, late to attend to patients'*
Stock out	*"services not good at all, could not get treatment last visit"*
Service not available	*"Services not available on weekends", "Due to NHLS strike Service of bloods not available" "No electricity for charging machine".*
Long waiting time	*"I don't have time to wait" "BP not taken and vital signs not done"*,
Don't know why	*"I should have been tested for pregnancy" " I Don't know as there was no explanation why this service could not be rendered today"*

The above illustrated clients perceived reasons for not receiving services.

In line with the above, clients were also asked to mention what they perceived as the priority need of the facilities, figure 6.5 below illustrated that overwhelming majority of clients indicated that adequate training of staff to deliver services and reduction of waiting time will be the first two priority needs. Other priority needs identified by clients are illustrated below

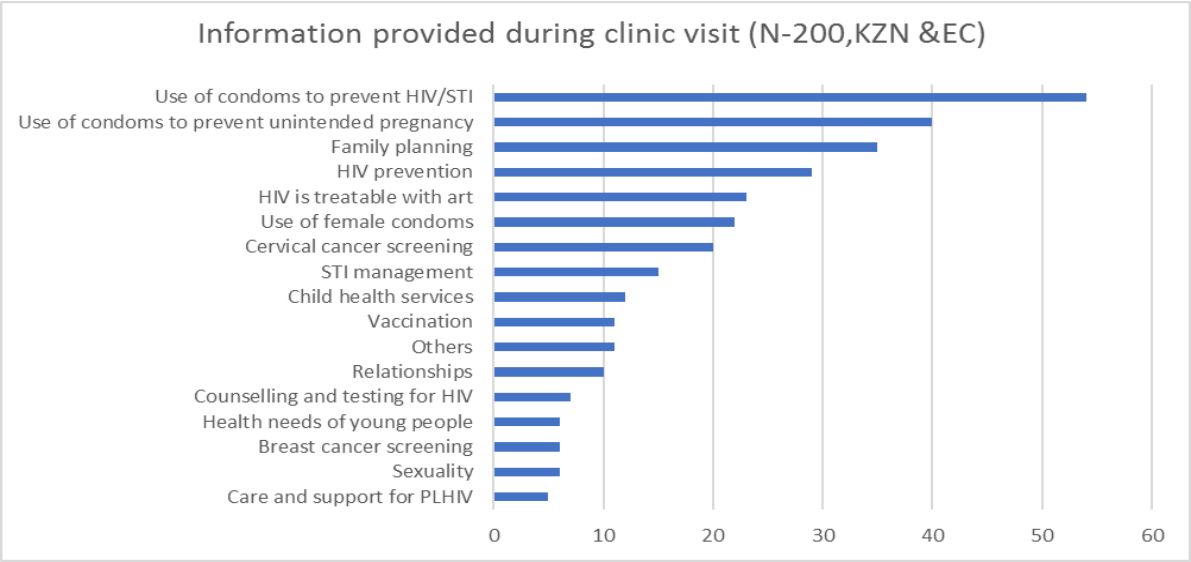
Figure 6.5: Clients perception of facility Priority needs



6.6. Information provided during clinic visit

Clients indicated that Use of Condoms to prevent HIV/STI, Use of Condom to prevent HIV/STI and unwanted pregnancy, FP, and HIV is treatable are the top information provided by service providers during this visit episode to the 10 facilities. In contrast to this, information on care and support for PLWHIV and Sexuality were the least mentioned. The figure 6.6 below illustrates this.

Figure 6.6: Information provided to clients during clinic visit



The following figures illustrated the type of information provided to clients broken down to district levels. There are some similarities and differences that will help to contextualise the findings.

Figure 6.7: Information provided UThukela

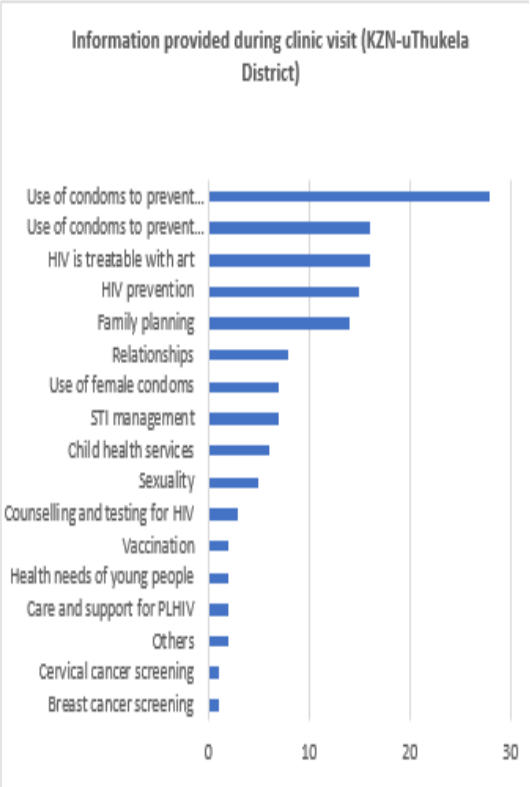
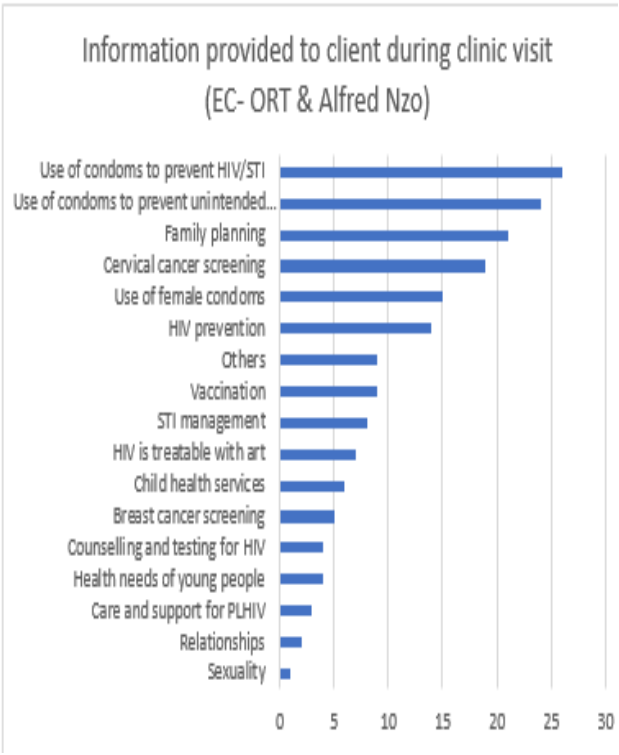


Figure 6.8: Information provided OR Tambo/Alfred Nzo



6.7. Service users' perception of receiving SRH and HIV Services

Level and reason for preference for same facility SRH and HIV service

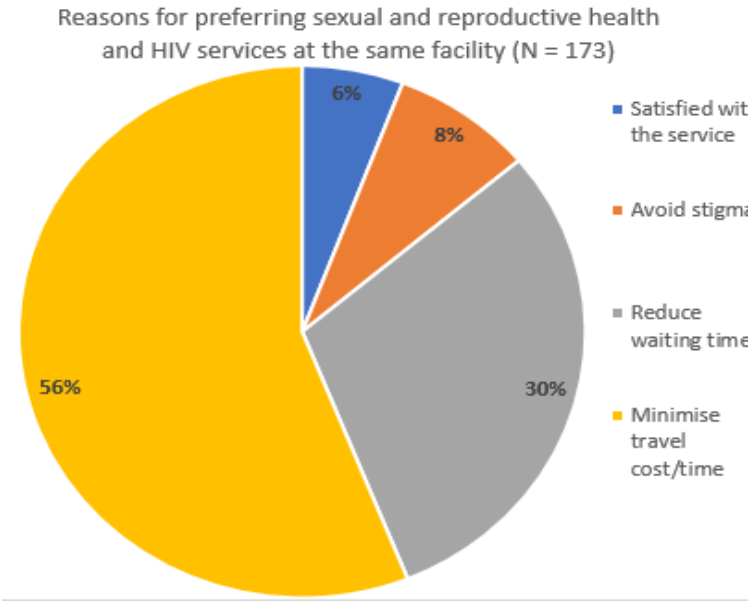
Overall, over 70% of clients from all the 10 health facilities assessed indicated their preference to receiving SRH and HIV services from same facility. The table below shows the level of preference for receiving SRH and HIV services in same facility

Table 6.2 Clients preference for same facility SRH and HIV services

Province/District	Facility name	Level of clients Preference for SRH and HIV services in same facility
Eastern Cape: OR Tambo and Alfred Nzo District	Amadiba Clinic	90%
	Ndela Clinic	95%
	Libode Clinic	95%
	Tombo CHC	90%
	Ntapane Clinic	80%
KwaZulu-Natal: UThukela District	AE Haviland Clinic	70%
	Ncibidwane Clinic	70%
	Wembezi Clinic	85%
	Injisuthi Clinic	85%
	Ntabamhlophe Clinic	90%

According to clients, minimise travel cost and time (56%) and reduce waiting time (30%) came out strongly as the two main reasons for preferring sexual and reproductive health services at the same facility. Clients responses indicated that being Satisfied with the service (6%) and avoidance of stigma (8%) are the two least reasons for preferring SRH and HIV services in the same facilities. This reasons are illustrated in Figure 9 below.

Figure 6.9: Reasons for preferring SRH and HIV services in same facility

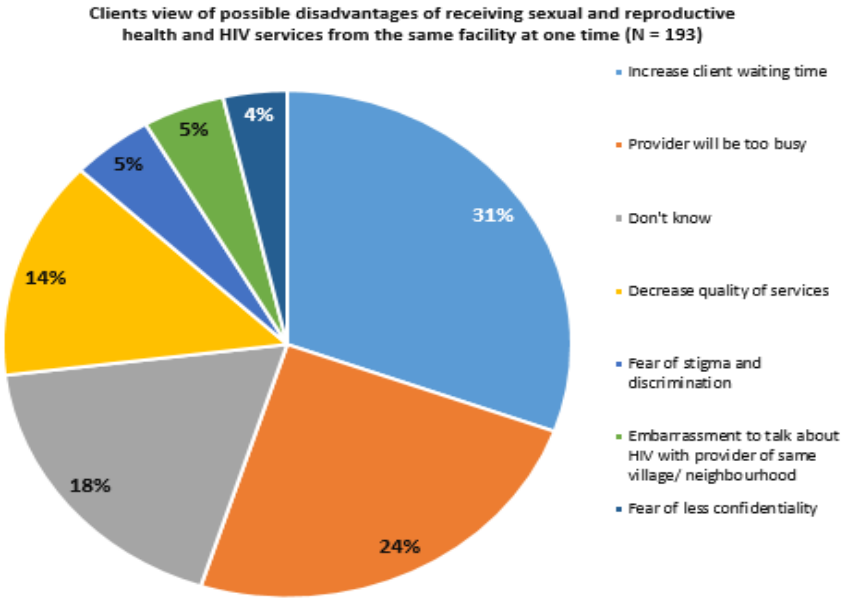


6.8. Clients perceived disadvantages of receiving services at same site

In looking at the perceived disadvantage of receiving SRH and HIV services from same facility at one time, majority of the clients (55%) reported that receiving the services from the same facility at one time will lead to an increased waiting time (31%) and will make the service providers too busy (24%). However, less proportion of clients interviewed indicated that it will lead to decrease quality and fear of stigma and discrimination. See figure 6.10 below for illustration.

It looks contradictory for the clients to have chosen 'reduce waiting time' as one of the top two reasons for preferring the service at same facility in Figure 6.9 above, and also indicates in Figure 6.10 that this service delivery method also possibly have a disadvantage of increasing waiting time. More exploration is required to be able to fully understand this concept.

Figure 6.10: Clients perceived disadvantages of receiving SRH and HIV services from same site at one time



Comparing Figures 6.11 and 6.12 below, while the top two possible disadvantages identified by clients from UThukela facilities are increase waiting time and decreased quality of service, OR Tambo and Alfred Nzo facilities clients indicated that providers will be too busy and increase waiting time are the top two perceived disadvantages.

Figure 11: Clients perceived disadvantages of receiving SRH and HIV services from same site at one time (UThukela District)

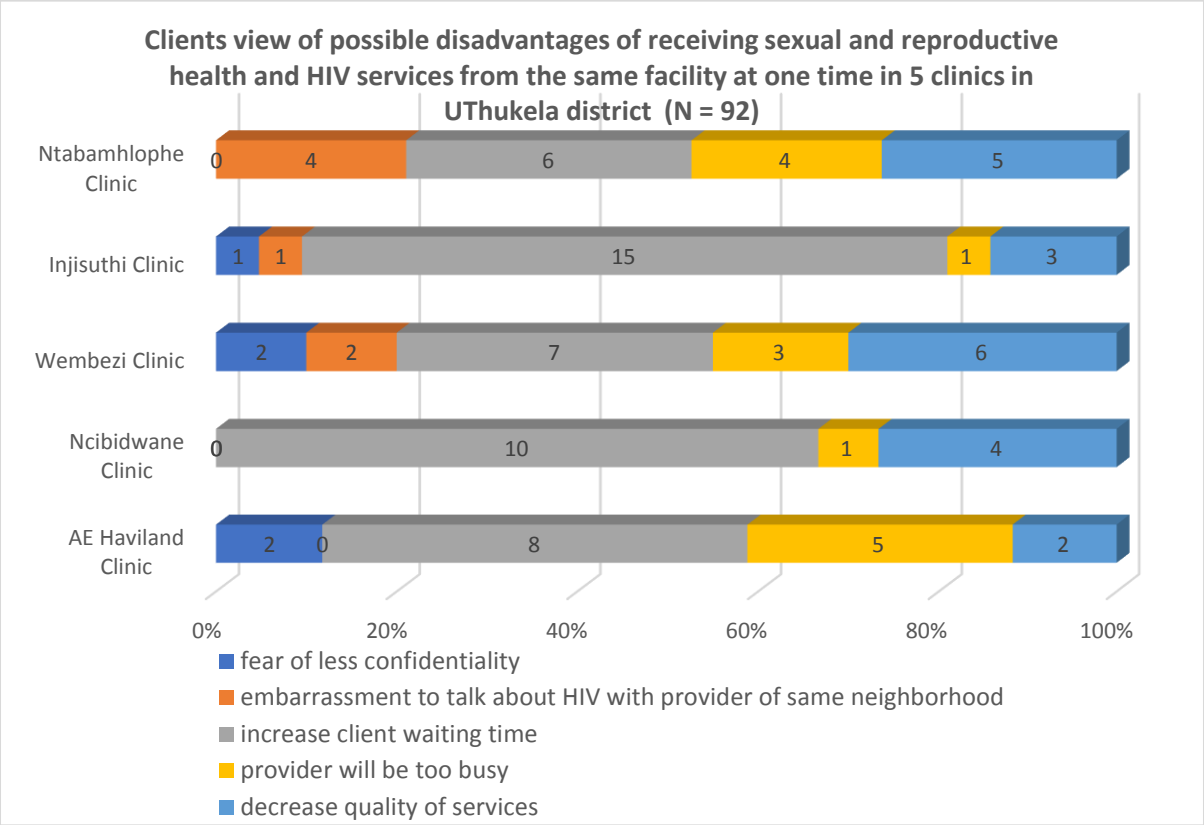
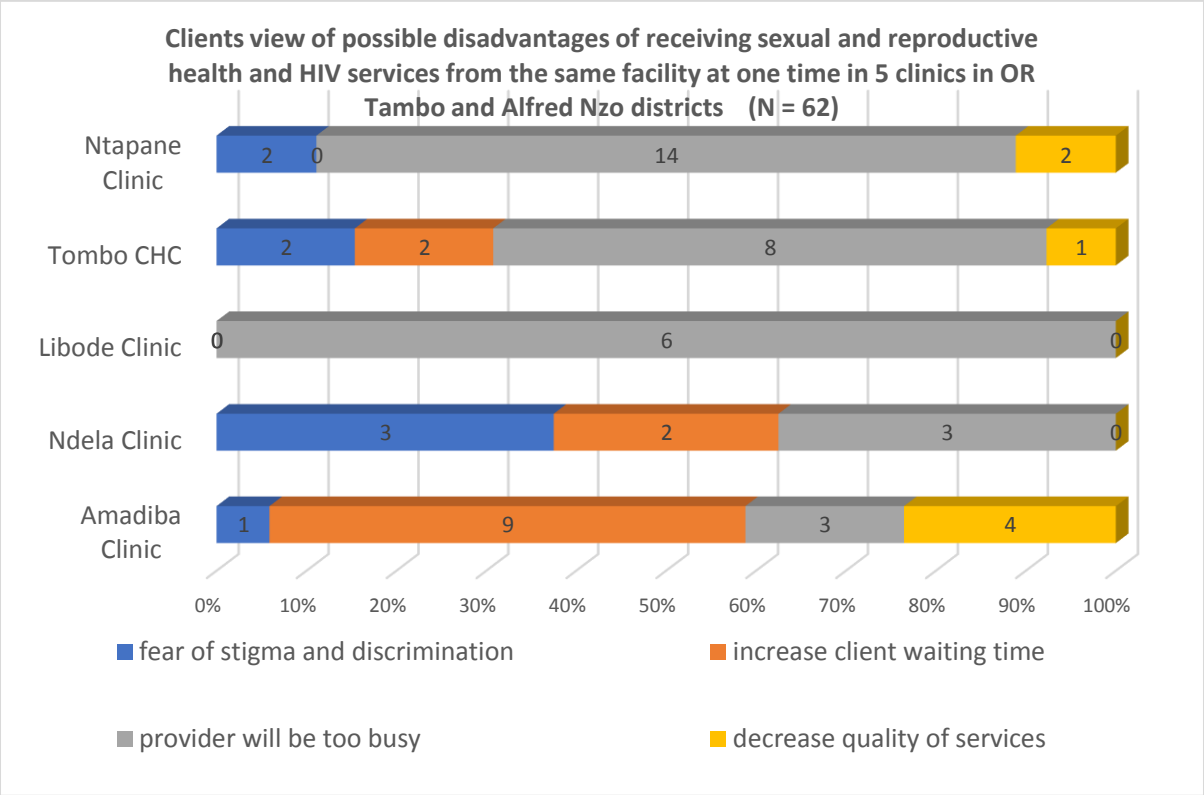


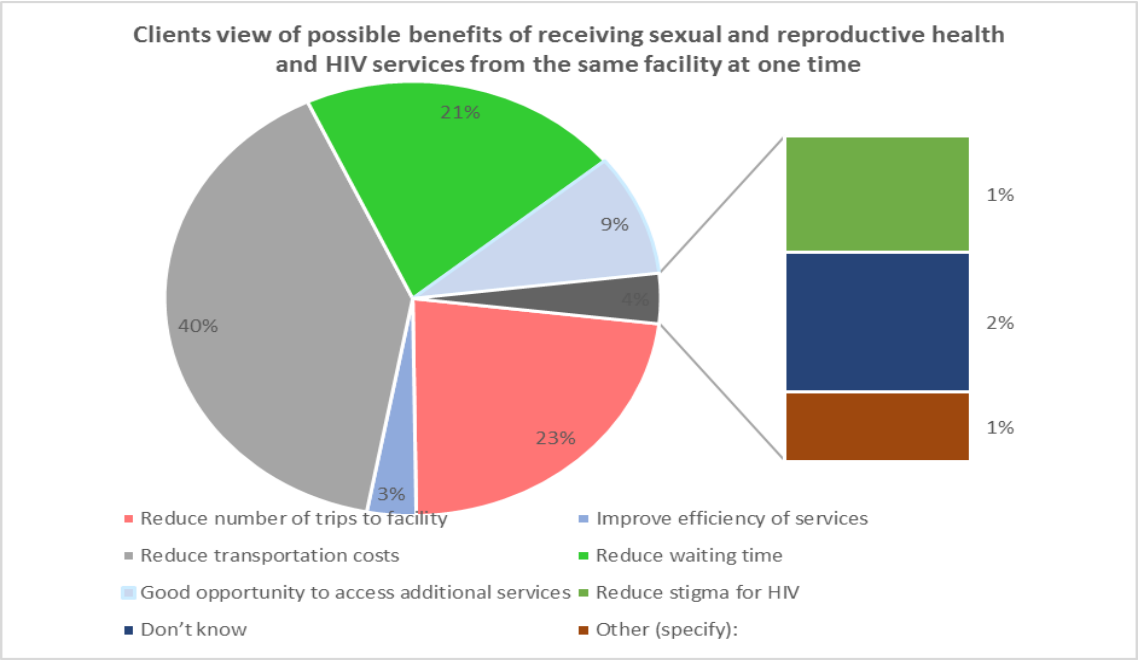
Figure 12: Clients perceived disadvantages of receiving SRH and HIV services from same site at one time (OR Tambo & Alfred Nzo Districts)



6.9. Clients perceived benefits

According to clients, reduced transport cost is the biggest benefit of offering SRH and HIV services in the same facility, this is closely followed by reduce number of trips to facility and reduce waiting time.

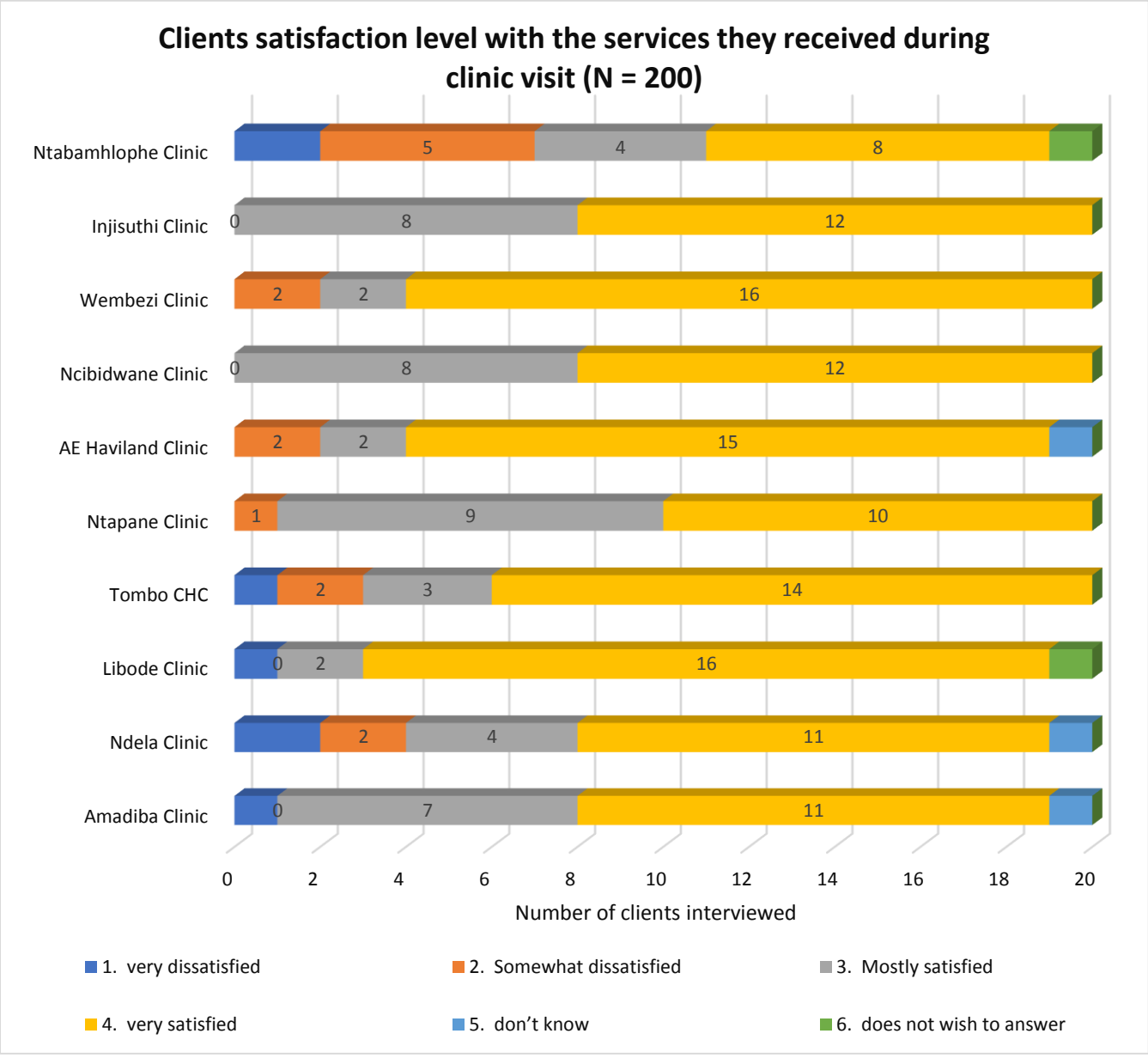
Figure 6.13: Clients perceived benefits of receiving SRH and HIV services at same day and same time



6.10. Clients satisfaction with the facilities

Overall, clients are satisfied with the services they received at the facility, although the degree of satisfaction varies from 80% very satisfied clients from Wembezi and Libode to Ntabamhlophe clinic having only 60% as either mostly satisfied or very satisfied. Ntabamhlophe also recorded the highest degree of dissatisfaction. See Figure 14 below for illustration.

Figure 6.14: Clients satisfaction with services



7. Findings: Service provider perspective

7.1. Profile of HCW

A total of 37 (Female-89%, Male-11%) service providers were interviewed in all the 10 health facilities. The table below shows the breakdown of the number by facilities and districts.

Table 7.1: Number of service providers interviewed by facilities

Alfred Nzo & OR Tambo (Eastern Cape)	Number of service provide interviewed
1. Ndela PHC - Alfred Nzo	3
2. Amadiba clinic-Alfred Nzo	4
3. Libode Clinic- OR Tambo	3
4. Ntaphane Clinic-OR Tambo	4
5. Tombo Clinic-OR Tambo	4
UThukela (Kwa-Zulu Natal)	
6. Injisuthi Clinic	4
7. Ntabamhlophe Clinic	4
8. Wembezi Clinic	3
9. AE Havilland Clinic	4
10. Ncibidwane Clinic	4
Total	37

As illustrated in Figures 7.15 and 7.16 below, the highest categories of the service providers interviewed are Clinical Nurse Practitioner (CPN)/ Professional Nurse (68%), Operational Manager (19%), while counsellor and staff nurse (Enrolled Nurses) are 8% and 5% respectively.

Most of the service providers interviewed are from the chronic (49%) and Maternal and Child Health (30%) entry points. In some cases, especially in Eastern Cape same staff provided services to more than one entry points because of shortage of staff.

Figure 7.1: Service provider designation

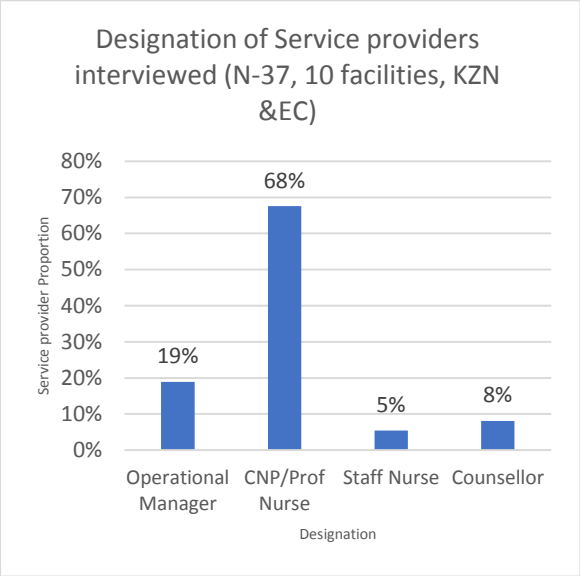
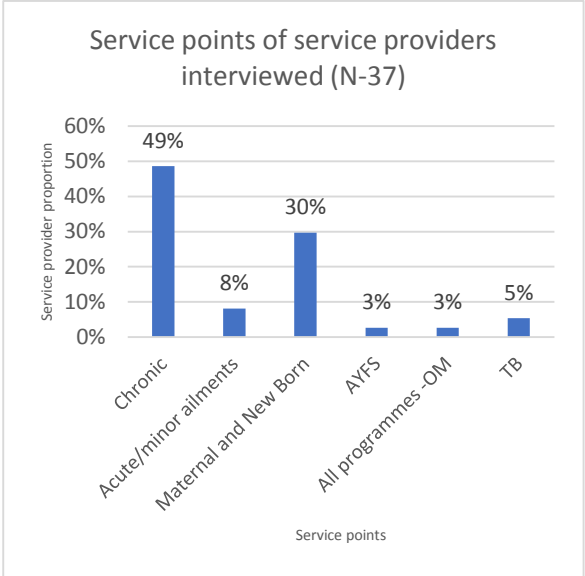


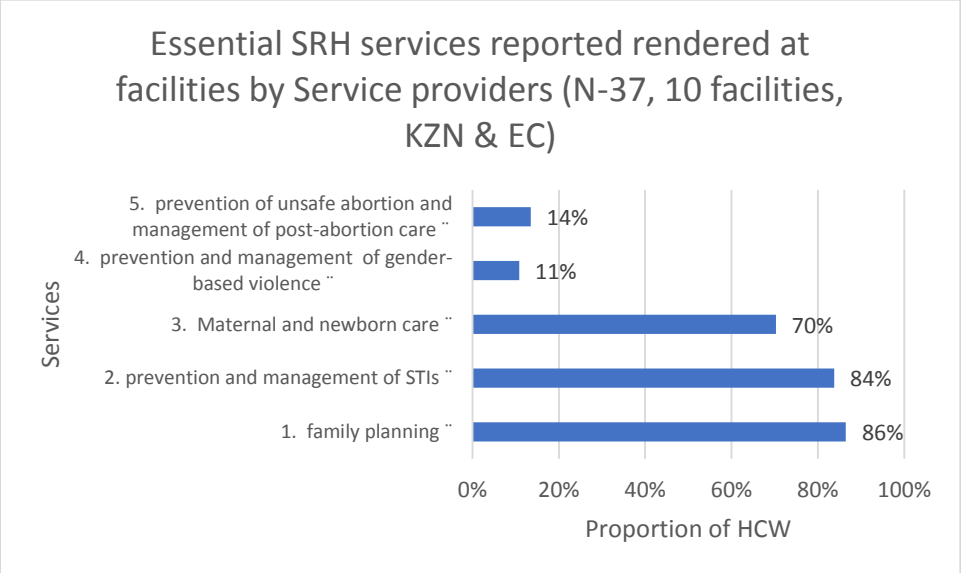
Figure 7.2: Service points of service provider



7.2. Service Availability

7.2.1. SRH service availability

Figure 7.3: Essential SRH services rendered by facilities as reported by service providers

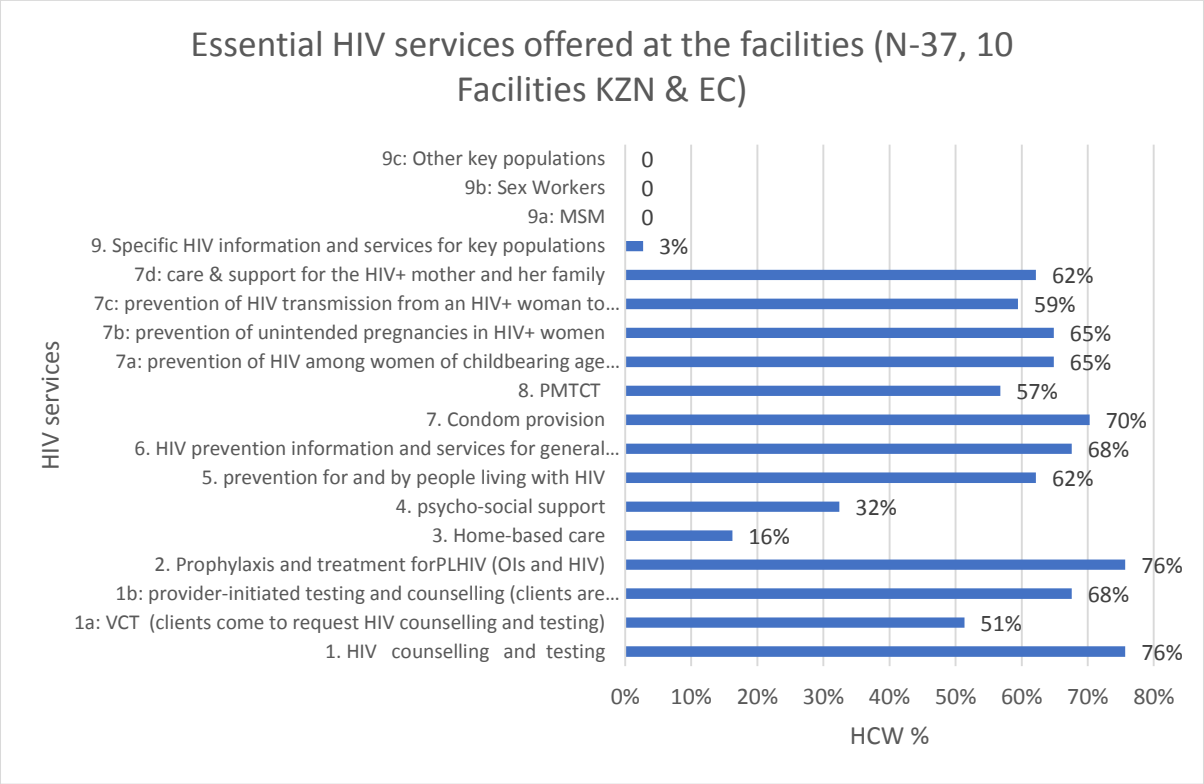


All assessed facilities (10) provide FP, STIs, and Maternal and Newborn care as an essential package of PHC service availability. However, service providers indicated availability of Family Planning (86%), STIs Prevention and management (84%) and Maternal and Newborn care (70%) services in their facilities, the least available services according to service providers are gender-based violence (GBV) (11%) and prevention of unsafe abortion and management of post-abortion care (14%), the GBV and abortion management and prevention services are generally reported to be referred out of facilities. Furthermore, Tuberculosis services were also indicated to be available in all ten facilities. There is a

disparity between what service is actually provided by the facility and what the service provider indicated as available. The reason for this is not clear to the reviewer and will need further exploration.

7.2.2. HIV service availability

Figure 7.4: Essential HIV services rendered as reported by the service providers



According to the service providers, HIV services are provided in all the facilities that were accessed (10 facilities), the most available HIV service are HIV Counselling and Testing (HCT) (76%) and Prophylaxis and treatment for PLHIV (OIs and HIV) (76), followed by Condom provision (70%). Most other HIV services are in the mid-range of availability (52% to 68%). The least available HIV services are those for key populations (0%), providing specific HIV information and services for Key populations (3%), Home Based Care (16%), psychosocial support (32%)

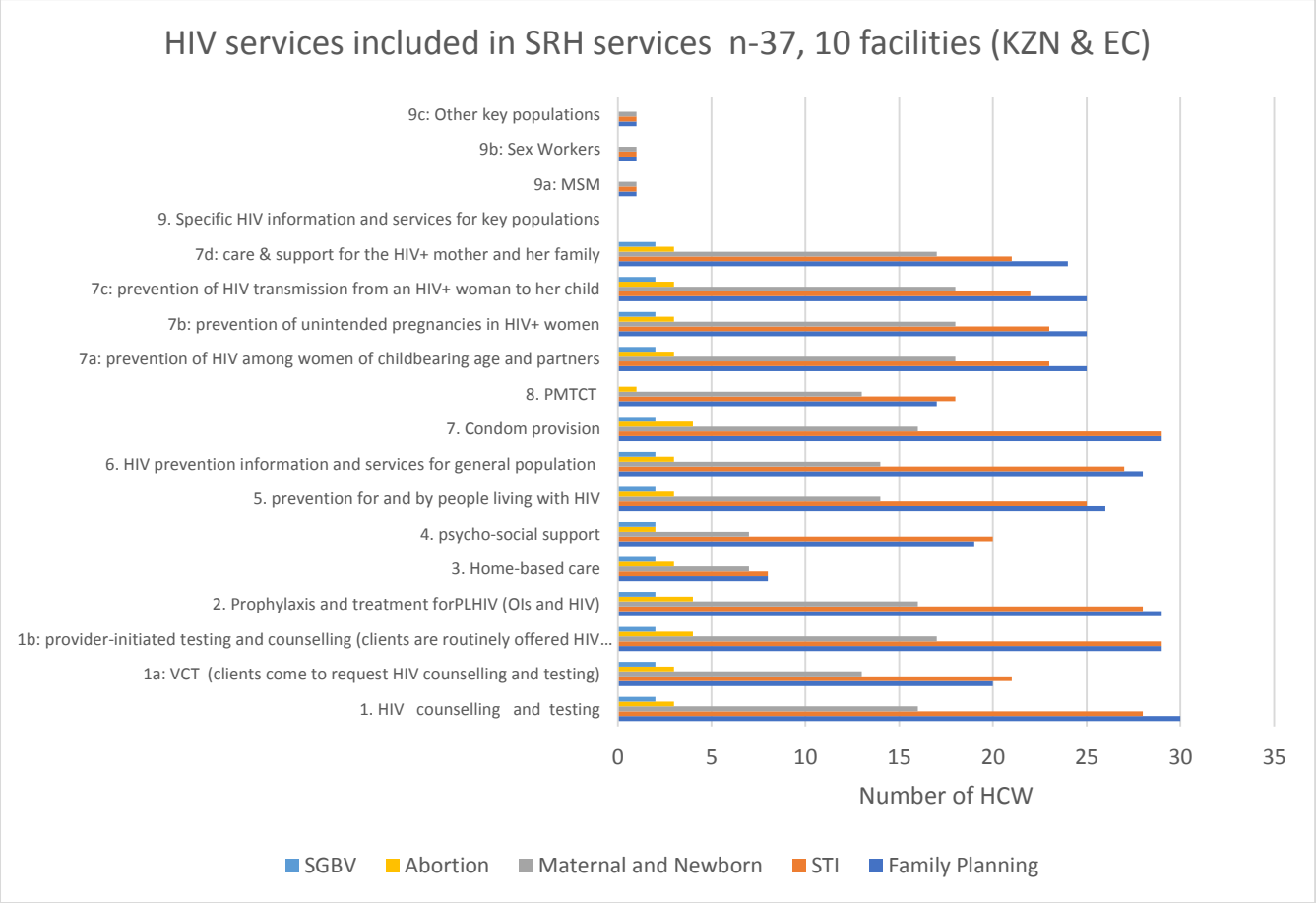
Service providers reported offering more Provider Initiated Testing and Counselling (PITC) (68%) than Voluntary Counselling and Testing (VCT) (51%) as types of HCT services. Service providers also indicated the availability of Prevention of mother to child transmission (PMTCT) services (57%), with prong 1; primary prevention of HIV for women of childbearing age (65%)and prong 2; preventing unintended pregnancies among women living with HIV (65%) reported to be more available than prongs 3 and 4; prevention of HIV transmission from women living with HIV to their children (59%) and care and support to mothers living with HIV, their children and families (62%)

7.2.3. HIV integration into SRH

Figure 7.5 below illustrates the provision of HIV services within the SRH services. According to the service providers, HIV services have more probability of being included in the Family planning and STI services, this is less likely with the Maternal and Newborn services. HIV services are least likely to be included in prevention and management of abortion services and SGBV services. Hence, clients seeking FP and STI services are more likely to receive a wider range of HIV services as part of the service provided by service provider.

Generally, HIV Services such as HIV Counselling and testing, PITC, Prophylaxis and treatment for PLWHIV, HIV Prevention for PLWHIV, HIV prevention information services to general population and condom provision services are indicated to be the most likely services included in SRH services. In contrast, HIV services to key population like MSM, Sex workers have the least possibilities of being includes in the SRH services.

Figure 7.5: HIV Services included in SRH services



How HIV services are rendered within SRH

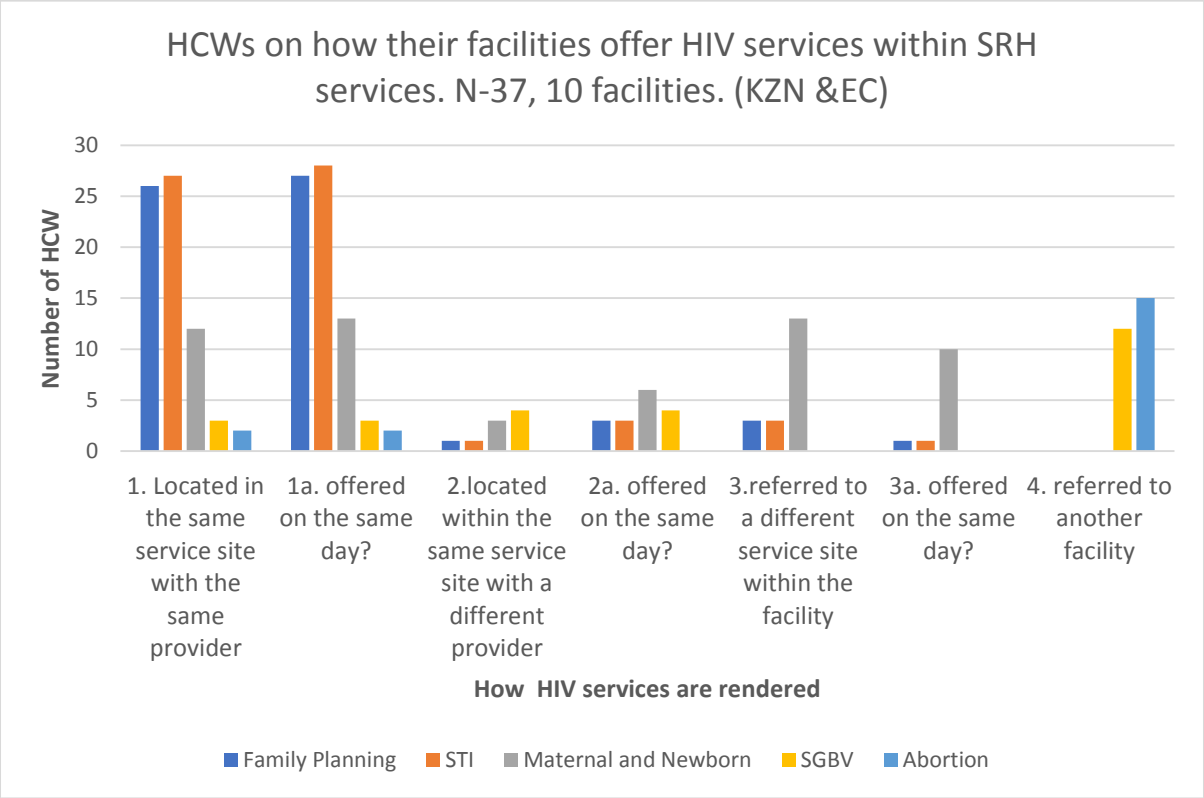
When HIV services are offered within SRH services, these are most often implemented by the same service provider at the same site on the same day. The least common method is to refer the client to another facility. Service providers reported that it is a very high probability that HIV services will be provided in the same service site with the same service provider at the FP and STI management

service point. Furthermore, it is more likely that these services are offered on the same day within the FP and STI management service sites

Service providers reported that for clients seeking Maternal and Newborn services, there is an almost equal probability that the clients will either be provided with HIV services in the same site by the same provider or be referred to another service point within the same facility. However, there is a high probability that the services will be offered on same day.

Generally, services for SGBV and Abortion are referred to another facility.

Figure 7.6: How HIV services are rendered within SRH services

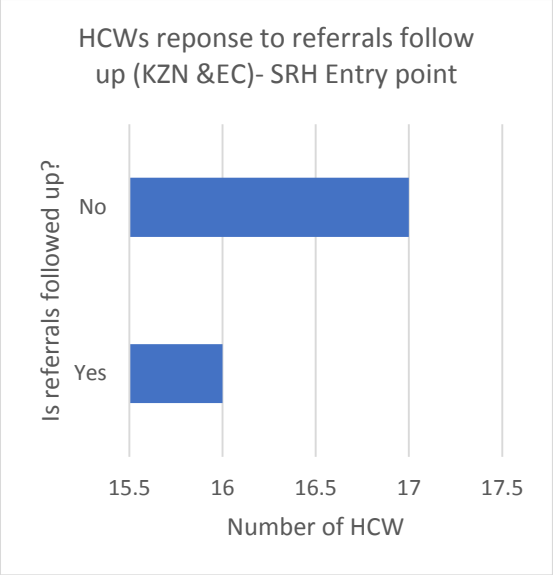


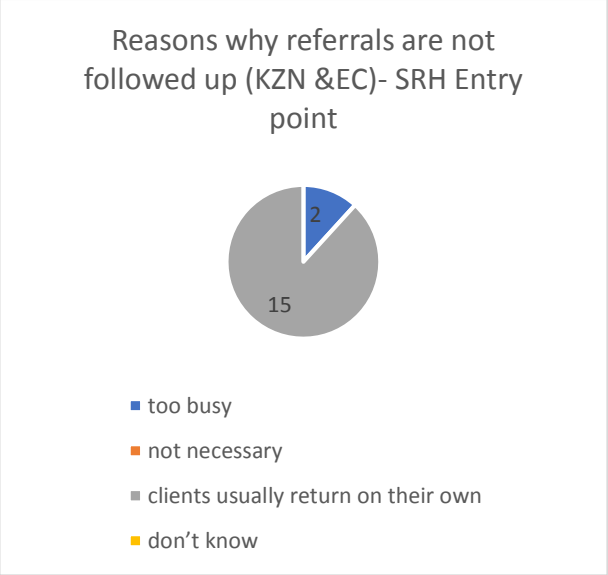
Referrals from SRH service point

According to the service providers that were interviewed, referrals are not followed up most of the time. The reasons provided for the negative response of the overwhelming majority of service providers (88%) is that 'clients usually return on their own' even when not followed up. The rest of the service providers with negative responses (12%) attributed the reason to being 'too busy'.

It could be deduced that since the majority of the clients that are referred out of the facilities are clients with SGBV and Abortion, these are also the clients that will be significantly affected by this practice.

Figure 7.7: Referral from facilities

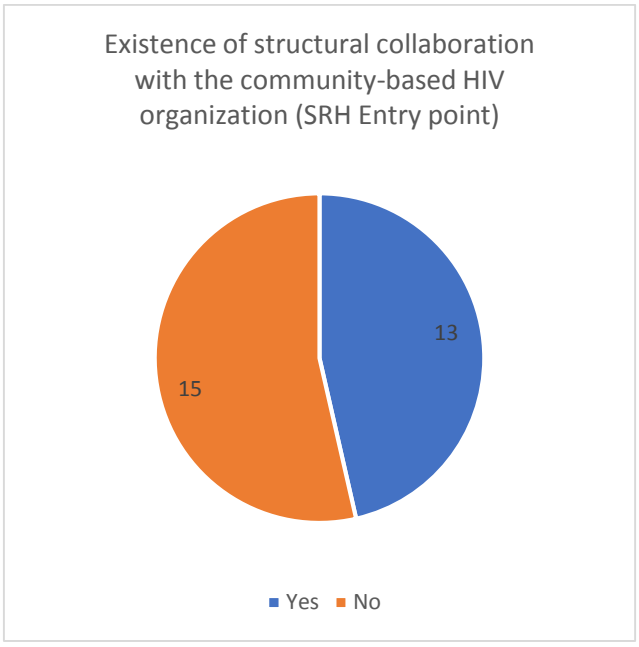




Collaboration of SRH with the community based HIV organization

Among the 28 service providers that responded to this question, 54% indicated that there is no structural collaboration between SRH entry point with the community-based HIV organizations. Furthermore, the reason provided for non-collaboration includes *"lack of knowledge of their existence", "no formal memorandum of understanding"* and that "*they were approached for collaboration but the CBOs are not funded to support SRH"*. Whilst the rest (46%) of the service providers indicated a positive response they could not provide evidence that this occurs.

Figure 7.8: Existence of collaboration with the community



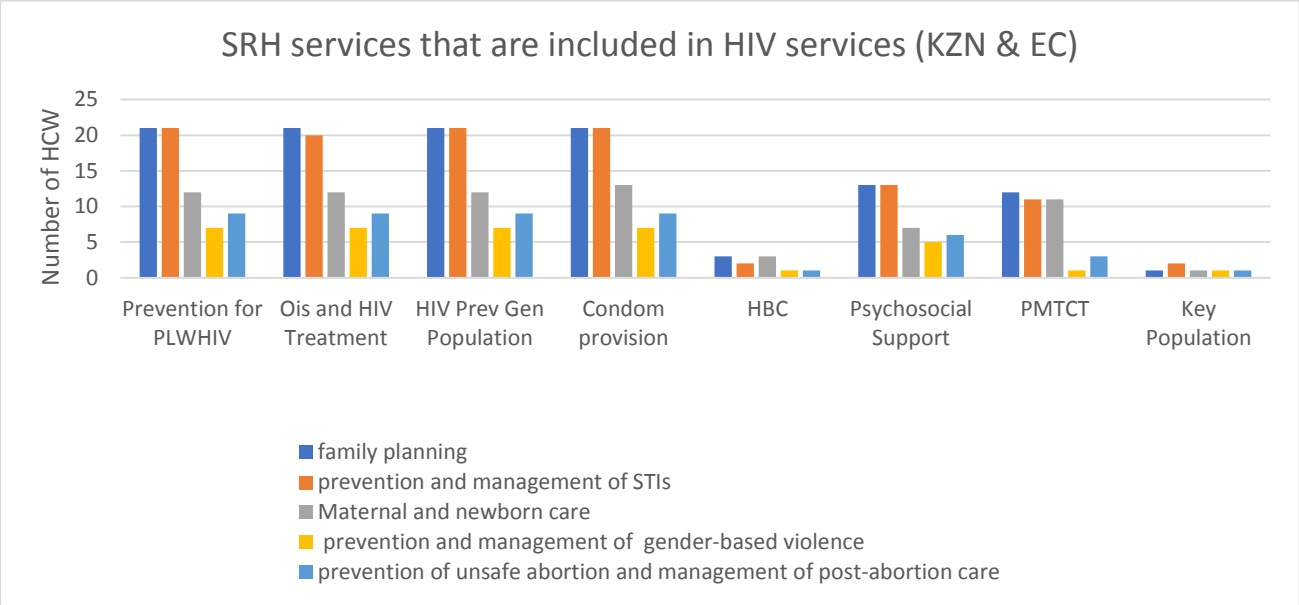
7.2.4. SRH integration into HIV

According to the service providers, SRH services have more probability of being included in the Prevention for PLWHIV, OIs and HIV treatment, HIV prevention for general population and Condom provision services, Hence, clients seeking these services are more likely to receive a wider range of

needed SRH services as part of the service provided by service provider. The service providers indicated a less probability that clients seeking psychosocial support and PMTCT services will receive a comparative less range of SRH services when compared with the earlier group. SRH services are least likely to be included in HBC and Key population services.

Generally, SRH Services such as FP and prevention and management of STIs are indicated to be the most likely services included in HIV services. In contrast, SRH services of SGBV and prevention and abortion related care have the least possibilities of being included in the HIV services. This is illustrated by the Figure 7.9 below

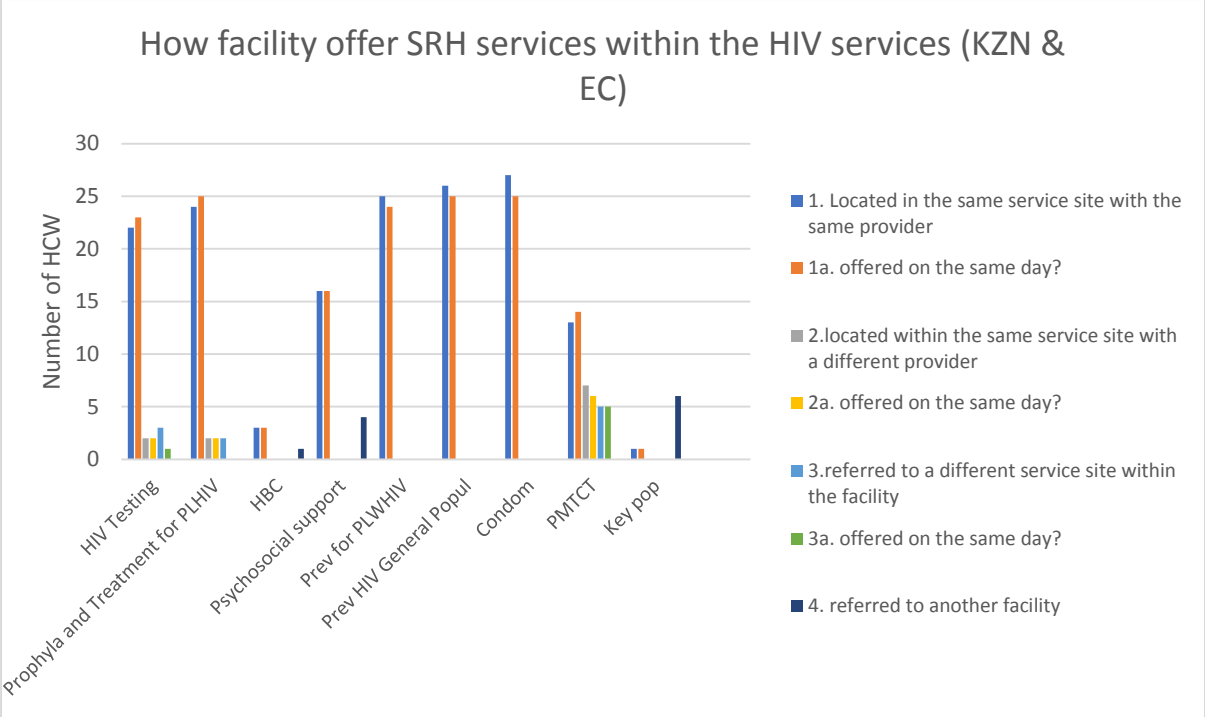
Figure 7.9: SRH services included in HIV services



How facilities offer SRH services within the HIV services

When SRH services are offered within HIV services, these are most often implemented by the same service provider at the same site on the same day. The least common method is to refer the client to another facility. Furthermore, it is more likely that these services are offered on the same day within these service sites. Service providers reported that it is a very high probability that SRH services will be provided in the same service site with the same service provider at all the listed HIV service points with the exception of the Key population and psychosocial support where there is a high probability of referral to another facility.

Figure 7.10: How facilities offer SRH services within HIV services



Collaboration of HIV with SRH based organizations

Among the service providers that responded to this question, 67% indicated that there is no structural collaboration between SRH entry point with the SRH organizations. Furthermore, the reason provided for non-collaboration includes *"lack of knowledge of their existence" and "no formal memorandum of understanding*". Whilst the rest (33%) of the service providers indicated a positive response they could not provide evidence that this occurs.

HCWs perception of constraints of delivering linked HIV and SRH services

Figure 7.11: Collaboration of HIV with SRH CBO

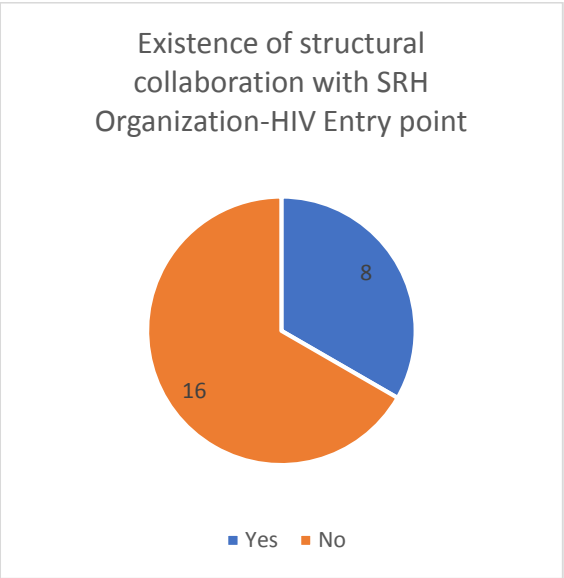


Figure 7.12: Protocol supporting integration

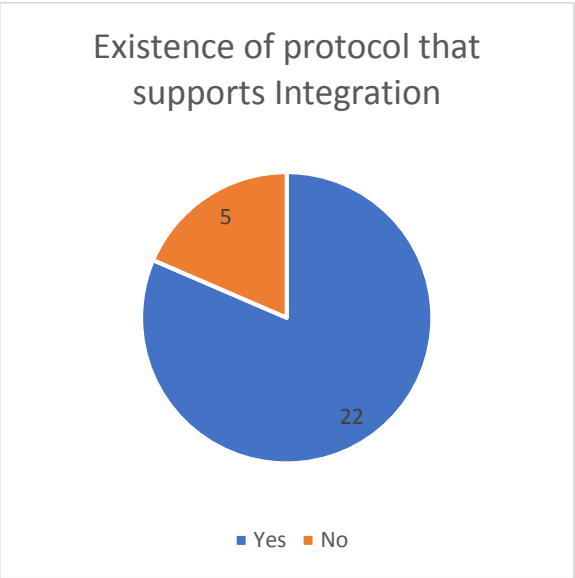


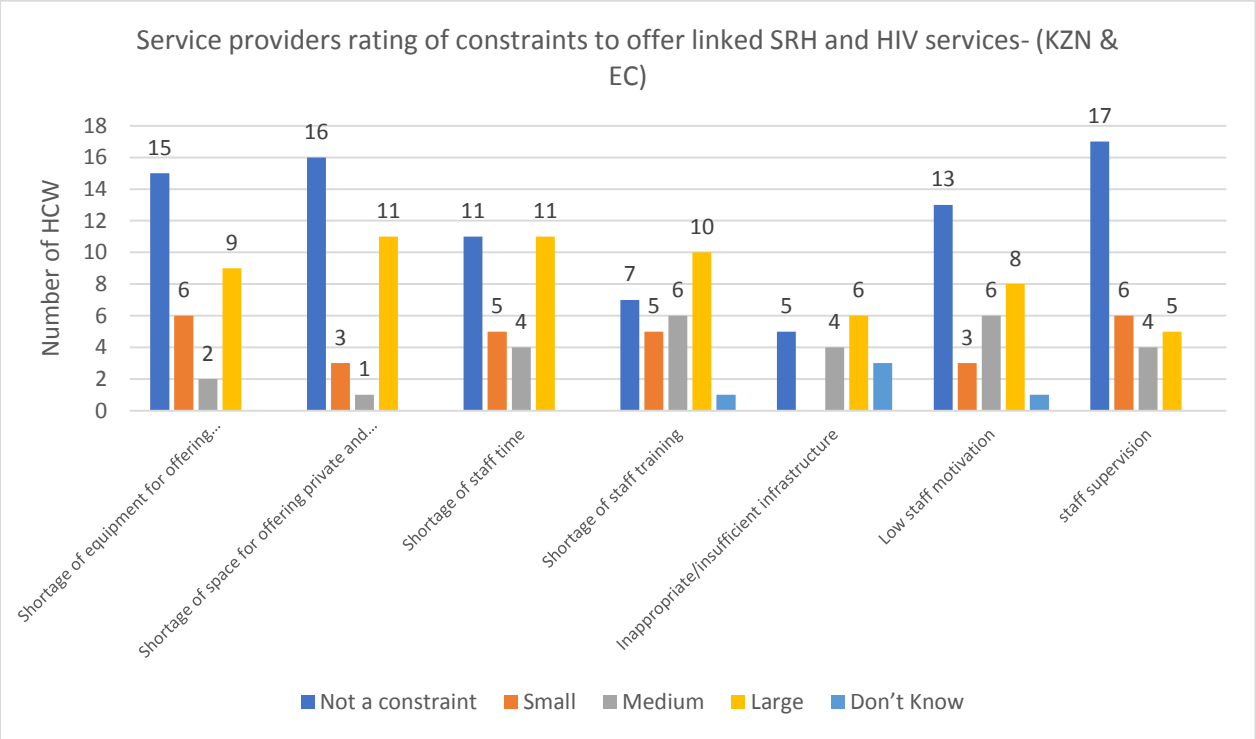
Figure 7.12 above, 81% of service providers indicated the existence of protocol that supports integration. Some of these service providers mentioned PCA 101, guidelines such as FP, ART and integrated training materials like the one for the comprehensive HTS. The 19% that responded

otherwise indicated that there is no *"one single protocol or guideline"* that supports integration. Many also express concern about having to use too many guidelines as reference during consultation. *"Those of us that are not yet trained need to reference many guidelines while consulting"*

A number of activities were also identified to support integration at the facility level. These include in-service training, introduction of Ideal Clinic and pilot sites for Health Insurance. UNFPA support to other NGOs on integration was also indicated.

7.2.4 Constraints to offering linked SRH and HIV services

Figure 7.13: Constraints to offering linked SRH and HIV services

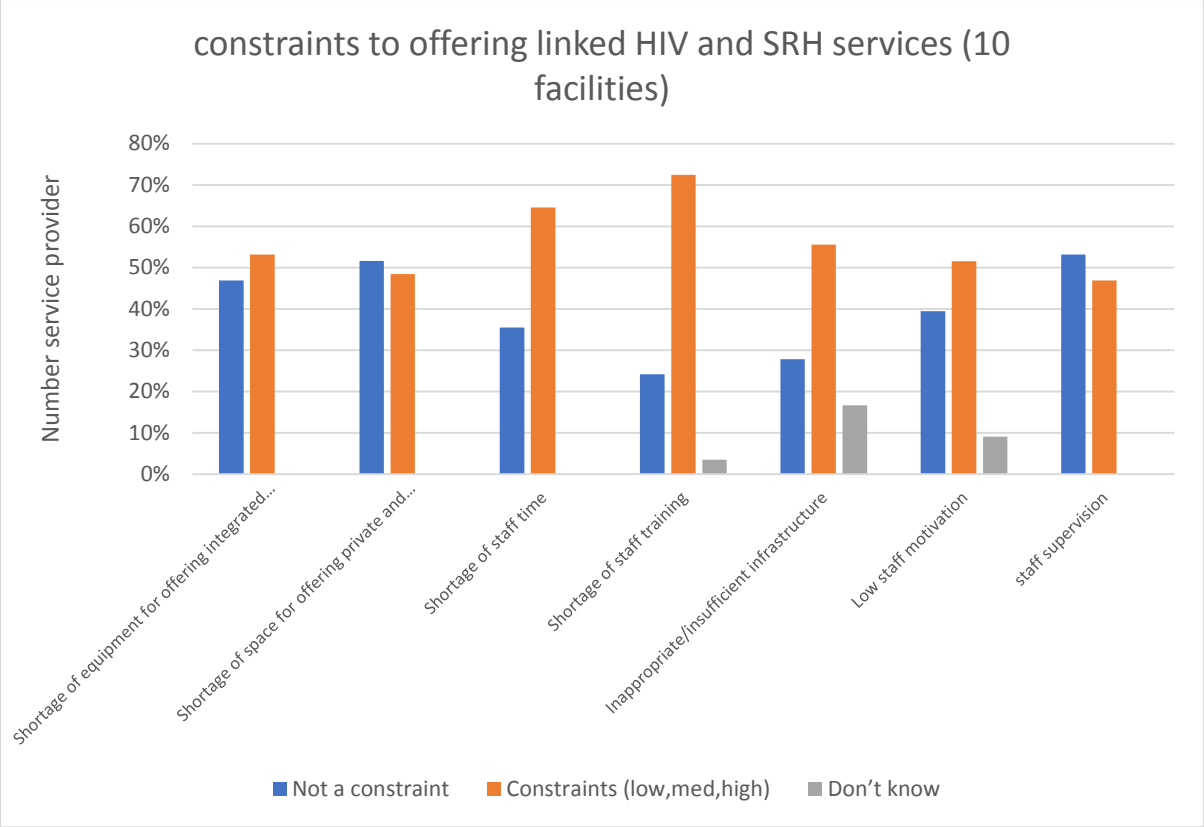


According to the service providers rating of constraints that impedes on the offering of linked SRH and HIV services, the main constraints are: shortage of equipment, space, time, training and low staff motivation. Some staff also expressed their concern about the time spent with clients. *"The patients waiting for me in the waiting area will wonder why I spent so much time with a client, he might think I am discussing personal stuff or socialising in the consulting room".*

Overall, as shown in Figure 7.14 below except for space and staff supervision more service providers indicated that all other indices are constraints to their work.

The biggest constraints identified by the service provider is Shortage of Staff training, with over 70% of staff indicating this as a constraint

Figure 7.14: 'Constraints' versus 'not a constraint'

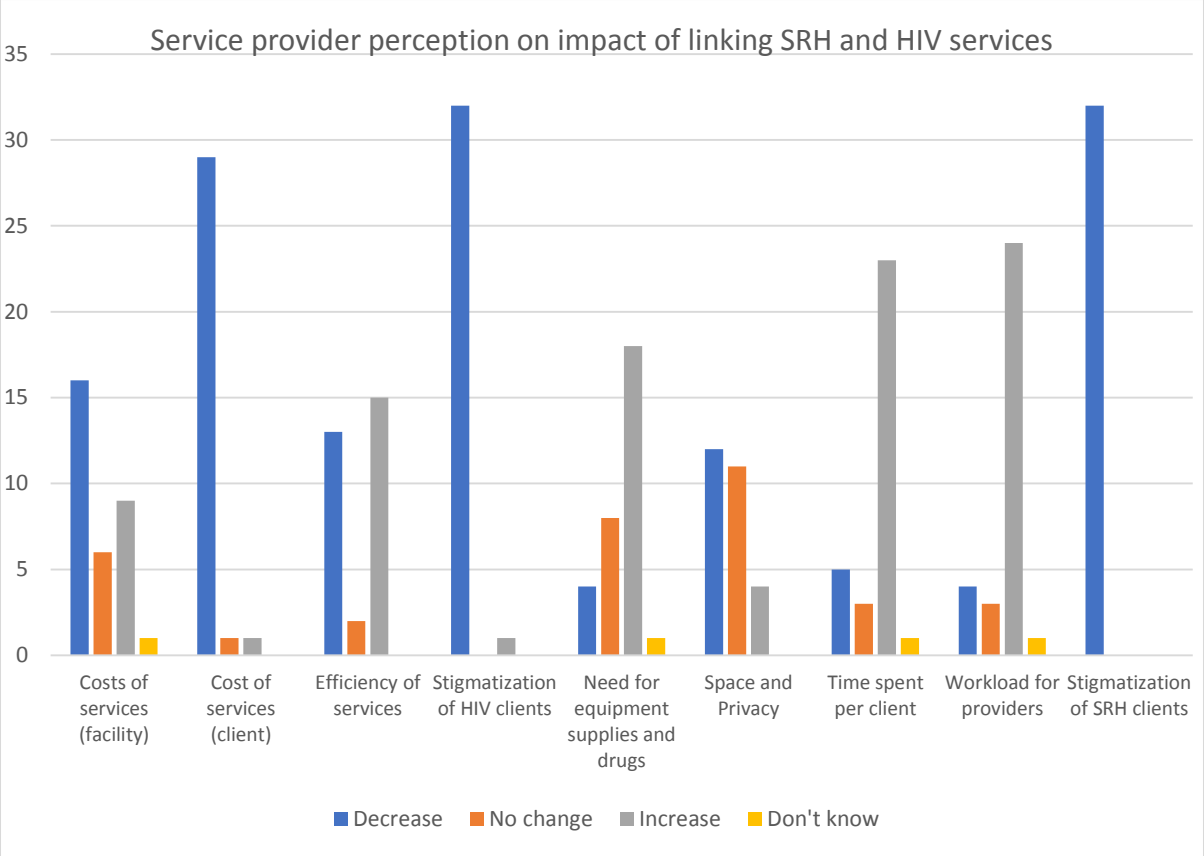


7.2.4 Perception of impact of linking SRH and HIV

Figure 7.15 illustrates the perception of service providers on impact of linking SRH and HIV services. Majority of the service providers indicated a 'decrease' in the cost of service to facility and clients, stigmatisation of HIV and SRH clients. Slightly more service providers indicated that linkage will lead to a 'decrease' in space and privacy with just a slightly less number indicating 'no change' will occur.

Overwhelming majority of service provider indicated a perception of an increase in workload for service providers (75%), time spent per client (72%) and need for equipment (58%).However, Efficiency of service is also perceived to be increased with linkage.

Figure 7.15: Perception of impact of linking SRH and HIV


Service provider perception on impact of linking SRH and HIV services
35
30
25
20
15
10
5
0
Costs of services (facility)
Cost of services (client)
Efficiency of services
Stigmatization of HIV clients
Need for equipment supplies and drugs
Space and Privacy
Time spent per client
Workload for providers
Stigmatization of SRH clients
Decrease
No change
Increase
Don't know

8. Specific District Findings

The aim of this session is to further provide granular details of specific and important findings at district and facility levels and not to repeat what is already contained under the findings of the report.

8.1. KwaZulu-Natal –UThukela

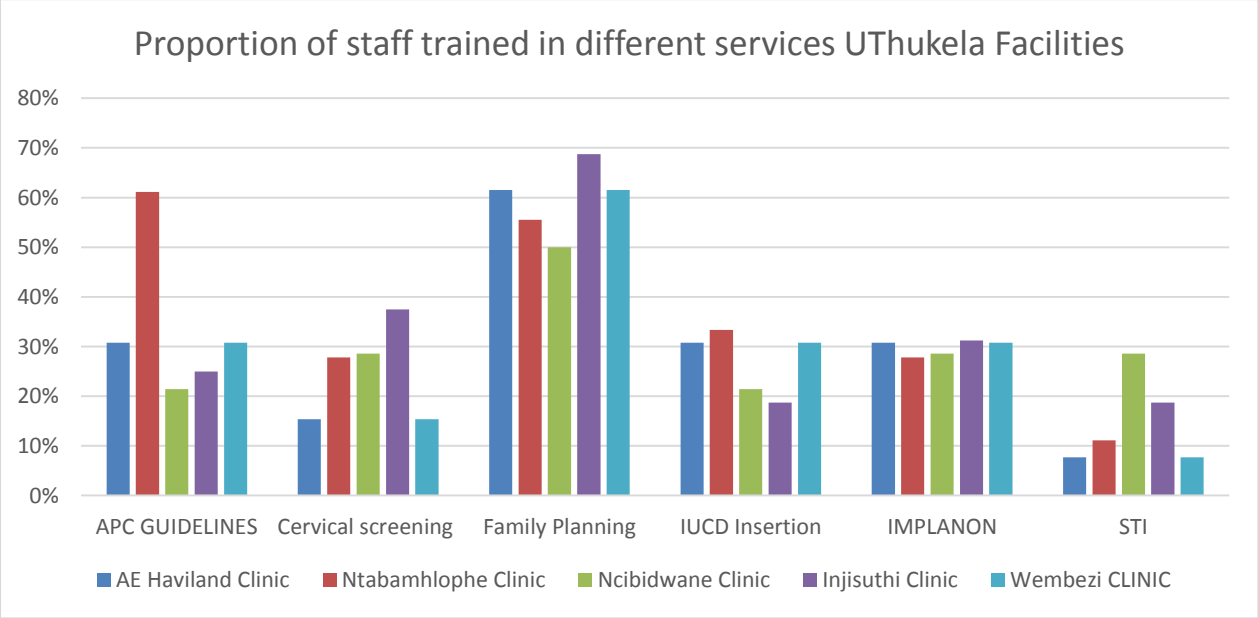
8.1.1. UThukela facilities Skills Audit

The skills audit focussed more on the SRH services and it shows that more staff are trained in Family Planning than any other SRH services. All other services or procedure have less than 40% of staff trained. Except for staff at Ntabamhlope that have about 60% of their staff trained APC training, the proportion of staff that are trained in APC is also very low (below 30%). APC guideline is one of the guideline that service providers that participated in this assessment regarded as a facilitator of integration of services at PHC facility level.

The interpretation of this skills audit is limited, however, it could be deduced that apart from FP, generally less than 40% of staff are trained in SRH services that were audited. It is also not clear if there is a relationship between the high level of provision of FP services within the HIV service point expressed in this assessment (Figure 7.9) by the service providers and the level of training. The relationship between the low level of staff trained in STI Prevention and management and high level of STI service integration (Figure 7.9) cannot be explained in the same way.

Capacitating staff to be confidence in performing their duties is critical and could instil confidence in providing integrated services to clients rather than referring out of the service points for the services that could have been provided, caution should also be taken not to interpret training as a formal workshop covering a particular topic for days. Capacity building can effectively be provided using different approaches; in-service training, mentorship and supportive supervision.

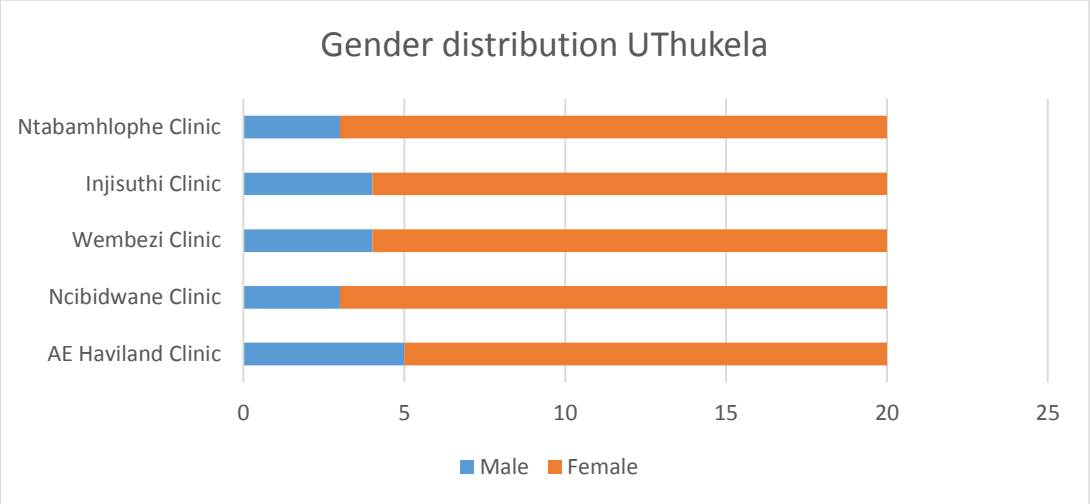
Figure 8.1: Staff Audit n UThukela facilities



8.1.2. UThukela Service users' perspective

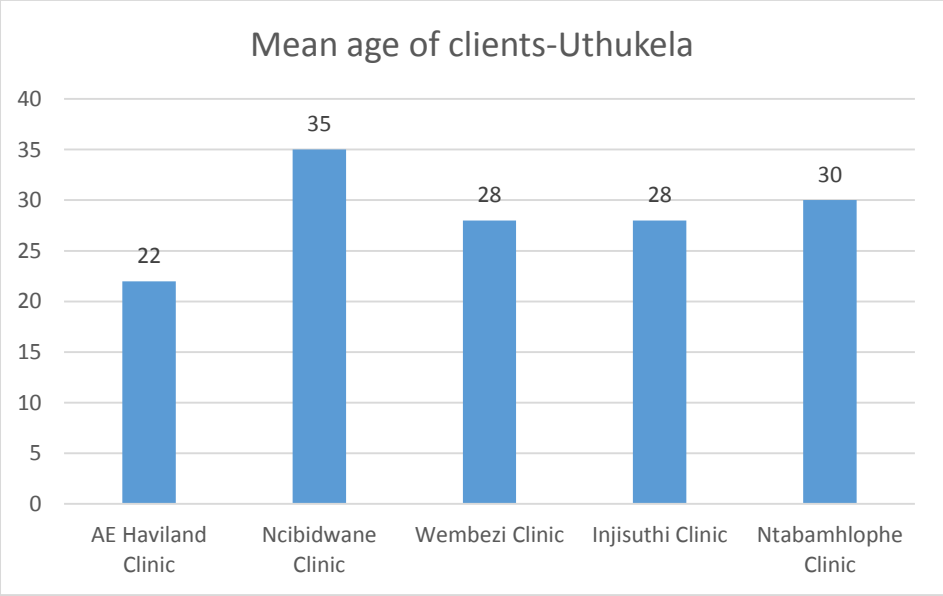
Overall 100 service users were interviewed in UThukela district (about 20 from each facility) The profile of these service users are provided below.

Figure 8.2: Gender distribution of UThukela facilities



For all clinics, Female clients constitute the majority and this is consistent with the higher female health seeking behaviour that is the norm in South Africa Health activities.

Figure 8.3: Mean age of clients interviewed in UThukela facilities



The figure 8.3 above illustrates that the mean age of the Ncibidwane clinic is the highest and all other clinics have a mean age of between 25-30 years except AE Haviland Clinic with a lower mean age of less than 25 years.

The overall mean age of 29 years cannot be considered to be significantly contributory to the low level (Figure 8.4) of information on cervical cancer provided to clients during clinic visits, Eastern cape also has an overall mean age of 30 years with a significantly higher level of information provided to clients

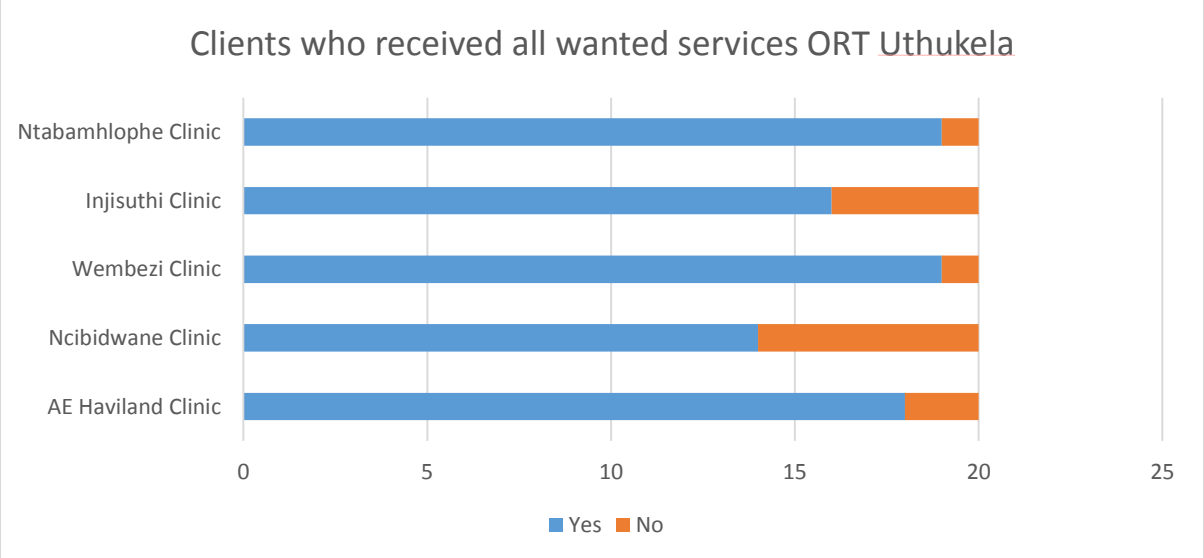
on cervical cancer (Figure 8.18). The eligible age for cervical cancer screening by using Pap smear is 30 years and above for HIV negative patients. Although in women of reproductive age with HIV this is done as soon as diagnosis is made.

Figure 8.4: Information provided UThukela

8.1.2.1 What proportion received sought service?

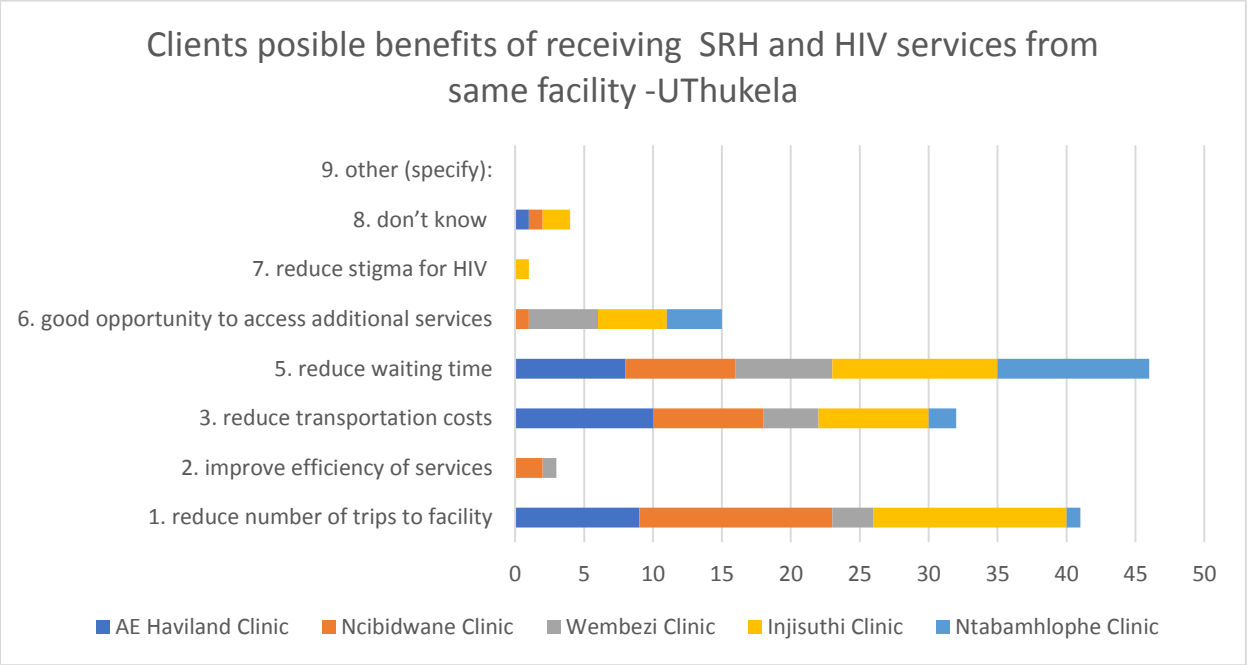
When asked if the service users received the services that they wanted, Figure 8.5 below indicated that the overwhelming majority of Clients from Ntabamhlophe (UThukela), Wembezi (UThukela), and AE Haviland Clinic indicated that they received the services that they came for. Ncibidwane Clinic has the lowest number of Clients who received all the services that they wanted.

Figure 8.5: UThukela clients who received all services that they wanted



As illustrated in figure 8.6 below, clients indicated that the major benefits of receiving same facility SRH and HIV services are 'reduce waiting time', 'reduce number of trips to the facility' and 'reduce transportation cost'. The least chosen perceived benefit are 'reduce stigma for HIV" and 'improve efficiency of services'

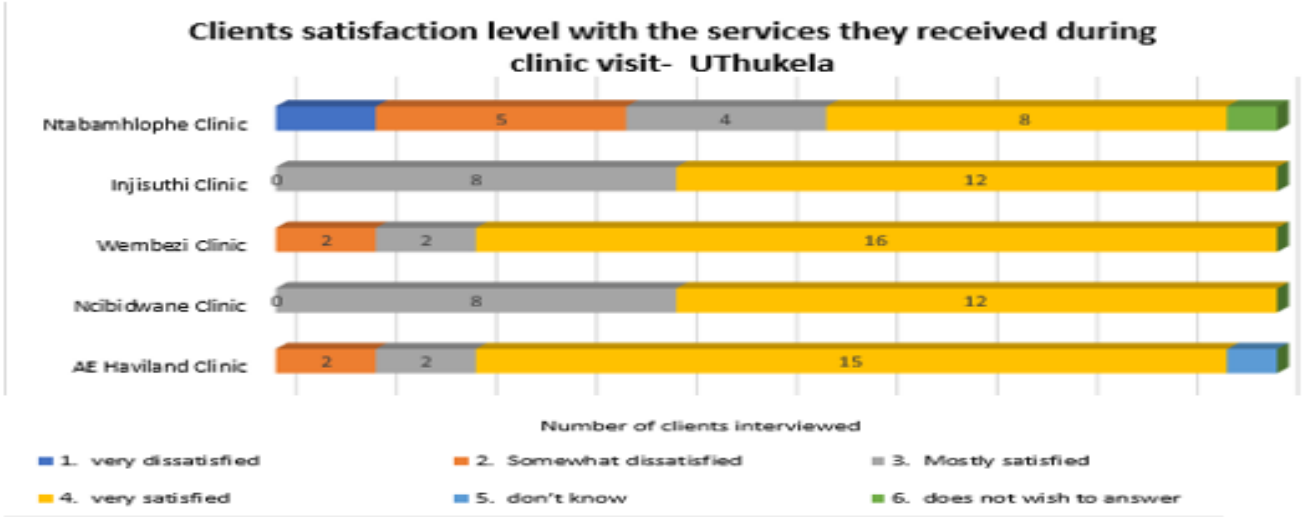
Figure 8.6: UThukela Clients perceived benefits of receiving same facility SRH and HIV services



8.1.2.2. UThukela Clients satisfaction with the facilities

Overall, overwhelming majority of clients were satisfied with the services they received across all UThukela facilities (represented by grey and yellow colour in the figure below), although the degree of satisfaction varies from high level of very satisfied clients from Wembezi to Ntabamhlophe clinic which has the highest number of dissatisfied clients.

Figure 8.7: Clients satisfaction with services in UThukela facilities



8.1.3. UThukela Service providers' perspective

Figure 8.8: Service provider designation

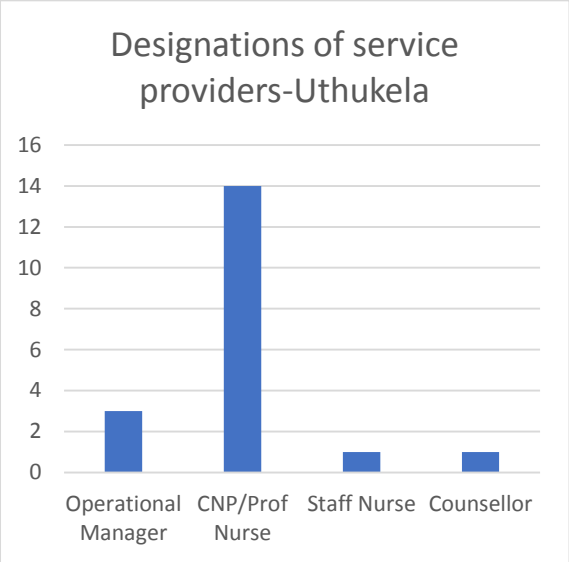


Figure 8.9: Service points of service provider

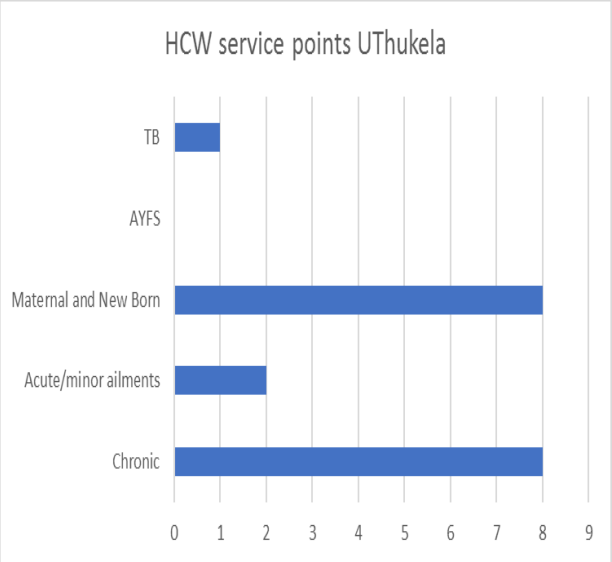
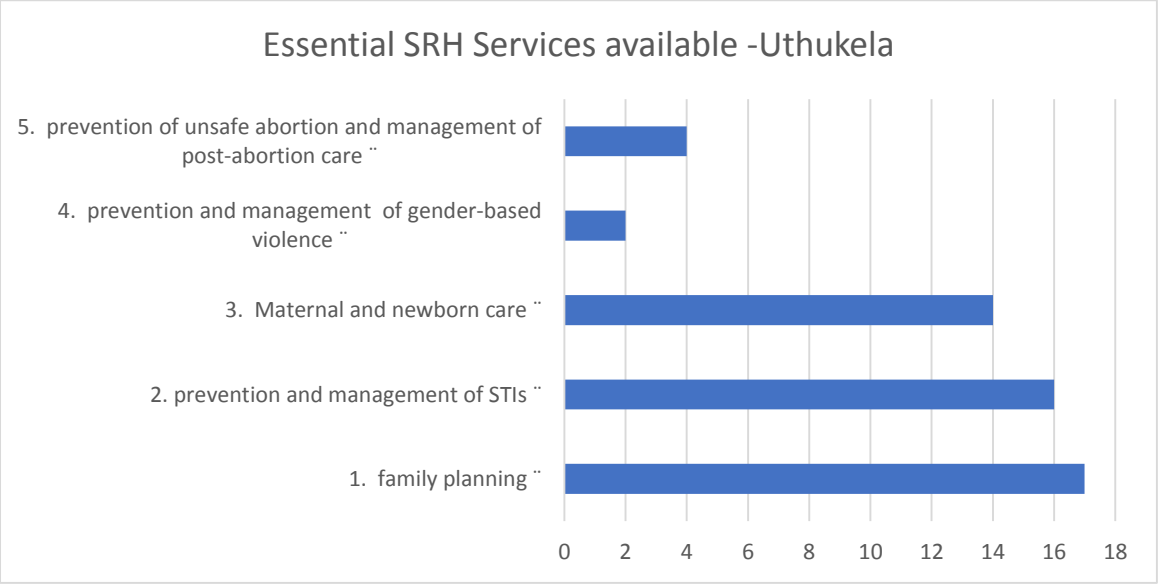


Figure 8.8 shows a total of 19 service providers were interviewed at the 5 facilities, with an average total of 4 per facility. Majority (14) of the service providers interviewed are in the category of Professional Nurse, even the category of the Operational Manager (2) can be categorised as part of the PN.

Figure 8.9 illustrates that the majority of the of the service providers interviewed are primarily from the Maternal and Newborn, and Chronic service streams. AYFS are usually taken as an additional responsibility for the service provider that primarily functions in other streams; a service provider from the chronic stream could also be the AYFS Champion for the facility. The only staff nurse interviewed in all the facilities is the one covering the TB programme.

8.1.3.1. SRH service availability

Figure 8.10: Essential SRH services rendered by facilities as reported by service providers

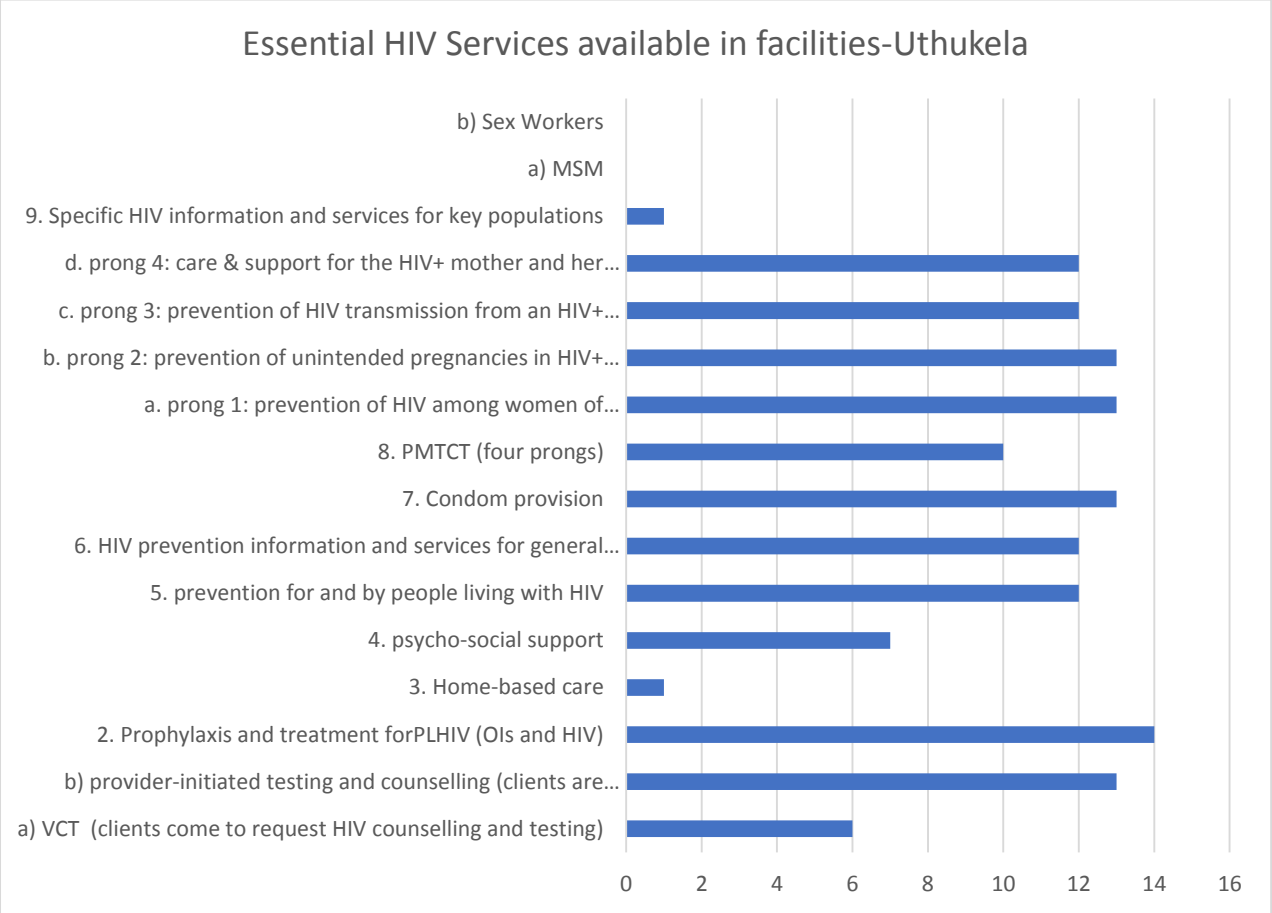


All assessed facilities in UThukela district provide FP, STIs, and Maternal and Newborn care as an essential package of PHC service. However, when asked about the availability of these services, not all service providers indicated availability of the services in their facilities. The reason for this was not asked as part of this survey. While there is no conclusive evidence that this reporting gap is because of the lack of knowledge about the service availability, it calls for clinics to ensure that service providers are conversant with all the services provided in their facility and the miimum package that should be delivered.

Family Planning, STIs Prevention and management and Maternal and Newborn care services were respectively indicated as available. Whilst the least available services according to service providers are gender-based violence (GBV) and prevention of unsafe abortion and management of post-abortion care

8.1.3.2. HIV service availability

Figure 8.11: Essential HIV services rendered as reported by the service providers



According to the service providers, HIV services are provided in all the facilities that were accessed, the most available HIV services are Prophylaxis and treatment for PLHIV (OIs and HIV) Provider-initiated testing and counselling (PITC), condom provision and PMTCT services. A number of service providers that did not initially indicate that they provide PMTCT services provided a positive response when the services were broken down into the prongs; it could mean that they found it easier to identify with the prongs rather than saying PMTCT because of the details provided. remembering

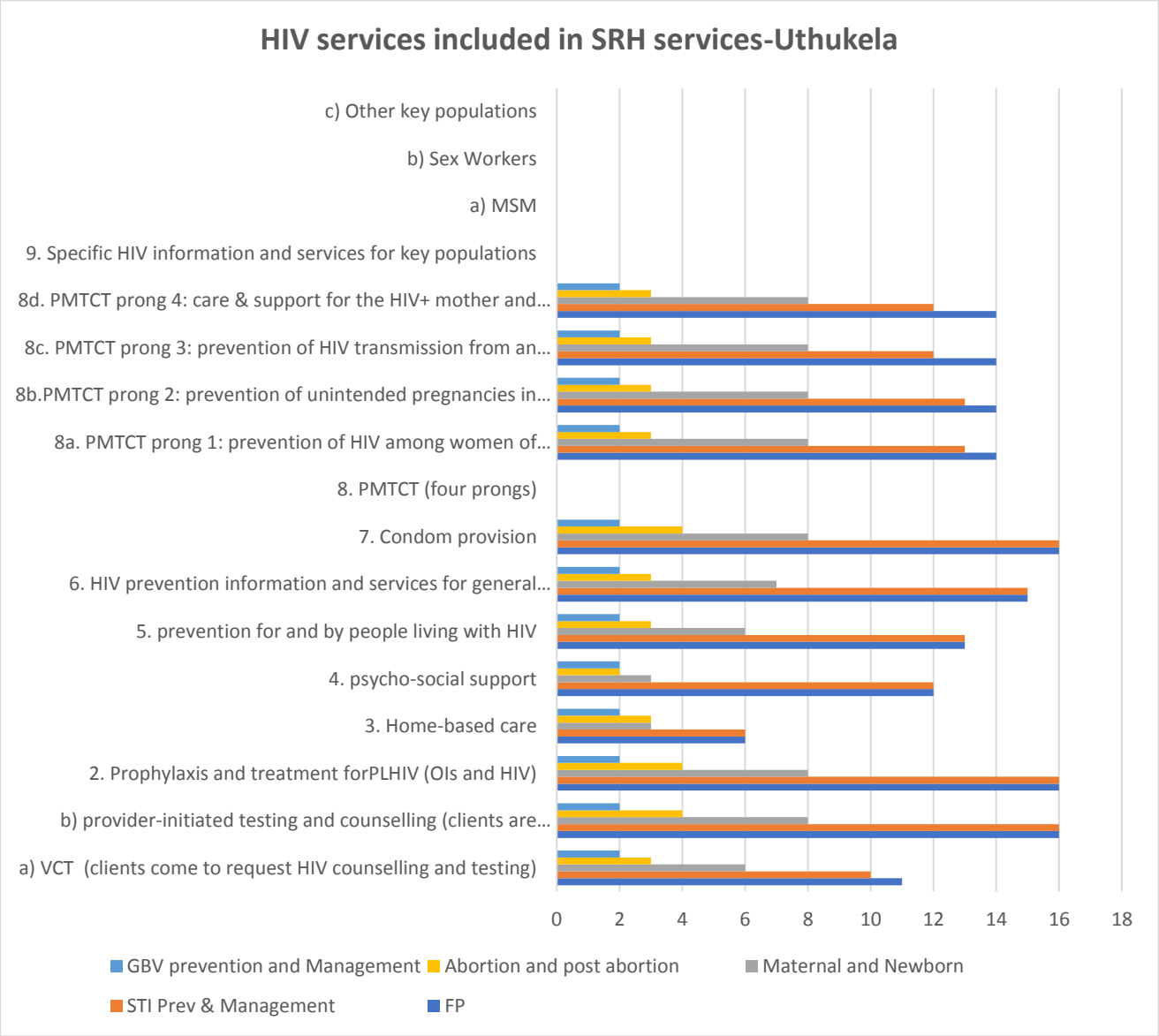
different prongs than just asking about PMTCT. The least available HIV services are providing specific HIV information and services for Key population and Home Based Care.

8.1.3.3. HIV integration into SRH

Figure 8.12 below illustrates the provision of HIV services within the SRH services. According to the service providers, HIV services have more probability of being included in the Family planning and STI services, this is less likely with the Maternal and Newborn services. HIV services are least likely to be included in prevention and management of abortion services and SGBV services. Hence, clients seeking FP and STI services are more likely to receive a wider range of HIV services as part of the service provided by same service provider.

Generally, PITC, Prophylaxis and treatment for PLWHIV and condom provision came out on top as HIV services that are well integrated into the SRH. In contrast, HIV services to key population like MSM, Sex workers have the least possibilities of being includes in the SRH services.

Figure 8.12: HIV Services included in SRH services

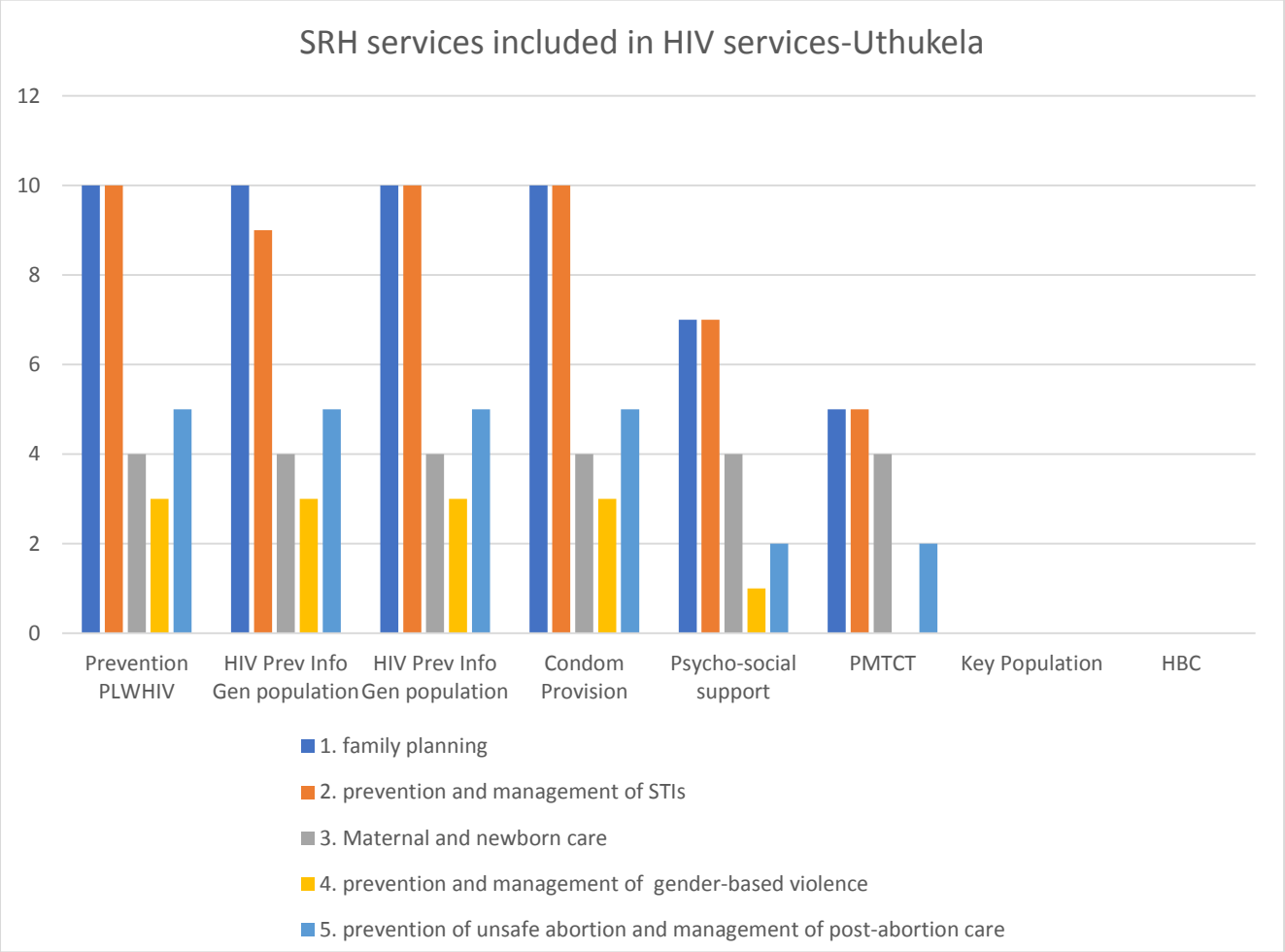


8.1.3.4. SRH integration into HIV

According to the service providers, SRH services have more probability of being included in the Prevention for PLWHIV, HIV prevention for general population and Condom provision services, Hence, clients seeking these services are more likely to receive a wider range of needed SRH services as part of the service provided by service provider. The service providers indicated a less probability that clients seeking psychosocial support and PMTCT services will receive a comparatively less range of SRH services when compared with the earlier group. SRH services are least likely to be included in HBC and Key population services.

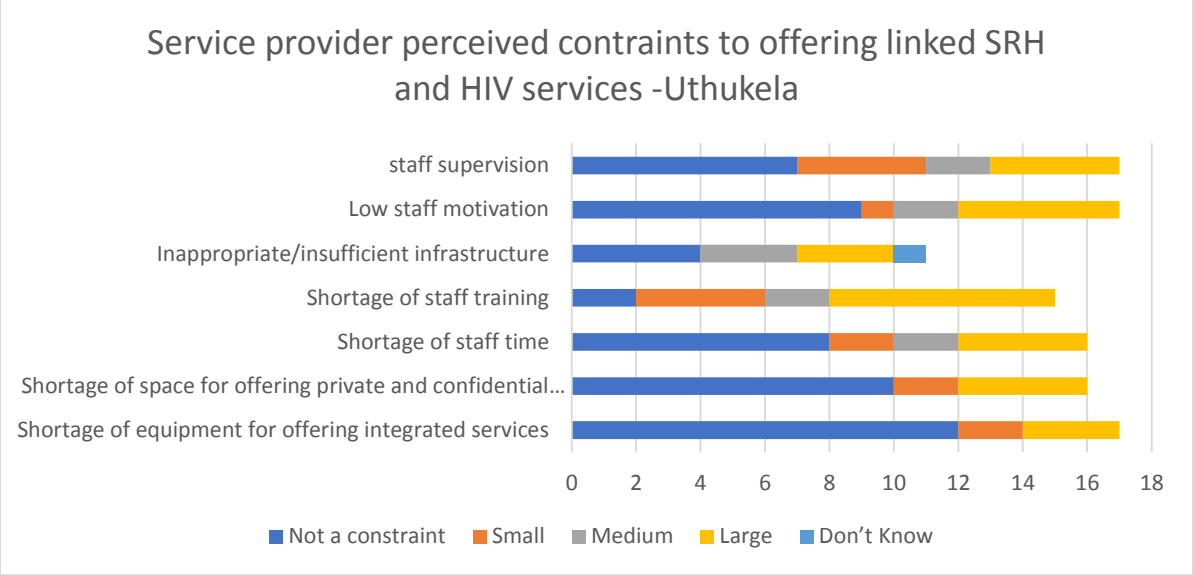
Generally, SRH Services such as FP and prevention and management of STIs are indicated to be the most likely services included in HIV services. In contrast, SRH services of SGBV and prevention and abortion related care have the least possibilities of being included in the HIV services. This is illustrated by the Figure 8.13 below

Figure 8.13: SRH services included in HIV services



8.1.3.5. Constraints to offering linked SRH and HIV services

Figure 8.14: Constraints to offering linked SRH and HIV services



According to the UThukela service providers (Figure8.14) rating of constraints that impedes on the offering of linked SRH and HIV services, the main constraints are: shortage of training, staff supervision, time, and low staff motivation. Overwhelming majority indicated that shortage of equipment and space are not of major constraints to offering linked services.

8.1.4. UThukela findings summary

Table: 8.1: UThukela summary table

	Summary findings	**Discussion/ Recommendations**
Staff Audit	More staff are trained in Family Planning than any other SRH services. All other services or procedure have less than 40% of staff trained	Capacity building can effectively be provided using different approaches; in-service training, mentorship and supportive supervision
Clients perspective	Overwhelming majority of clients received all the services they wanted. Ncibidwane Clinic has the least number of clients that received all the services they wanted	Providing minimal package of integrated service will help to ensure a wider range of services that might be wanted by the clients are covered
	major benefits of receiving same facility SRH and HIV services are 'reduce waiting time', 'reduce number of trips to the facility' and 'reduce transportation cost'	
	Overwhelming majority of clients are satisfied with the services they received across all UThukela facilities. Ntabamhlophe clinic has the higher proportion of clients that are not satisfied	
Service providers perspective	Least available HIV services are Key Population	Ensure the development of the minimum package of services at the PHC level to facilitate appropriate services are offered at the level of care

	Least available SRH services are Prevention of unsafe abortion and management of post abortion are and management of SGBV	
	HIV services have more probability of being included in the FP and STI services, this is less likely with the Maternal and Newborn services. HIV services are least likely to be included in prevention and management of abortion services and SGBV services	Carry out patient flow analysis and service scoping per facility to identify facility specific approach to integration of services
	SRH services have more probability of being included in the Prevention for PLWHIV, HIV prevention for general population and Condom provision services clients seeking psychosocial support and PMTCT services will receive a comparatively less range of SRH services when compared with the earlier group	
	Constraints are: shortage of training, staff supervision, time, and low staff motivation.	Address constraints directly; provide capacity building opportunities to staff on integration, ensure appropriate supportive supervision

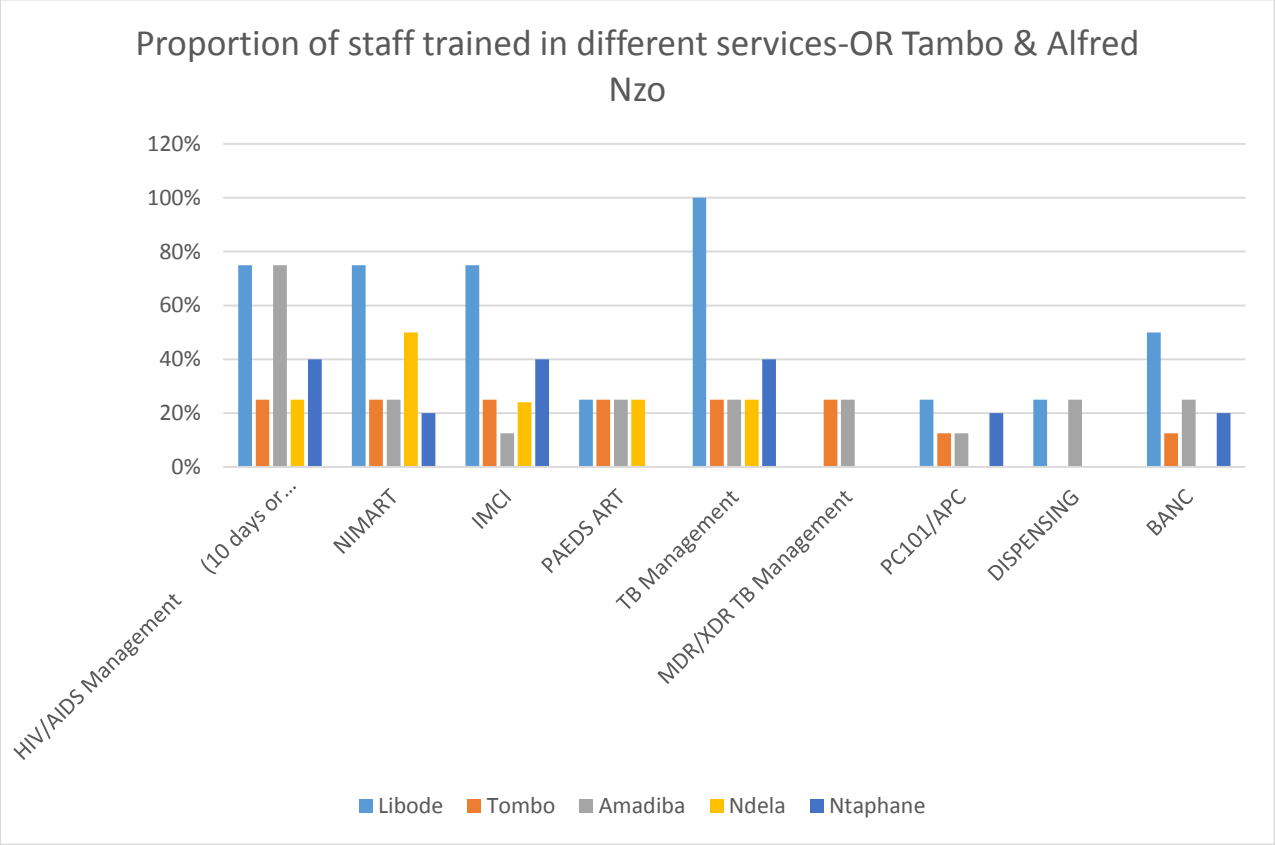
8.2. Eastern Cape – Or Tambo and Alfred Nzo

8.2.1. Eastern Cape Facilities Skills Audit

The Figure 8.15 below analysed from the audit report that was provided by the management. Generally, a low proportion of staff are trained (< 30%) across the board in all the service areas that were analysed. Libode clinic consistently showed a higher proportion of staff trained among the facilities. More service provider across all the five facilities are more likely to have attended HIV related training (HIV management, NIMART, PEADS ART) and TB training (TB management, MDR TB management) than BANC and PC 101/APC.

The interpretation of this skills audit is limited, however, it could be deduced that the skill audit demonstrated a need for further skills assessment at the facilities to be able to specifically facilitate delivery of integrated package of service. Capacitating staff to be confidence in performing their duties is critical and instils confidence in providing integrated services. caution should also be taken not to interpret training as a formal workshop covering a particular topic for days. Capacity building can effectively be provided using different approaches; in-service training, mentorship and supportive supervision.

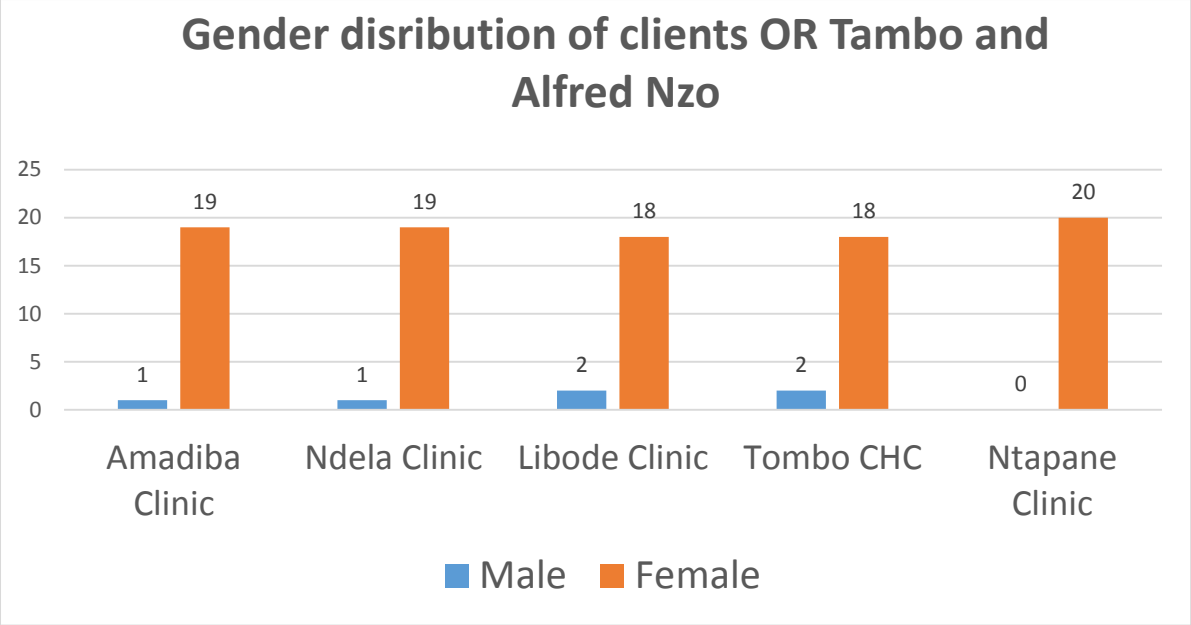
Figure 8.15: Staff Audit n UThukela facilities



8.2.2. Eastern Cape service users' perspective

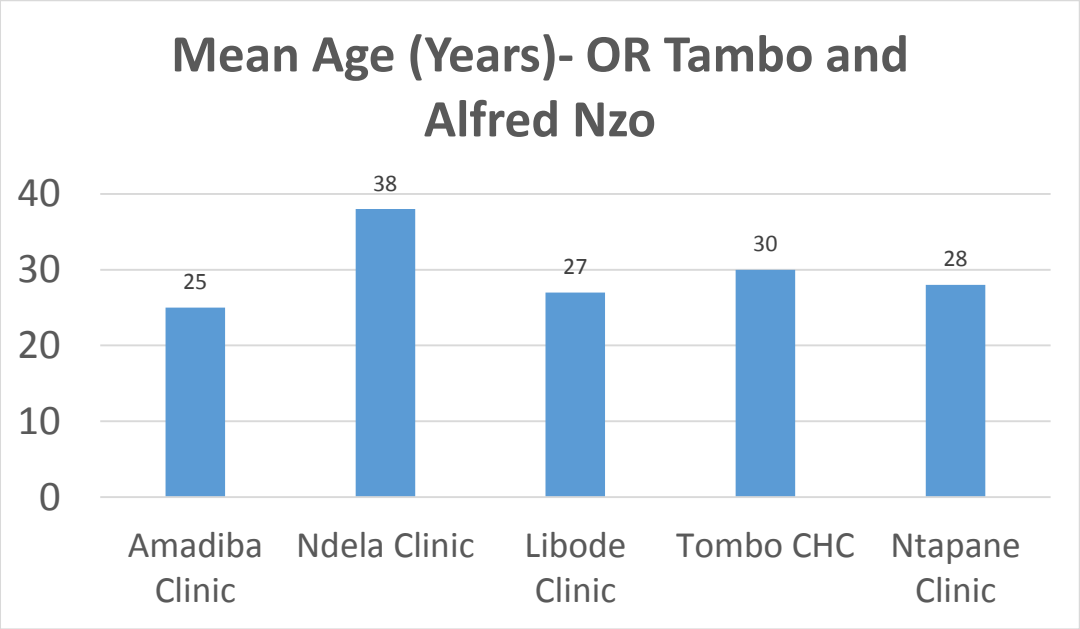
Overall 100 service users were interviewed in OR Tambo & Alfred Nzo districts (about 20 from each facility) The profile of these service users are provided below.

Figure 8.16: Gender distribution of in OR Tambo & Alfred Nzo facilities



For all clinics, Female clients constitute the majority and this is consistent with the higher female health seeking behaviour that is the norm in South Africa Health activities.

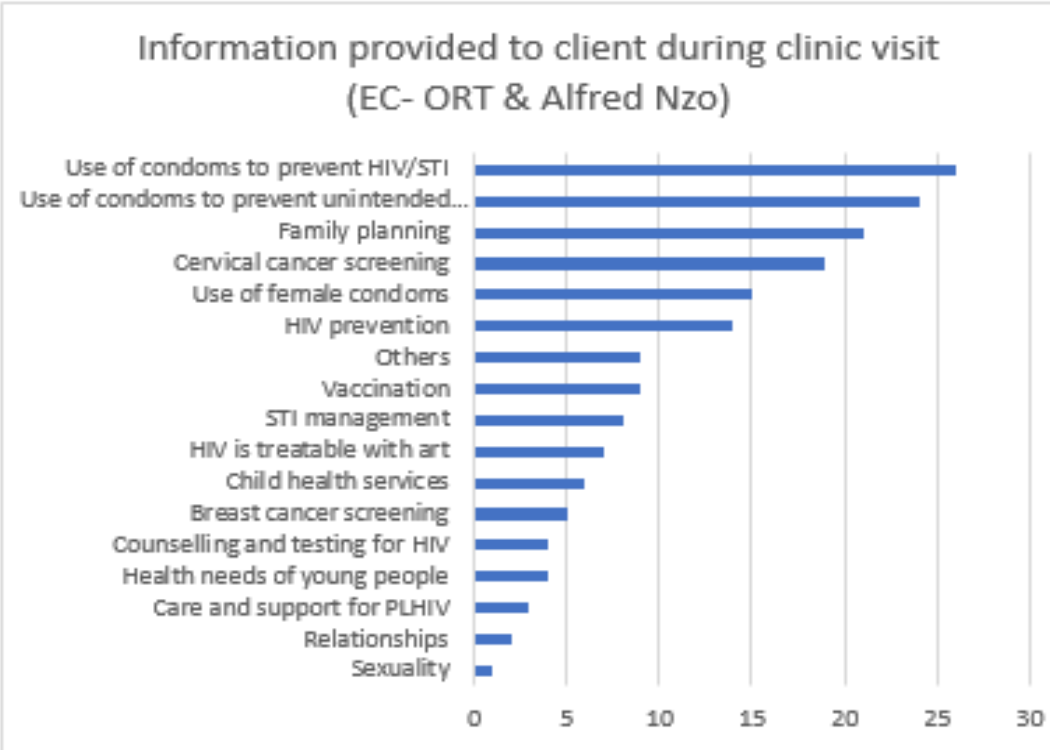
Figure 8.17: Mean age of clients interviewed in in OR Tambo & Alfred Nzo facilities



The figure 8.17 above illustrates that the mean age of the Ndela clinic is the highest and all other clinics have a mean age of between 25-30 years except. The overall mean age of the five facilities is about 30 years which is comparable to that of KZN-UThkela district.

Figure 8.18 shows that use of condom, FP, cervical cancer screening are the most common information provided to clients on clinic visits.

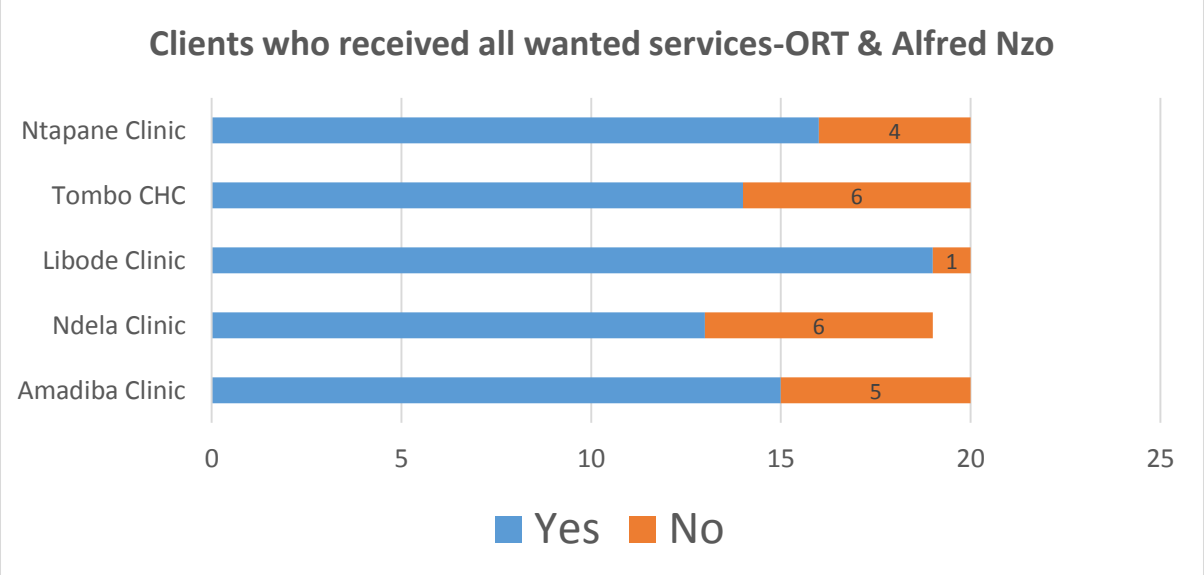
Figure 8.18: Information provided OR Tambo & Alfred Nzo



8.2.2.1 What proportion received sought service?

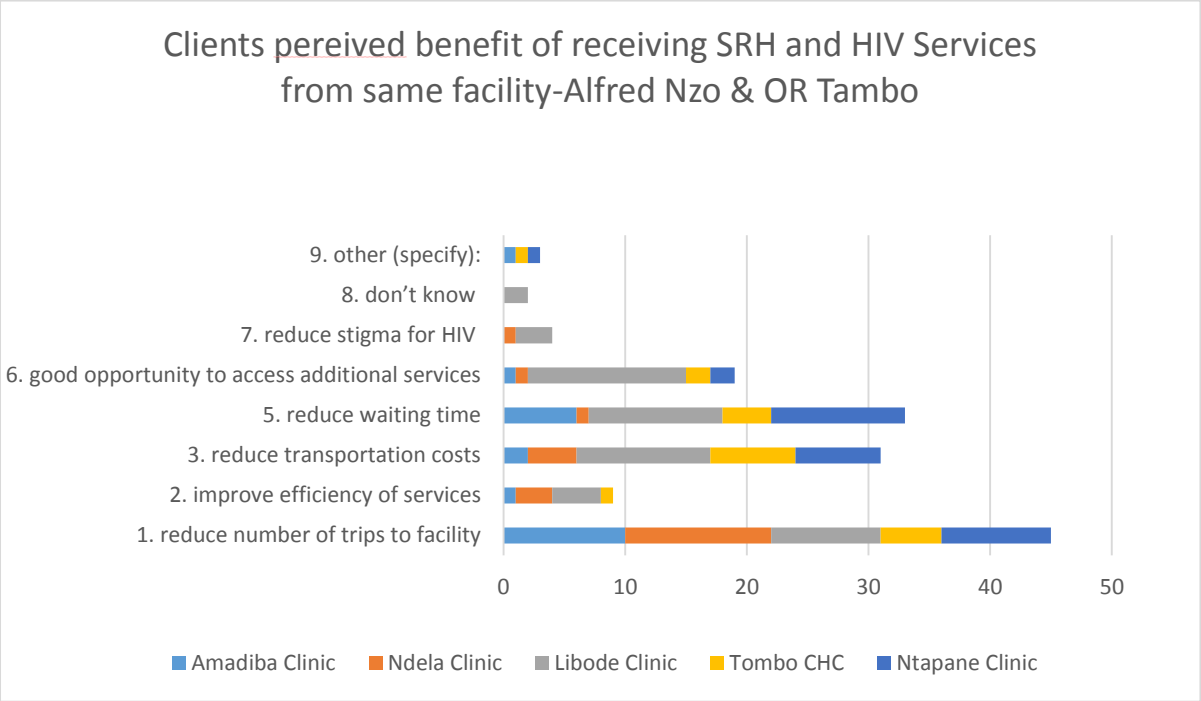
When asked if the service users received the services that they wanted, Figure 8.19 below indicated that almost all clients from Libode Clinic indicated that they received the services that they came for, Libode clinic also have the highest proportion of trained staff in the skills audit; but this cannot be directly attributed but need further exploration. Tombo and Ndela Clinics has the highest number of clients that did not receive the service they wanted in the assessment.

Figure 8.19: OR Tambo & Alfred Nzo clients who received all services that they wanted



As illustrated in figure 8.20 below, OR Tambo & Alfred Nzo clients indicated that the major benefits of receiving same facility SRH and HIV services are, 'reduce number of trips to the facility' 'reduce waiting time' and 'reduce transportation cost'. The least chosen perceived benefit are 'reduce stigma for HIV" and 'improve efficiency of services'. This is consistent with the UThukela findings.

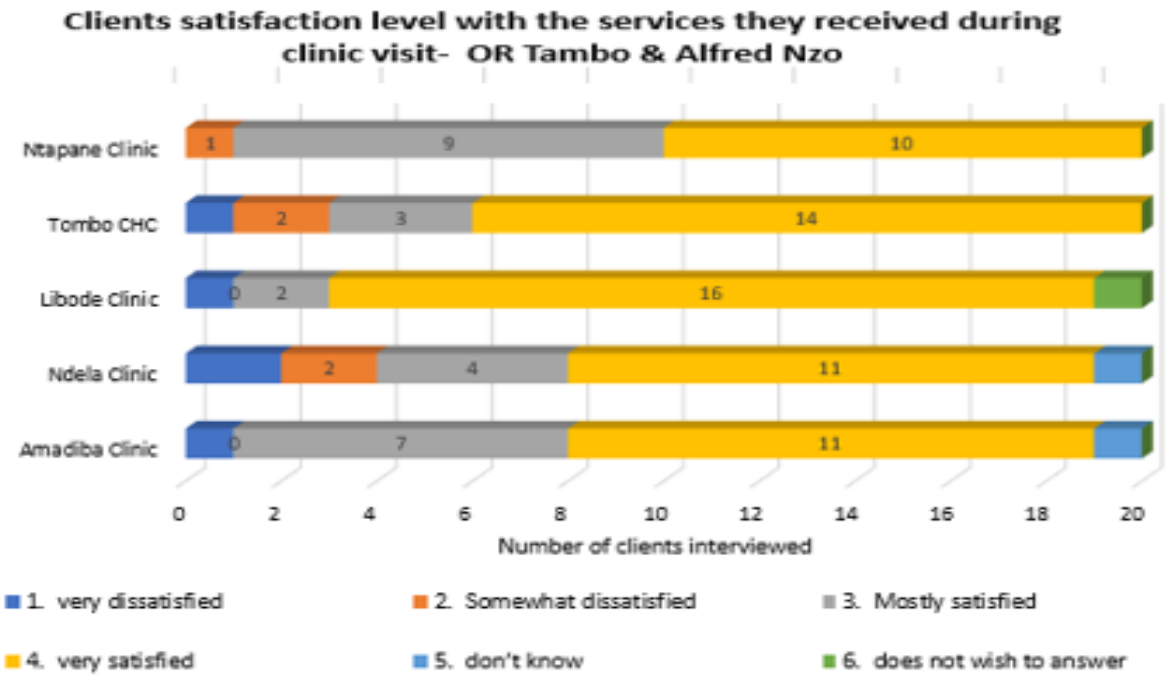
Figure 8.20: OR Tambo & Alfred Nzo clients perceived benefits of receiving same facility SRH and HIV services



8.2.2.2. OR Tambo & Alfred Nzo clients' satisfaction with the facilities

Overall, majority of clients were satisfied with the services they received across all OR Tambo & Alfred Nzo facilities (represented by grey and yellow colour in the figure below), although the degree of satisfaction varies from high level of very satisfied clients with Libode clinic having the highest number of clients that were satisfied. This is consistent with figure 8.19 above where clients from this clinic indicated that they received all the services they wanted. As illustrated in figure 8.21 below Ndela clinic also has the highest number of dissatisfied clients. However, this client satisfaction level does not correspond to the waiting time of Libode clinic (3h05) that was only surpassed by Ndela clinic (4h40) during the assessment (Table 3.2).

Figure 8.21: Clients satisfaction with services in OR Tambo & Alfred Nzo facilities



8.2.3. OR Tambo & Alfred Nzo service providers' perspective

Figure 8.22: Service provider designation

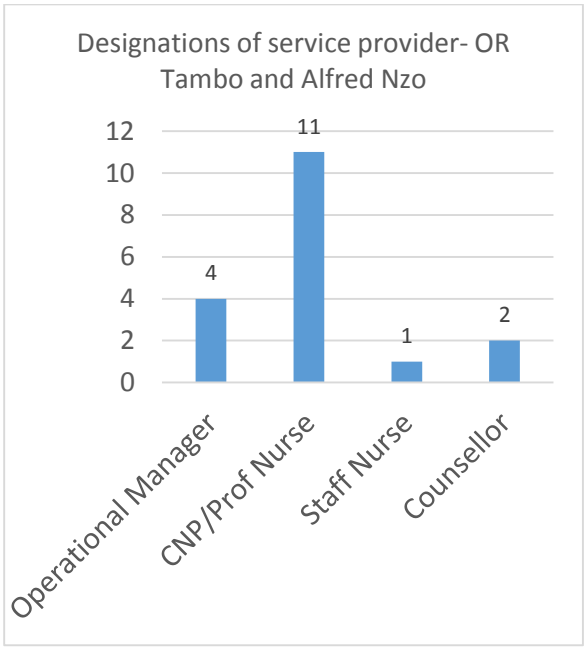


Figure 8.23: Service points of service provider

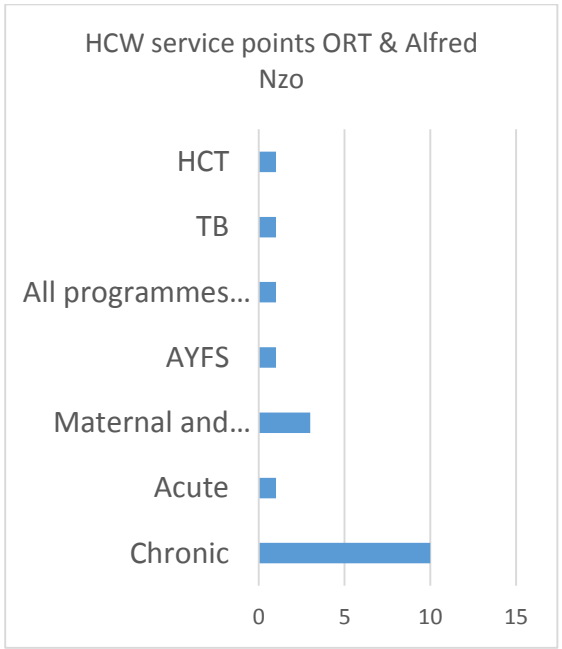
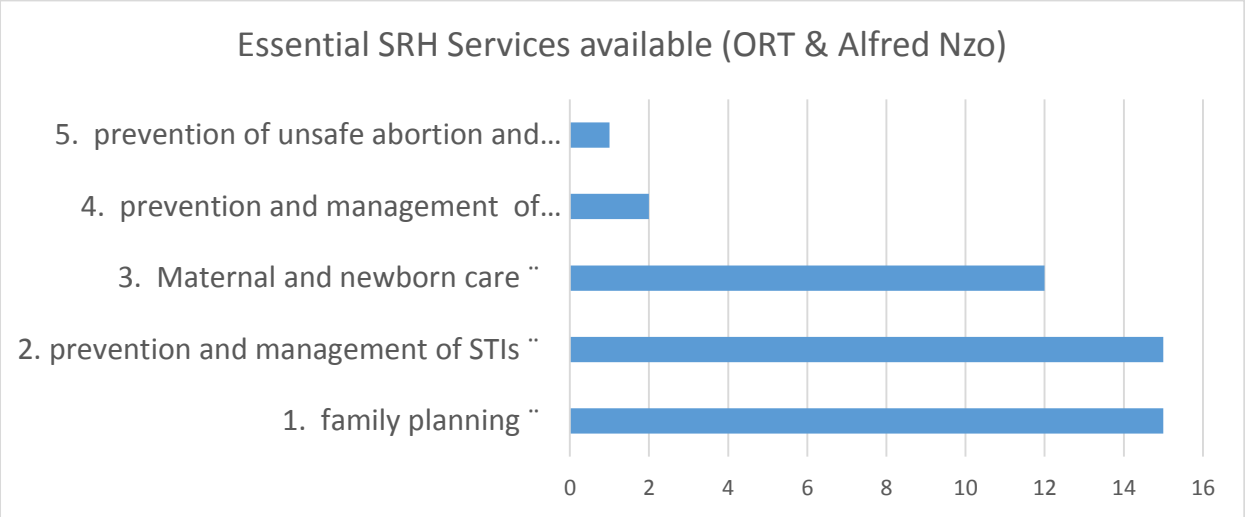


Figure 8.22 shows a total of 18 service providers were interviewed at the 5 facilities. Majority (11) of the service providers interviewed are in the category of Professional Nurse, even the category of the Operational Manager (4) can be categorised as part of the PN.

Figure 8.23 illustrates that the majority of the of the service providers interviewed are primarily from the Chronic service streams. Others are from Maternal and Newborn, TB, AYFS and HCT service points while one operational manager indicated coverage of all programmes.

8.2.3.1. OR Tambo & Alfred Nzo -SRH service availability

Figure 8.24: Essential SRH services rendered by facilities as reported by OR Tambo & Alfred Nzo service providers

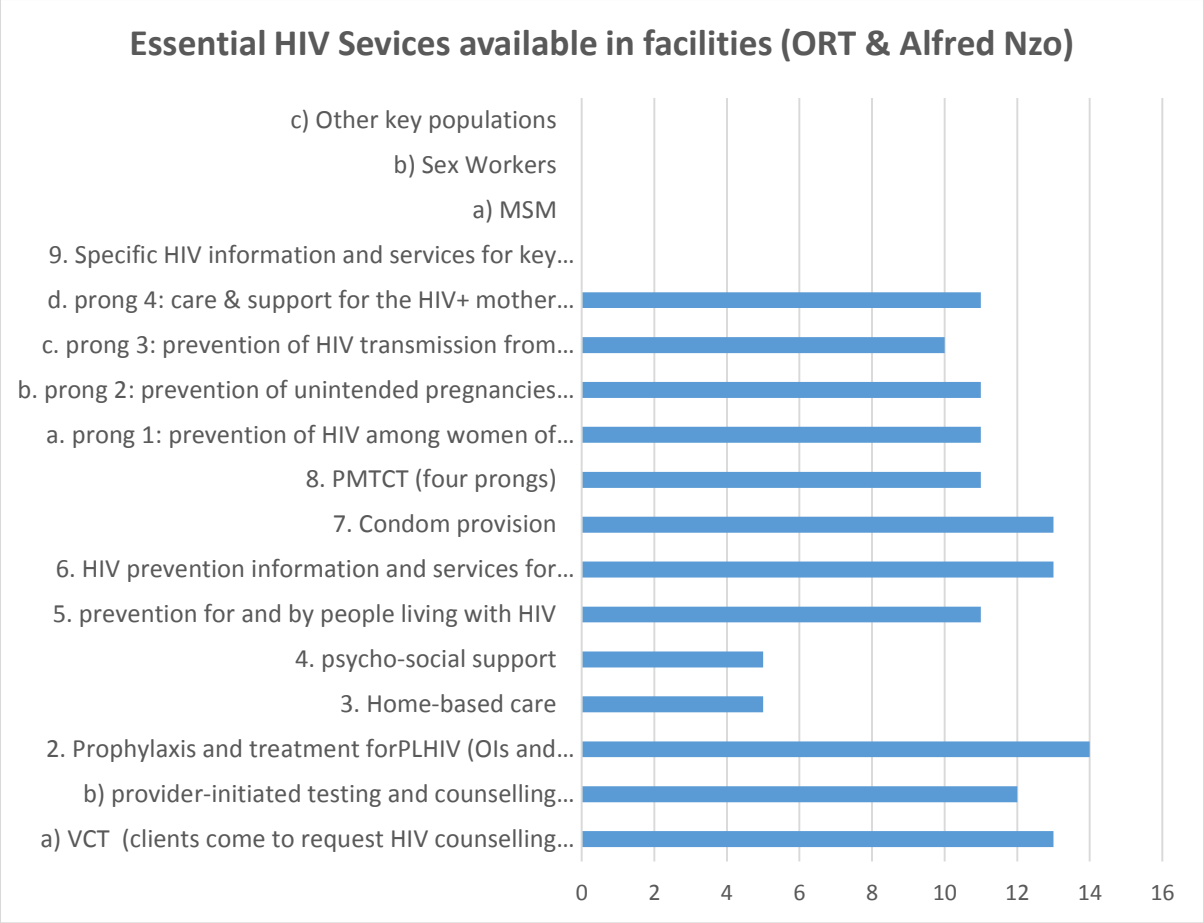


All assessed facilities in OR Tambo & Alfred Nzo districts provide FP, STIs, and Maternal and Newborn care as an essential package of PHC service. However, when asked about the availability of these services, not all service providers indicated availability of the services in their facilities. The reason for this was not asked as part of this survey. While there is no conclusive evidence that this reporting gap is because of the lack of knowledge about the service availability, it calls for clinics to ensure that service providers are conversant with facility service package that should be delivered.

Family Planning, STIs Prevention and management and Maternal and Newborn care services were respectively indicated as available. Whilst the least available services according to service providers are gender-based violence (GBV) and prevention of unsafe abortion and management of post-abortion care. These findings are in concordance with Uthukela's.

8.2.3.2. OR Tambo & Alfred Nzo HIV service availability

Figure 8.25: Essential HIV services rendered as reported by the OR Tambo & Alfred Nzo service providers

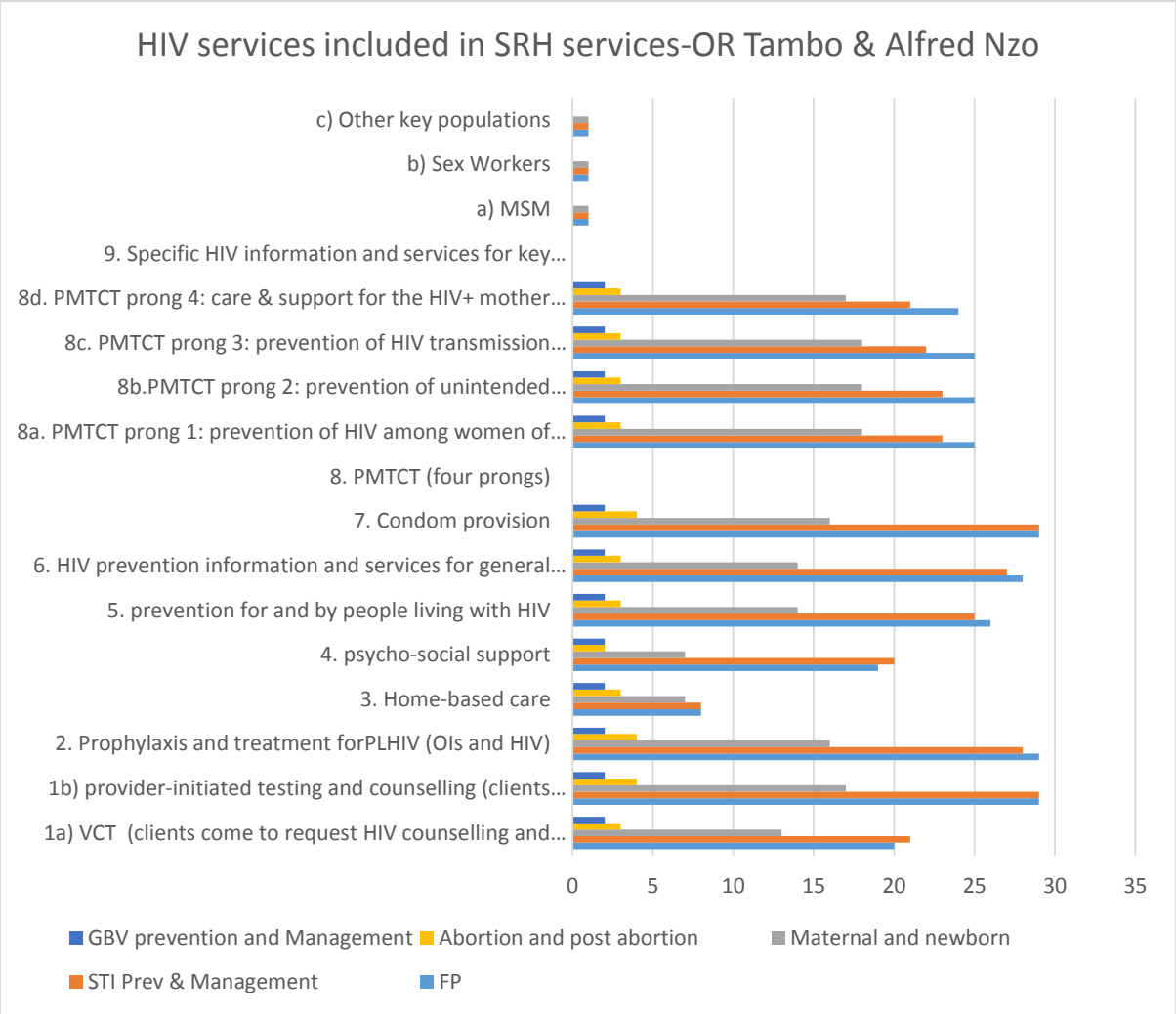


According to the service providers, HIV services are provided in all the facilities that were accessed, the most available HIV services are Prophylaxis and treatment for PLHIV (OIs and HIV) VCT, condom other HIV prevention services apart from PMTCT and condom. The least available HIV services are Key population, Psychosocial support and Home Based Care.

8.2.3.3. HIV integration into SRH

Figure 8.26 below illustrates the inclusion of HIV services within the SRH services. According to the service providers, HIV services have more probability of being included in the Family planning and STI services, this is less likely with the Maternal and Newborn services. HIV services are least likely to be included in prevention and management of abortion services and SGBV services. Hence, clients seeking FP and STI services are more likely to receive a wider range of HIV services as part of the service provided by same service provider. This finding is similar to the UThukela's.

Figure 8.26: HIV Services included in SRH services

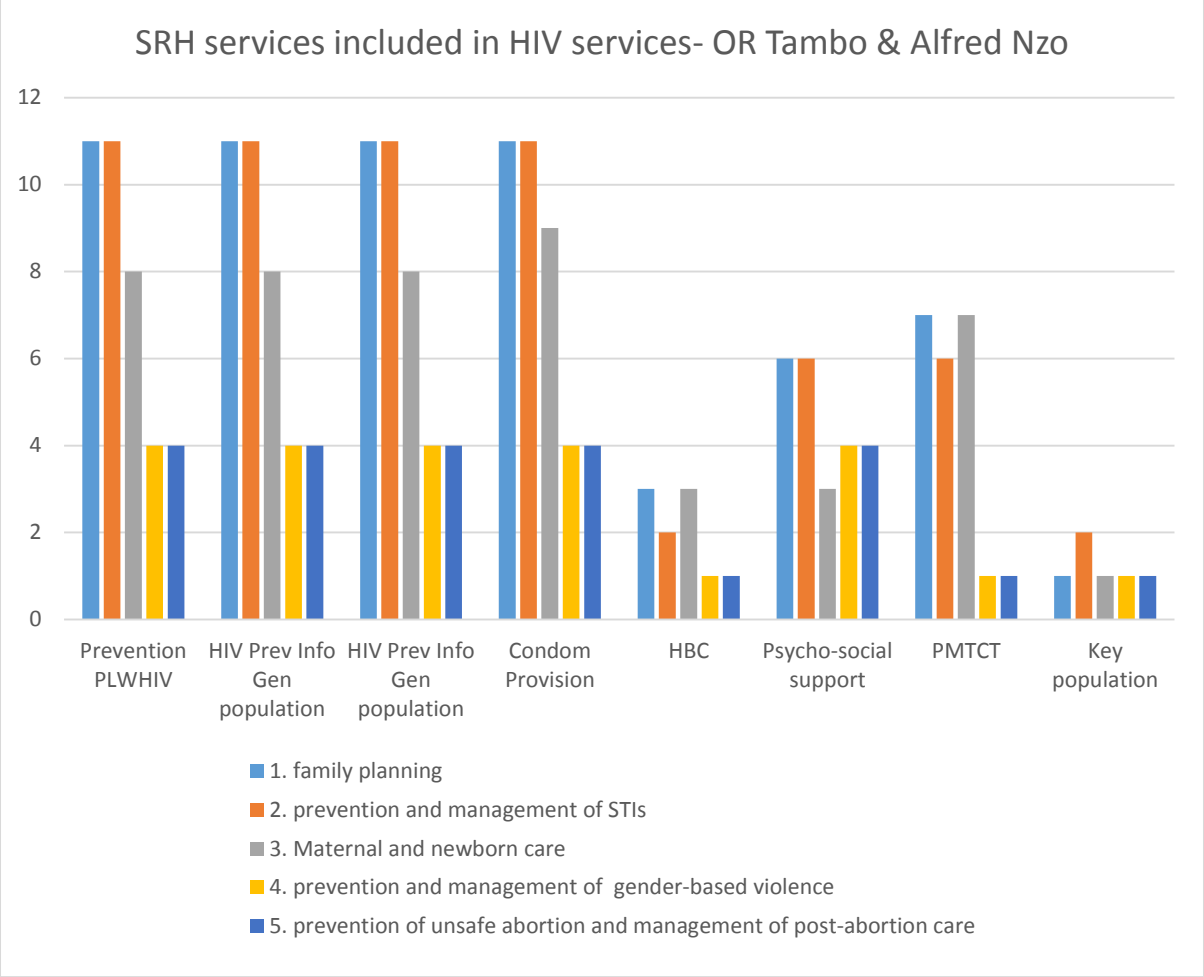


8.2.3.4. SRH integration into HIV

According to the service providers, SRH services have more probability of being included in the Prevention for PLWHIV, HIV prevention for general population and Condom provision services, Hence, clients seeking these services are more likely to receive a wider range of needed SRH services as part of the service provided by service provider. The service providers indicated a less probability that clients seeking psychosocial support and PMTCT services will receive a comparatively less range of SRH services when compared with the earlier group. SRH services are least likely to be included in HBC and Key population services.

Generally, SRH Services such as FP and prevention and management of STIs are indicated to be the most likely services included in HIV services. In contrast, SRH services of SGBV and prevention and abortion related care have the least possibilities of being included in the HIV services. This is illustrated by the Figure 8.27 below. The findings is in concordance with the Uthukela's.

Figure 8.27: SRH services included in HIV services



8.2.3.5. Constraints to offering linked SRH and HIV services

According to the OR Tambo & Alfred Nzo service providers (Figure 8.28) rating of constraints that impedes on the offering of linked SRH and HIV services, the main constraints are: shortage of staff time, shortage of equipment, and low staff motivation. This are closely followed by shortage space for offering private and confidential service and shortage of training. In contrast to UThukela district, majority indicated that staff supervision is not a constraint. The constraints on shortage of staff is corroborated with the high vacancy rate below (Figure 8.29)

Figure 8.28: Constraints to offering linked SRH and HIV services

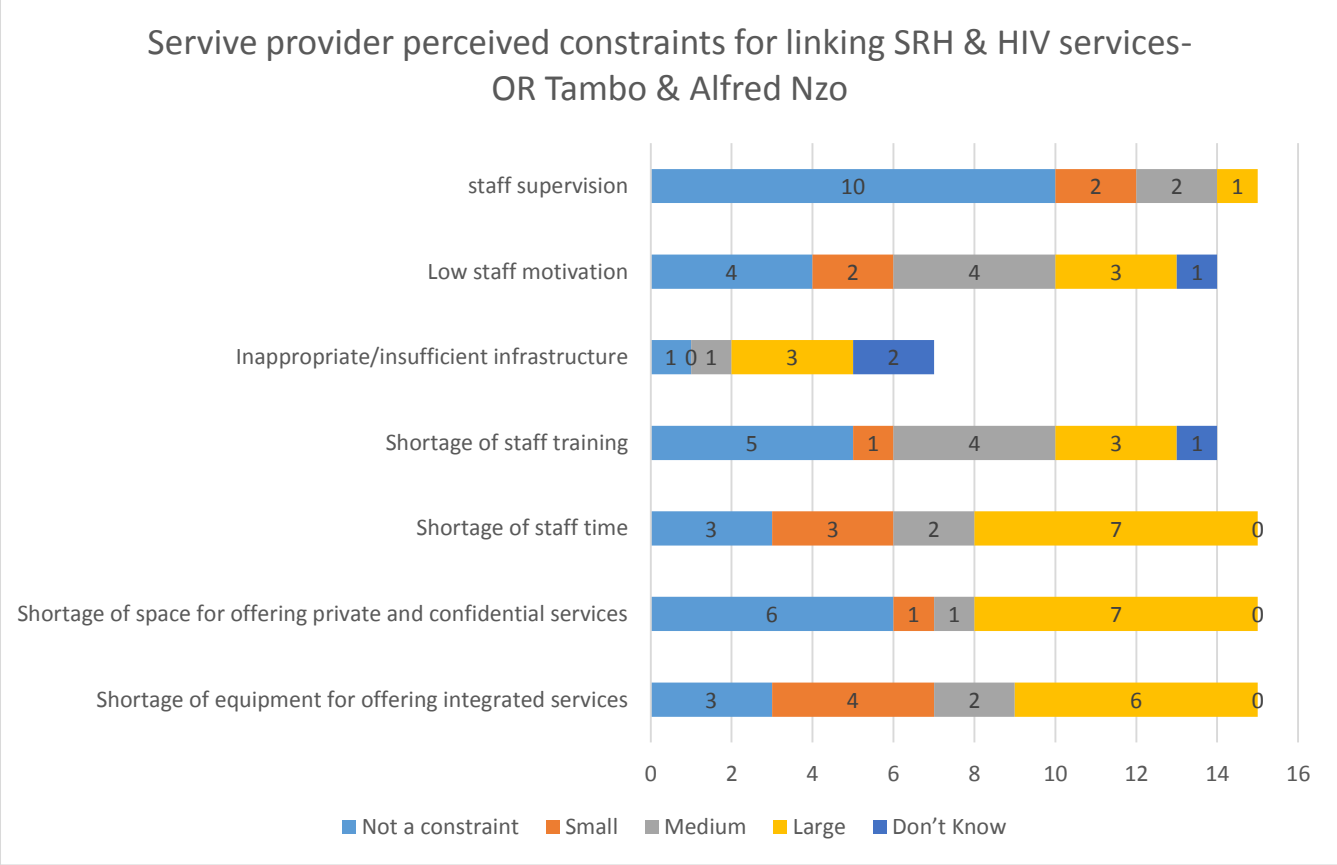
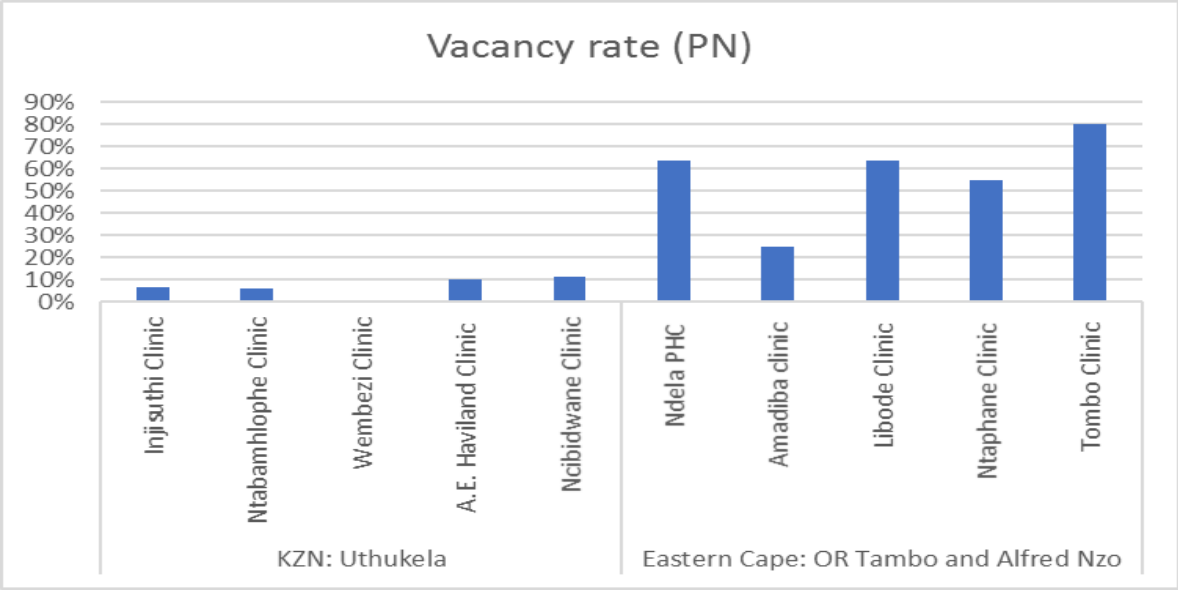


Figure 8.29: Vacancy rate



8.2.4. OR Tambo & Alfred Nzo findings summary

Table: 8.1: OR Tambo & Alfred Nzo summary table

	Summary findings	Discussion/ Recommendations
Staff Audit	Generally, a low proportion of staff are trained (< 30%) across the board in all the service areas that were analysed. Libode clinic consistently showed a higher proportion of staff. Service provider are more likely to have attended HIV related training and TB training than BANC and PC 101/APC. Only one SRH training reflected	A need to build the capacity on essential PHC package. Capacity building can effectively be provided using different approaches; in-service training, mentorship and supportive supervision.
Clients perspective	Majority of clients interviewed indicated they received all wanted services. Libode being the highest and Tombo and Ndela Clinics recording the least number of clients that received wanted service	Providing minimal package of integrated service will help to ensure a wider coverage if services that the client wants. This can also help in improving the service satisfaction level of clients
	Major benefits of receiving same facility SRH and HIV services are, 'reduce number of trips to the facility' 'reduce waiting time' and 'reduce transportation cost'.	
	Overall, majority of clients were satisfied with the services they received. Libode clinic have the highest number of satisfied clients among the five facilities	
Service providers perspective	HIV and SRH services are provided in all the facilities. Although there is disparity between the service package indicated by service provider and that which exist in the establishment	Ensure the development of the minimum package of services at the PHC level to facilitate appropriate services are offered at the level of care
	Clients seeking FP and STI services are more likely to receive a wider range of HIV services as part of the service provided by same service provider	Carry out patient flow analysis and service scoping per facility to identify facility specific approach to integration of services
	SRH services have more probability of being included in the Prevention for PLWHIV, HIV prevention for general population and Condom provision services	
	The main constraints of service provider in OR Tambo &Alfred Nzo are shortage of staff time, shortage of equipment, and low staff motivation. Corroborated with high vacancy rate in facilities	Address constraints directly; provide adequate staffing level for facility, address the shortage of equipment and carry out interventions that can motivate staff

9. Summary and discussion

This session seeks summarise the findings and provide answers to the questions that the TOR expected to be answered as a result of the rapid assessment of the Ten (10) facilities. These responses are based on the findings of the survey. The questions as specified in the TOR are as follows:

1. What has been integrated?
2. How are the services integrated?
3. What are the facilitators of integration?
4. What are the current gaps including capacity building needs?
5. Which entry points could be utilized to fast track integration of services?
6. Which models could facilitate integration of services?
7. Which components of SRH/HIV/TB and SGBV can be integrated?
8. What are the opportunities for integration, including community based models?

9.1. What has been integrated?

At Political and policy level there is a Constitution that protects the individual's right to access quality health. There is also an integrated National Strategic Plan for HIV, TB and STIs 2017-2022 that laid out the strategic approach to breaking the cycle of transmission and drives a major national push to scale up comprehensive sexuality education and linkage to Sexual and Reproductive Health Services.
There is consultation of all appropriate national programmes including SRH and HIV in the policy development circle; this process is facilitated by the organogram that structurally placed HIV, TB, Maternal, Child and Women Health under the same branch with an oversight from a Deputy Director-General who is a champion for integration. Many National Policies also show cross-referencing of relevant information from other existing policies. However, implementation and budgeting takes place in parallel, the HIV programme has a Conditional Grant that is ring fenced and guided by the Division of Revenue Act (DORA) while the SRH is financed with the Equitable share of the NDOH budget.

At systems level the Partners support is very disproportionate and tends to follow the HIV budget with very few partners supporting SRH and Integration with HIV programme. The provinces that were assessed have an integrated planning sessions but implementation, supervision and budgeting are in parallel. There is no indicator structured to facilitate integration of SRH and HIV at provincial level. There is an existence of Provincial Strategic documents that outline plans for programmes and also with no indicators for integration observed.

HIV has a strong link with the community because some programmes are funded by donors to implement community based interventions, however, the SRH programme with very few community partners collaboration could not harness this opportunity because of donors' funding scope that sometimes excludes SRH integration.

At facility level, integration of services is better than other levels and in some cases this happens as a default because of the limited number of staff that is available. Clients mostly receive their SRH and HIV programme within the same facility on same day and there are concern of both clients and service providers on the waiting time, staff workload and staff training around what and how to integrate; this concern was also raised at the provincial level. Overall, there is a high level of satisfaction among the clients for the services they receive and clients' preference shows a very high proportion prefers to receive the SRH and HIV services in one facility at the same time to save them the cost and time for

waiting. Service providers indicated that shortage of staff training, shortage of time and infrastructural challenge as the main constraints for offering linked SRH and HIV services.

9.2. How are the services integrated?

Family Planning services have more probability of being included in the Prevention for PLWHIV, OIs and HIV treatment, HIV prevention for general population and Condom provision services. Hence, clients seeking these services are more likely to receive a wider range of needed SRH services as part of the service provided by service provider. Clients seeking psychosocial support and PMTCT services will receive a comparatively lower range of SRH services when compared with the earlier group. SRH services are least likely to be included in HBC and Key population services. In addition, SGBV and prevention and abortion related care have the least possibilities of being included in the HIV services, the provision of HIV services within the SRH services corroborated the findings above with HIV services having more probability of being included in the Family planning and STI services. HIV services are least likely to be included in prevention and management of abortion services and SGBV services. Hence, clients seeking FP and STI services are more likely to receive a wider range of HIV services as part of the service provided by service provide and the reverse is true.

HIV Services like HIV Counselling and testing, PITC, Prophylaxis and treatment for PLWHIV, HIV Prevention for PLWHIV, HIV prevention information services to general population and condom provision services are indicated to be the most likely services included in SRH services. In contrast, HIV services to key population like MSM, Sex workers have the least possibilities of being includes in the SRH services.

Generally, the least integrated are SGBV and prevention and management of abortion related care for SRH; these services are normally referred out of facilities, there is a concern for the follow up of these clients because majority of the service providers indicated low follow up practices. In addition, the HIV services to key population are the least integrated, the perception of service providers on this is not knowing what to do in order address the need of this special population, many also expressed the view that they are not found in their community.

9.3. What are the facilitators of integration?

The assessment revealed that at the national level having a strong political will and supportive integrated national Strategic Plan and structurally positioning both HIV and SRH unit to report to the same supervisor facilitates integration. At implementation level, capacity building of staff, implementation of Ideal clinic concept at PHC level and having the right infrastructure plays major roles in integration.

9.4. What are the current gaps including capacity building needs?

This assessment identified gaps and opportunities to strengthening integration at all levels; these include a need for service providers to further understand the minimum package of SRH and HIV integrated service provision, strengthening the capacity of service provider to identify minimal PHC package of integrated services that can be carried out for Key populations, SGBV, abortion care, psychosocial support, even though these services are almost always referred out of the entry service

points, building the capacity of the service provider on the minimal package of services to be rendered before referral and emphasising the importance of following up is crucial.

The two districts identified different major constraints to linking SRH and HIV services, While UThukela district identified shortage of training, staff supervision, time, and low staff motivation as the key constraints OR Tambo & Alfred Nzo Identified shortage of staff time, shortage of equipment, and low staff motivation as key. The high vacancy rate of the five facilities assessed in Eastern Cape (OR Tambo & Alfred Nzo) is also a major gap. Lack of space for maintaining confidentiality was also identified.

The role of Civil Society Organisations (CSO) in SRH programming is not prominent, despite the high level of CSO support received by HIV programme, SRH could not tap into this resources, the main reason provided is around the issue of HIV-only focused funding design. The capacity of the service provider should be built on how SRH services can be integrated without necessarily increasing cost of delivery of services.

The general perception is that even though there is a joint planning at provincial level, this is not carried over to programme management and supervision. There is also no standardise set of indicators that can be used to monitor the progress of SRH and HIV integration.

Lastly, from the perspective of clients, the highest priority need identified is 'adequately trained staff for relevant services and reduction of waiting time'. Any intervention carried out on building the capacity of staff is most likely to produce a positive client satisfaction in these facilities. Capacity building can effectively be provided using different approaches; in-service training, mentorship and supportive supervision.

9.5. Which entry points could be utilized to fast track integration of services?

The assessment focused on key entry points for care which include acute care, chronic care and maternal, child and women's health and adolescent and youth friendly services. While clients from seven facilities (>75%) indicated that they received all the services they came for at the facilities, there are however opportunities to fast track the integration of services.

Generally, even though key HIV and SRH services like HIV testing and counselling, condom, FP, STI services are of high level of integration, there are still gaps in Maternal and Newborn, abortion and SGBV service integration at all entry points. There are indications from both the clients and the service providers that not all entry points are integrating SRH services; TB entry points in some facilities run as a parallel service with little SRH integration.

Adolescent and Youth Friendly Services also provide an opportunity for fast tracking integration, especially among the targeted age-group. However, these services are not consistently implemented at all facilities assessed.

There is generally a high level of concordance among districts between the information provided to clients during clinic visits, of importance is the low level of information provision on Health needs of young people, breast cancer screening, and sexuality information. UThukela district survey participants indicated a very low information on cervical cancer screening. This is not supportive of the DHIS information that indicates that UThukela district is a high achiever with over 80% cervical cancer screening coverage. A major constraints identified in the provision of cervical cancer screening service is lack of required equipment and service providers indicated that the procedure is time

consuming. Further reasons for this should be explored to provide clarity on the observation. However, an opportunity exists to further strengthen the inclusion of this information at every service points when appropriate.

Providing a clear and simple guidance on opportunities for integration at all service points and building the capacity of the service providers will be key enablers in fast tracking integrated services at all entry points, in addition, this will help to provide guidance to service providers on which service to appropriately integrate at entry points. This is particularly critical since there is high rotation of staff within the facility service points due to shortages in some facilities.

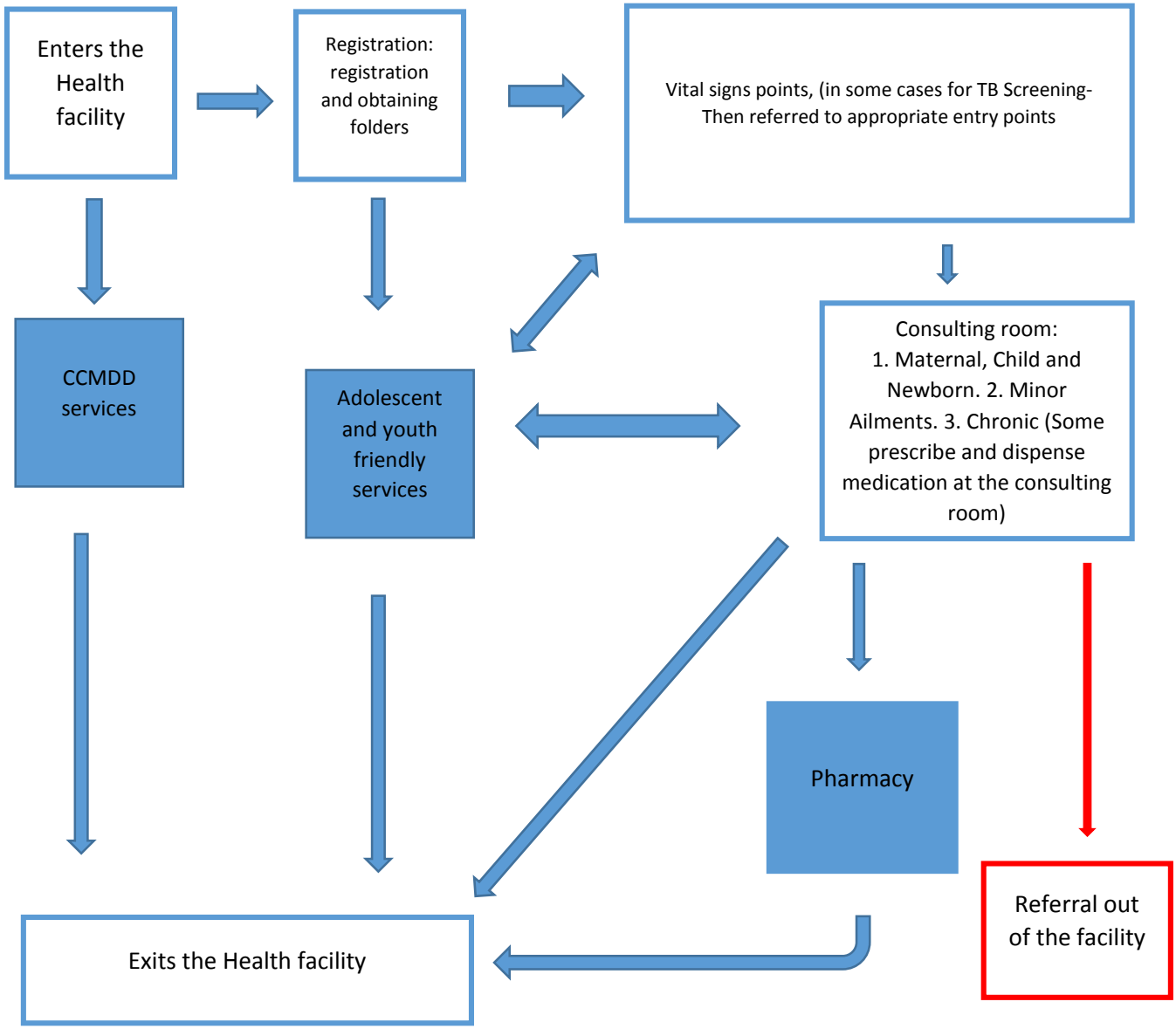
9.6. Which models could facilitate integration of services?

There is a similar model of offering the integrated services in all the facilities. This is a model that has the potential of facilitating integration by offering Integrated SRH and HIV services by the same service provider at the same room on the same day. Some services like the cervical cancer screening are often referred to another room in the same facility due to placement of equipment. The least common method is to refer the client to another facility for services like key population, abortion and SGBV, and psychosocial support. While these referred services require the services of a higher level of care, it is not clear if service providers have a uniform understanding of the appropriate package of services to be provided at the PHC facility before referral and the need to follow up on referral

9.6.1. Patient flow:

Patient flow is generally determined by many factors at the facility level, these include infrastructural set-up, space availability, availability of staff etc. When clients enter the facility for an intended service, he/she can go straight to the CCMDD service point if for scheduled periodic chronic medication, if not, then client goes to the registration desk to be registered and obtain clinic folder. Depending on the service client can access other services like AYFS for a special youth friendly service or goes straight for vital signs. After leaving the vital sign service point, client enters into either of the three service streams or entry points (Maternal, Child and Newborn, Minor Ailments or Chronic). The ideal situation is to provide patient centred services at these service points without referring patients to any other entry points, however, in some cases clients are referred within facilities to different service points for different reasons. Some facilities consult, prescribe and dispense medication in the same consulting room and therefore eliminating the need for clients to go to the pharmacy after leaving the consulting rooms. The blue blocks in the flow chart represents services that are not always available in all the facilities; some facilities were not observed to have AYFS. The red arrow and block represent out of facility referral

Figure 9.1: Health facilities service flow chart



The flow chart modelled above is a hybrid of models that exists across the ten facilities; some facilities introduced administering the choice of client's family methods at the point of taking vital signs, others completely eliminated clients passing through the pharmacy for medication dispensing.

Infrastructural challenges also made this model more complex in some facilities with facilities space challenges compromising provision of clear and accurate client pathway without missing the next service points (especially when service points are located in different buildings all over the compound of the health facility)

Overall, the model of service will generically follow the hybrid above, but the challenges and opportunities that exists in each facility will ultimately help to contextualise the model of integration. The best model will be facility dependent; based on availability of staff, space and infrastructural set up.

9.7. Which components of SRH/HIV/TB and SGBV can be integrated

The findings from the rapid assessment indicated that there could be some level of integration of services at all service points. The implementation of integration at this points will not happen by default, this will emerge from carefully assessing each service point and coming up with a minimum package of services or activities that can easily be integrated at the service point without compromising quality and outrageously increasing waiting time. As reported by the service providers, there are some services that will not be able to take place in the same room by the same provider due to specialised equipment needs and the length of time the procedures take, a good example is Pap smear for cervical cancer screening; provision should be adequately made to link this type of services to the appropriate service points without significantly increasing waiting time and compromise patient care.

9.8. What are the opportunities for integration, including community based models?

The survey recognised the fact that clients have principal reasons for coming to the health facilities, these reasons are well within the key components of the SRH and HIV services, however, there are also expectations that service providers will offer some other services beyond this main reasons for coming to the clinics. Unfortunately, meeting these untold expectations contribute to the level of satisfaction that clients expressed about the services they received. This study finding showed that services that are least mentioned as the main reasons for accessing services 'jumped' to the top of the list of services that the clients felt they should have received and did not receive, these are psychosocial support, HIV Counselling and Testing, Nutrition support and abortion services. These are missed opportunities in these cases, providing a minimum package for service integration and linkages, appropriately building the capacity of service providers and exploring existing community structures can address the need of the clients to a good extent and prevent some of these missed opportunities from occurring.

There is also an opportunity in collaborating with many community based and civil society organisations that are funded to provide HIV focused interventions at the community level. Developing a model of integrating SRH into the activities of this community structures where feasible will improve the level of integration at the community level. This can be achieved by active engagement of the HIV unit at all levels.

Facility managers can follow these 10 simple steps towards strengthening SRH and HIV integration in their facilities:

1) Convene a facility based team or use the platform of the routine meeting to discuss integration
2) Define the present patient flow in your facility
3) Discuss the core services that is being rendered at each stream or entry point (Maternal, Child and New born, Minor Ailments or Chronic)
4) Use the template in Annexure 1 to identify, services that is being provided in the streams (individually)
5) Also list the services that are not being provided in that stream
6) Identify which services can be integrated and which can be linked for successful referral
7) Prioritise the list
8) Re-evaluate your patient flow and ensure it will support your new approach
9) Agree on implementation
10) Monitor implementation and evaluate progress

10. Conclusion and recommendations

In the light of the findings in this report, the following key recommendations are proposed, these recommendations are practicable and is sensitive enough to strengthen integration at the 10 facilities assess when implemented:

1) Department of Health (DOH) with the support of partners should develop a minimum package of services that can strengthen integration at facility level. This package can be complemented by designing some Job aids that can practically guide integration at the three existing service streams or entry points (Maternal, Child and Newborn, Minor Ailments or Chronic). This minimum package of services should take into cognizance the low integration of SGBV, prevention and management of post abortion services, psychosocial support, AYFS and key population

2) The DOH and partners should innovatively look into and address the inadequate training issues that came out strongly from the study, this approach should not just lead to organisation of training workshops but should look at a way of strengthening in-service training, mentorship and supportive supervision to address this training gap. The content and guide of this capacity building support should address facility specific factors that affects integration

3) The facility managers and team of the 10 assessed facilities should re-evaluate the patient flow process in order to optimise the opportunities and mitigate the weaknesses of their facilities to provide integrated services. This approach should aim at reduction of waiting time, improved quality of service and staff efficiency. It is also critical to do this in order to mitigate the infrastructural challenges and for the facility team to own the product of the re-evaluation. As described in chapter 9 of this report many pathways can be followed and it should be generic to facilities. This can be supported but not led by partners.

4) As part of the facility re-evaluation process, there is a need for the team to identify opportunities that exist for integration at all entry points of the facility. A simple template sample like Annexure 1 can be used and built upon to facilitate this process. The process will also be helped by the Ten steps towards strengthening integration listed in chapter 9

5) Stakeholders should continue to emphasise that integration should not be viewed as a consulting room process. It must start from the point of entry into facilities and all through the patient flow in order to be able to optimise the opportunity that exists at every service point. Successful referrals and linkages should also be emphasised. Examples of good practises that came out of the validation workshop and can be considered by the facility team includes:

    a. Pregnancy test being done at the vital sign service point for eligible women of reproductive age group.
    b. Provision of the chosen family planning method at a service point before the consultation room, some facilities recognised the vital sign point as an appropriate point, also because this point is manned by appropriate cadre of staff that can provide the service.
    c. Proactively screening for Cervical Cancer can through the use of eligibility criteria can also be done for appropriate referral for pap smear before reaching the consulting room

6) Use the opportunity of the re-evaluation process described above to encourage team building among the staff members with the aim of supporting any service point that will need help at any time due to high patient load; for example, only the PN in chronic team should not be left to attend to patients till 17h00, while the ANC PN had finished seeing patients since 13h00.

7) Establish a sensitive communication strategy as part of the process of introducing the new approach. The platform of health education delivery at the facility level should be used to educate patients on the benefit of integrating SRH and HIV services.

11. References

a) Statistics South Africa (2017): Mid-year population estimates 2017, www.statssa.gov.za.
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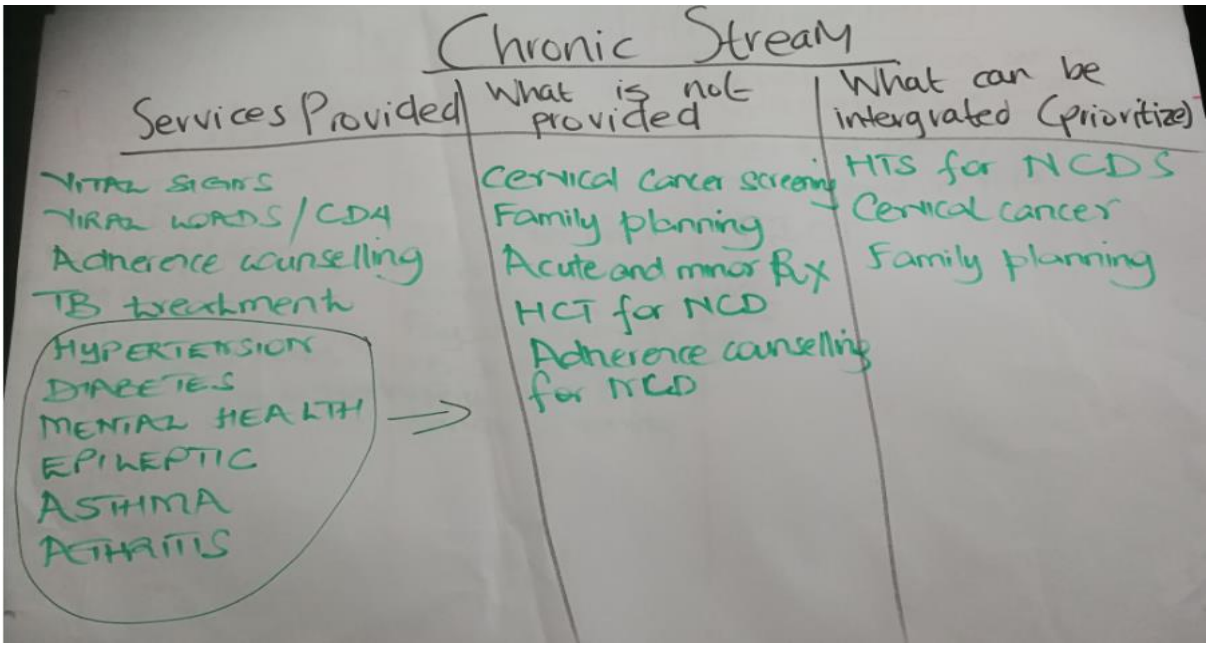
c) WHO/UNFPA (2005): Sexual and reproductive health and HIV/AIDS: A framework for priority linkages.
d) IASC (2005). Guidelines to gender-based violence in humanitarian settings. Geneva.
e) UThukela DHP (2017): UThukela District Health Plan.
f) Massyn N, et al (2016): District Health Barometer 2015/16. Durban: Health Systems Trust.
g) South African HPV Advisory Board (2010): Cervical cancer and human papillomavirus: South African guidelines for screening and testing. South African Journal of Gynaecological Oncology.

12. Annexures

Annexure 1: Validation meeting summary



Annexure 2: Data collection tools