Integration of Sexual and Reproductive Health & HIV Services in South Africa:
Symposium on Progress and Challenges
Proceedings
20 to 21 September 2011
Durban, South Africa

MatCH
Maternal, Adolescent and Child Health
Department of Obstetrics and Gynaecology
University of the Witwatersrand
## List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACG</td>
<td>Adjusted Clinical Groups</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>BCS</td>
<td>Balanced Counselling Strategy</td>
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<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
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<tr>
<td>CHC</td>
<td>Community Health Centre</td>
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<td>CHP</td>
<td>Centre for Health Policy (University of the Witwatersrand)</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<tr>
<td>DoH</td>
<td>Department of Health (South Africa)</td>
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<td>EC</td>
<td>Emergency Contraception</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>HCT</td>
<td>HIV Counseling and Testing</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HSN</td>
<td>Health Systems Navigation/ors</td>
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<tr>
<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
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<tr>
<td>KZN</td>
<td>KwaZulu-Natal (Province)</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MatCH</td>
<td>Maternal, Adolescent and Child Health</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MCWH</td>
<td>Maternal, Child and Women's Health</td>
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<tr>
<td>MCYWH</td>
<td>Maternal, Child, Youth and Women's Health</td>
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<tr>
<td>MMC</td>
<td>Medical Male Circumcision</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NIMART</td>
<td>Nurse Initiated Management of ART</td>
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<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care/Centre</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission (of HIV)</td>
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<tr>
<td>PNC</td>
<td>Post Natal Care</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TIMS</td>
<td>Training Information Management System</td>
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<td>TOP</td>
<td>Termination of Pregnancy</td>
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Summary

Background

Despite the clear link between unsafe sex and the risk of both unintended pregnancies and the acquisition of HIV and sexually transmitted infections (STIs), health services do not adequately address the interconnections between sexual and reproductive health (SRH), family planning (FP) and HIV/AIDS prevention. International fora have stressed the need for improved integration of services to address the comprehensive SRH needs of women and men in the context of HIV/AIDS. In 2004, the Glion Call to Action, for example, called for strengthening the particular link between FP and the prevention of mother-to-child transmission of HIV (PMTCT).

There are a lack of clear policies on integration within South African health services and studies in South Africa have found substantial barriers to providing an integrated service due to on-the-ground realities of vertical service provision, logistical difficulties, and the need for extensive re-training of health care providers. Proponents of integrated SRH services argue that they can lead to improved efficiency and effectiveness of the health care system, as well as to improved SRH outcomes. These potential benefits include increases in contraceptive prevalence and declines in unplanned pregnancies, maternal mortality and the incidence of HIV and other STIs. In addition, combining SRH services may improve efficiency by requiring fewer client-provider contacts, reducing duplication of services, ensuring continuity of care and empowering staff to perform multiple tasks. Linking services may also help to reach under-served groups, such as adolescents and men.

Programme and Discussion

The Integration Symposium was attended by over 50 participants, all with experience in the area of health service integration. The programme included formal input on SRH and HIV/AIDS integration, covering technical aspects, research, policy, programmatic and integration resources, based on international, regional and local experiences. A copy of the programme can be seen in Appendix 1 and the individual presentations can be found in Appendix 2. A panel discussion, followed by breakaway workgroups, developed and consolidated key strategic points pertinent to SRH/HIV integration that were raised during the course of the meeting. Following the meeting, key priority areas were identified by MatCH Symposium coordinators and suggestions for an implementation strategy were developed (drawing on input received during the Symposium). These are presented in the following section “Key Priority Areas for Integration and Implementation Strategies”.

Symposium Participants

Organisations represented included: the Department of Health (DoH) at several levels (National, KZN Province, eThekwini District and eThekwini health facilities); eThekwini Municipality; McCord Hospital (Durban, KZN); MatCH (University of the Witwatersrand); Women’s Health Research Unit (University of Cape Town); Centre for Health Policy (University of the Witwatersrand); Support Worldwide; Ibis Reproductive Health; Population Council; Family Health International (FHI360) and The William and Flora Hewlett Foundation. Details of individual participants can be found in Appendix 3.

Purpose of the symposium

MatCH (Maternal, Adolescent and Child Health), a Division under the Wits Health Consortium, of the University of the Witwatersrand is working closely with the eThekwini District and Municipality to develop and implement a service delivery model that integrates SRH and HIV/AIDS services in a sub-district of eThekwini. Participants of this symposium reflected on the progress, successes and challenges of the diverse integration activities that have been part of the project. In addition, other integration projects and initiatives from KwaZulu-Natal (KZN) and beyond were presented for discussion. This symposium is a follow-up to the first Symposium held in 2007, which brought together many of the same participants at the very outset of the eThekwini Integration Project. In 2007 the aim was to conceptualise the key components of a pilot integration project which commenced in 2008.1

Key Priority Areas for Integration and Implementation Strategies

In this section, we present three ‘key priority areas’ considered by symposium participants to be essential to the successful implementation of SRH/HIV integration in KwaZulu-Natal, South Africa. Each priority area is followed by an outline of points to be taken into account when developing an implementation strategy.

Key Priority Area 1:

*Develop integrated training and mentoring programmes*

Ensure that comprehensive training and mentoring programmes continually address integration of SRH/HIV services.

Implementation Plan:

**Training and mentoring initiatives**

- Prioritise and standardise a comprehensive integrated training programme
- Revive the regional training centres in KZN/country for all providers and lecturers/tutors, as well as District and Sub-District trainers
- Revive/strengthen a system of skilled and dedicated trainers at all levels
- Establish a strong onsite clinical mentorship programme and systems for Monitoring & Evaluation (M&E) including the development of tools/checklists for mentoring and monitoring. This is the task/responsibility of sub-district/Community Health Centre (CHC) trainers (with visible support from District Trainers)
- Districts/Sub-Districts to collaborate with local partners, including the local government Departments of Education, Police, Justice, etc. and relevant local NGOs/CBOs
- Strengthening in-service/update training to be held regularly e.g. quarterly

**Training for communities**

- Regional office to set up a programme for training of communities e.g. Flagship programme; District and Sub-District trainers to implement the programme
- Develop a standardized/comprehensive programme for dedicated community facilitators
- Ensure community care givers receive training as listed under the section above

**Innovations to maximise integration efforts**

- Implement Health Systems Navigation and other innovative models for more effective referrals; recruit and train community members as navigators
- Develop a database of trained people: Professional; Community Care Givers; Adjusted Clinical Groups (ACG); Training Information Management System (TIMS) to be available at district and facility level
- Conduct annual skills audits
- Engage nursing colleges and universities in adopting integrated training curricula
- Nursing Council to amend policies, scopes of practice and licencing for task shifting
Key Priority Area 2: Develop minimum integration package that is tailored to individual facility needs

Ensure that a basic minimum package of integrated services exists at all facilities, that integration can be tailored at facility level and that key indicators are collected as part of an M&E package.

Implementation Plan:

Access to a minimum package

❖ Screening forms to be designed for identifying clients’ service requirements
❖ Screen the number of services needed according to specific criteria e.g. sex, age, relationship status, current health status
❖ Ensure clients are given information on all services provided – where to go for what services
❖ Ensure equipment, supplies and infrastructure for services are available

Model characteristics

❖ No ‘one-size-fits-all’ exists – rather, ‘facility specific integration strategies’
❖ Strengthen referral links
❖ Identify an Integration Champion/Integration Co-ordinator at facility/area level

Develop integration indicators

❖ Review existing indicators and build on these (rather than creating new indicators)

Identify and standardise service points for integration

❖ Identify and use service points to enable integration, for example, clients accessing either HIV or SRH can be offered services such as FP or fertility counselling, pap smears, STI testing and screening, based on their particular needs

Innovations to maximise integration efforts

❖ Implement a systematic screening checklist as part of the minimum package
❖ Develop a facility level mechanism of monitoring of services
❖ Regular monitoring of integration indicators by supervisors of SRH services
❖ Strengthen referral systems
Key Priority Area 3:
Support community involvement, including hard to reach groups, such as men and adolescents

Ensure that communities are engaged in integration activities, with a focus on schools and male involvement to maximise reach into the community.

Implementation Priorities:

Community input
- Maximise and strengthen existing structures and mechanisms (e.g. clinic committees) and ensure volunteer forums are sustainable and key members are replaced when necessary
- Communicate all new processes to the community, involving local councillors wherever possible
- Start with a ‘bottom-up’ approach

School health
- Reintroduction of the School Health Programme presents opportunities to integrate with the community and should focus on:
  - Health promotion, especially nutrition
  - Including social workers as an integral part of the school health team
- Involving health professionals in school life orientation programmes
- Policy changes on availability of contraception in schools are needed
- New Department of Education draft policy on teenage pregnancy in schools should address integrated service delivery

Male involvement
- Develop outreach strategy to visit workplaces, taxi ranks and taverns to reach men
- Involve community health workers in engaging men
- Advocate male involvement in integrated SRH/HIV services when engaging with key community stakeholders of influence (e.g. traditional leaders and older men)
- Use medical male circumcision (MMC) as a point of contact with men and to encourage their engagement with facilities

Innovations to maximise integration efforts
- Consider cultural context: involve mothers-in-law to maximise male involvement
- Conduct advocacy and targeted messaging to reach men using celebrities and men’s groups
Integration of Reproductive Health and HIV/AIDS: An Overview

Prof Jenni Smit, MatCH

A global overview of integration of reproductive health and HIV/AIDS was presented, which highlighted the historical landmarks and initiatives that have moved the international integration agenda forward. The current status of integration in South Africa, with a focus on specific changes in policies and service delivery as well as successes and challenges, was described. The urgent need to integrate reproductive services with HIV services is widely acknowledged in South Africa, where high HIV prevalence, maternal mortality and teenage and unplanned pregnancy continue to be major public health concerns. There is clear support and consensus for the need to integrate services in South Africa – yet the best way to integrate services remains elusive and may require different models depending on needs and context. In short, the “One size does not fit all” approach may be the way forward.

Key Lessons Learnt that make FP/HIV Integration Worthwhile

Dr Hloniphile Mabuza, FHI 360

Family planning is a key component of HIV prevention in addressing unintended pregnancies in HIV positive women. There are clear common needs of women seeking FP and HIV services from many sub-Saharan countries. In Nigeria and Kenya there is evidence of increased uptake of FP once integration efforts have been made in HIV services. In South Africa, an FHI-supported intervention in the Western Cape trained providers in a number of aspects of FP, including intrauterine contraceptive device (IUCD) insertion and strengthening referrals for sterilisation. Although the PMTCT intervention addressed many issues (including training of staff), challenges with commodities and supervision hindered the intervention. A second project focused on mobile service units in rural areas of four provinces and found that this was a viable option for expanding integration into rural areas. The key lessons learnt included:

❖ the need for broader health systems strengthening activities, which were key to overcoming a range of obstacles to integration;
❖ the no “one size fits all” approach dependent on the context of the service; and
❖ missed opportunities to deliver FP services to clients accessing HIV services

KZN Plan for Integration of Reproductive Health, Family Planning and HIV/AIDS Services

Jacqui Ngozo, KZN Department of Health

KwaZulu-Natal has the highest rates of HIV among the antenatal (ANC) population in South Africa, in particular in young women. There is an urgent need to improve access to and use of HIV and SRH services to address the high HIV prevalence and the associated stigma and discrimination. KZN province is preparing to rollout quality integrated SRH & HIV services aiming to decrease duplication of efforts and competition for scarce resources. This will enhance programme effectiveness, better utilise limited staff resources and improve access to services. Wide-ranging activities that will be implemented as part of the plan will include innovative strategies such as advocacy, the appointment of integration champions, marketing of SRH & HIV services and training for district master trainers. The challenges and actions required to ensure the plan can be successfully implemented were presented. The presentation also gave an update on the progress and reach of the recent HIV counselling and testing (HCT) campaign, and coverage of the PMTCT and Antiretroviral (ART) programme.

Progress in Integration of PMTCT into Maternal, Child, Youth, and Women's Health (MCYWH)

Precious Robinson, National Department of Health

The PMTCT programme in South Africa was vertically implemented at all levels including policy and staffing. The historical patchwork of services and vertical programmes resulted in many key components such as Maternal, Child and Women’s Health (MCWH) and HIV moving forward in parallel, leading to unequal resource distribution and lack of cooperation between departments. From 2004 there was a realisation that these programmes needed to be integrated. In order to do this most effectively, five key strategies were put forward to facilitate linkages at all levels of policy, systems and service delivery. The importance of Prong 1 (the primary prevention of HIV in women of childbearing age) and Prong 2 (the prevention of unintended pregnancies in women living with HIV) to improve MCWH were emphasized.
Session 1: Question and answer discussion points

The issue of integration champions was raised and how they would be identified. A suggested model was put forward where even the smallest facilities would be able to identify a member of staff who would take this role. All levels of care would be expected to identify individuals to lead integration efforts to ensure it was not an activity limited to particular services, facilities or levels of care.

Negative attitudes of providers in promoting the IUCD as a safe and effective method of FP were raised and this would need to be addressed to expand contraceptive choice.

The KZN 5-Point Contraceptive Strategy was highlighted as it includes a focus on integration of FP and HIV services. This strategy was due to be disseminated at a provincial level in October 2011.
Feasibility and Effectiveness of Integrating HIV Prevention and Testing into Family Planning Services in South Africa: Results of a Cluster Randomized Trial

Dr Saiqa Mullick, Population Council

Set in the North West Province, this trial aimed to integrate HIV services into FP services and compare this to standard practice. Family planning services were standardised and strengthened through training providers in the “Balanced Counselling Strategy” (BCS Plus). The study was rigorously evaluated, assessing the impact of integrated services on behavioural outcomes. Results showed high variability of effect across clusters and although quality of care scores were higher in intervention sites these were not significant. There was good evidence, however, that FP clients were more likely to have tested for HIV in the past year and there was a trend for higher condom use at last sex.

A Work in Progress: The McCord Experience with Integrated SRH and HIV Services

Dr Tamaryn Crankshaw and Dr Christie Cloete, McCord Hospital

The McCord Hospital has developed a model of integrated services through integration of its PMTCT and Post Natal Care (PNC) programmes at its Mamanengane Clinic, which provides services to HIV positive women and their infants (0-18 months), and at HIV treatment clinics, which now provide a range of services, including HIV treatment, Pap smears, TB screening, FP counselling and other related services. Post natal services for HIV positive women are available with a similar service profile. One of the current challenges is that the PMTCT clinic is physically separate from the ANC clinic and ANC nurses often lack HIV training.

Furthermore, the adult ARV clinic “Sinikithemba” provides integrated ARV and SRH services and is linked to the PMTCT programme. Two models of integration were discussed: a “room level” integration where all services were provided in one consultation, versus a “roof level” approach where services were provided on the same day but in different consultations. The relative advantages and drawbacks of each approach were put forward and the balance needed between them. The patient perspective was also considered and whether patients would be overwhelmed if too many services were provided in one consultation and would impact on waiting times and user fees.

Comprehensive HIV and SRH Linkages: Progress and Next Steps

Naomi Lince, Ibis Reproductive Health

A review of the evidence on integration with a focus on a major systematic review by WHO/UNFPA/IPPF/UNAIDS/UCSF was presented. Peer reviewed studies were often limited in the number of service linkages, while promising practices often linked 5 or more services. There was limited evidence from interventions linking HIV with abortion, adolescent, gender based violence and services for men and boys. Two current Ibis projects were also presented. In Kenya a randomized trial is measuring the impact of a comprehensive programme that integrates FP counselling and services into existing HIV care and treatment programmes. Challenges experienced include staffing shortages and a need to create a demand for services. In South Africa, Ibis is conducting participatory research to look at root causes of teenage pregnancy with a view to address service availability and organisation and provider attitudes to adolescent sexuality.

Linking State Support for Pregnant Women to Maternal & Child Health Services

Prof. Matthew Chersich, Centre for Health Policy and Dr Fiona Scorgie, MatCH

The Centre for Health Policy (CHP), on behalf of the South African government, are investigating the feasibility of state support for pregnant women. Hypothetically, this support would be available to pregnant women in need, and could take the form of cash, food, vouchers or other transfers up to the point of delivery at which point the Child Support Grant would take over. The feasibility study – led by CHP – will assess if this initiative could improve maternal and infant health outcomes by using the distribution of state support as an opportunity to link women with services during pregnancy and thereby promote healthy behaviours.
Session 2: Question and answer discussion points

The presentation on state support for pregnant women initiated a great deal of debate. There followed a discussion on how best such support could be administered with a focus on where it would be collected from and who would be eligible. If health care facilities were involved in the support mechanism, questions were asked about how this would affect security and workload of health care workers. Concerns were noted about how support like this would affect FP uptake as there may be a financial incentive to access the grant, and therefore an incentive to become pregnant. The presenters argued that there was strong evidence suggesting this was unlikely since research had shown that in the vast majority of cases, most of the Child Support Grant was spent on basic costs such as food, school and electricity, rather than frivolous items. Importantly, the need to explore other opportunities to link pregnant women with services (an under-explored form of integration) was the main objective of the presentation, rather than the option of a cash grant. Creative, realistic ways of integrating these services are needed. Symposium participants discussed these issues at some length, with most participants tending to doubt the value of such a support programme for pregnant women, owing to the possible dangers of it being misused.

The BCS Plus was discussed as a means of support for lay counsellors if SRH services and HIV services are integrated. This was raised as it was noted that lay counsellors have limited support in KZN as facility staff do not always have time to play this role.

Pregnancy rates among ART clients was discussed, and Christy Cloete responded that approximately 5 - 10 patients seen per month have become pregnant. It is not known if these pregnancies are planned or unplanned. When patients visit the clinic at McCord, an informal discussion on safer pregnancy is held and during consultations more direct questions are asked of patients. Currently there are approximately 5,000 patients on ARVs at McCord’s clinic.

The importance of MMC in an integration strategy was raised as crucial, with the need to include men wherever possible. Women need to be more informed about MMC, and it was agreed that MMC should be highlighted.

Missed opportunities for integration in Sexual and Gender Based Violence (GBV) services were noted, with few women accessing these services receiving an HIV test. Information on referral of women from these services was often not collected or missing. This was highlighted as a missed opportunity. It was also noted with regard to sexual assault, that health facilities did liaise with protective services in KZN, however many victims were referred to hospitals for EC– highlighting another missed opportunity to link them to local facilities.
The eThekwini Integration Project

This session gave an overview of the progress in the eThekwini Integration Project (“Structurally Linking HIV/AIDS and Family Planning Services in KwaZulu-Natal”) taking place in a Sub-District of eThekwini. An integration symposium was held in 2007 prior to the start of the project, to brainstorm and deliberate with key researchers and health service managers in this field on best practices and methods of implementation. The project is now in its latter implementation phase and this session presented findings on various components of the project to date.

Integration: The eThekwini Project Overview and Progress to Date

Cecilia Milford, MatCH

This presentation gave an overview of the background to the eThekwini Integration Project. The first year required extensive buy-in and the project team consulted widely with key stakeholders. The establishment of a district working forum and community and scientific advisory boards enhanced communication and buy-in. Following baseline research and feedback to the sites and key stakeholder groups, an integration model was developed with seven core intervention activities (Fig 1). A monitoring and evaluation plan was put into place to monitor the implementation. As the project progressed, several distinct nested activities were developed to strengthen integration, including the Health System Navigation (HSN) pilot, mentoring of staff and youth friendly services. Challenges to implementation included: lengthy buy-in activities; human resource shortages which impacted on training attendance; and concerns about an increasing workload.

Essential components of successful integration were identified as: community engagement; and strong partnerships with the DoH and site staff, primarily through the district working forum. Monitoring of activities was also important to track progress and to tackle emerging issues timeously.

Figure 1: The eThekwini integration model
Health Systems Navigation & Adolescent Interventions

Letitia Rambally, MatCH

The Health Systems Navigation concept is a combined peer support and outreach activity specifically aiming to assist patients navigating complex health-care arrangements. The HSN component of the eThekwini Integration Project was developed as one strategy to support facility integration efforts. The pilot was tailored to link SRH and HIV/AIDS services in selected participating project sites. The navigators were recruited from the community and trained to provide a range of client support services including referral, information giving, and promoting uptake of integrated services. Engaging with the community through outreach was also a key activity. Daily activities were closely monitored to establish areas of demand and workload. Feedback from providers in the sites indicated that Navigators were able to fill an important gap, linking clients with services and freeing up nurses to undertake other tasks. However, the Navigators were often given extra jobs to do that detracted from client contact efforts. Overall, the pilot was seen as highly successful and future plans aim to extend and expand the project to other facilities and to test the navigator concept in smaller facilities.

Although not yet at implementation stage, the planned adolescent pilot aimed to implement provision of a sustainable adolescent friendly service which will link expanded clinic services with community outreach through schools, sports and social clubs to encourage use of services.

Integration: Are We Getting There?
Experiences from Project Sites

Sr Tessa Beaunoir, Austerville Clinic

Austerville clinic is one of the facilities participating in the eThekwini integration project. Feedback was given on experiences in the facility since the start of the project, where the focus was to maximise and effectively make use of staff and limited resources. Training had given staff the skills and information needed to provide a wider range of services, including newer services such as HIV related services and female condoms. Clients are now seen in a more holistic way, with providers assessing their broader needs beyond the particular service they may have come for. The sites had combined several services and strengthened referral systems with Wentworth Hospital, their referral site. In particular, HIV and FP services had been strengthened resulting in shorter queues and improved time management. This had the knock-on effect of improving relationships with clients, which was further cemented by outreach services. Challenges had been faced and resistance to change had to be overcome. There was also a need for on-going training and motivation of staff.

Integration of eThekwini HIV Services

Dr Arthi Ramkissoon, MatCH

In eThekwini, as in other districts in South Africa, HIV services are moving into a phase characterised by the gradual decentralisation from hospital-based HIV services to community health centres and clinics. The shift of these services to PHC levels has had positive repercussions for integration as it has improved and facilitated access to HIV counselling and testing, in particular for men who have been linked into care. It has expanded maternal health services to include ART for pregnant women and also improved access toFP, cervical cancer screening and post exposure prophylaxis (PEP). The rollout of MMC has further opened integration opportunities as men can be tested for HIV, counselled around risk reduction and dual protection and linked with local PHC services for other related services.
Session 3: Question and answer discussion points

There was considerable discussion of the role of the Health Systems Navigators as agents of the facility. A question was raised about how trust issues played a role in the interaction between navigators, providers and clients. In response it was noted that there was some mistrust at first, however, navigators were accepted when benefits were seen and they were quickly absorbed into the system.

There were questions around liability issues of navigators (especially when giving information during the health talks). If incorrect information was given to a client who would be then held liable? This had been addressed in the eThekwini project by training, using extensive scripts and also clear guidelines as to when navigators should refer to providers ensuring that clear boundaries were set.

Sustainability and absorption of navigators into Government services: was this possible? This issue had been addressed in a number of ways. From the outset it was seen as important to model the role of a navigator on a similar job profile to an already existing support position in the services. The job description was carefully drawn up to work in a similar way to other complimentary roles such as Community Health Workers (CHWs). Once in place the navigators reported directly to a facility supervisor, meaning that navigators are already absorbed into the system in a similar fashion to a CHW. There would be a need to explore and establish who would be suitable to supervise the navigators in the facility in the long term. The CHW job description and CHW pay scale were also considered when the HSN pilot was developed. Applicants were expected to have similar qualifications and roles to CHWs. In addition the costs of the HSN component were recorded.

It was requested that some staff with experience of working with the navigators give feedback in this session: One sister based in the ARV clinic of a facility reported that when the navigators started they (nursing staff) could off-load time consuming tasks and this freed up their time. Another experience shared with the group was that: “The navigators are working hand in hand with other departments”. Within termination of pregnancy (TOP) services it was found that the navigators assisted the sisters in referral and follow-up when non-qualifying patients from TOP had to go to another service. Patients could also verbalise problems with the facility to the navigator and these problems were then reported to the sisters and addressed. Contact with the clients led to improved service provision.

There was also some discussion about training in the eThekwini Integration Project more broadly, and the projects plans for sustainability of training/mentorship. It was acknowledged that this was a challenge and the floor was opened for suggestions. The revival of the KZN training centre was put forward as a suggestion. This centre had played a key role in implementing SRH training in the past, yet had been disbanded some time ago.

Nurse Initiated Management of ART (NIMART) will require extensive monitoring. There was a suggestion that lack of experienced staff could be resolved by introducing an exchange programme where a facility member who had been trained would be attached to a different facility where the staff had not been trained. This programme could run for a short period in the region of two weeks.

Other areas of training included in the Integration Project were around improved data collection and completion of the various registers. Training emphasised correct use of registers and data entry. It was noted that time pressure and the large number of registers to be filled in was a challenge, as was the further requirement of compiling a tally sheet at the end of the week. One of the eThekwini project sites added that: “If we did what we always did, we will have what we always had” and reported that training had resulted in reduction in waiting times, thanks to integrating certain services.

It was noted that the government wanted to address the reduction of waiting times and furthermore, the group should consider the government’s suggestion when it says “go out into the community” and “If we are active in the community we will have less people coming to the clinic/facility”. The KZN Premier has said: “if a nurse or health worker is sitting in a facility and waiting, no one will come”. It would be better in the long run to play a pro-active role in the community via campaigns etc. It was reported that a hot line regarding health care was planned and a call centre was being set up. With regards to registers it was reported that there were plans for an electronic system which would ease data collection barriers.

The role of School Health Services was raised as an ideal opportunity to revitalise a service that had once played a crucial role in linking children with services. It was reported that there were plans to strengthen school health teams working down to ward level and linked to health facilities.
Panel Discussion

Developing an Integration Strategy for KwaZulu-Natal

Panel participants:
Otty Mhlongo (KZN DoH), Jennifer Moodley (UCT), Saiqa Mullick (Population Council), Naomi Lince (Ibis), Fiona Scorgie (MatCH), Tamaryn Crankshaw (McCord Hospital), Precious Robinson (NDoH)

The panel was asked to consider what the key elements of an integration strategy should be. One of the main points focused on both by panel members and symposium participants was the essential components of a minimum integration package. There was a consensus that there was a need to define a minimum package of integrated services. The following is a list of key points raised:

❖ There was a call for integrated policy meetings to bring programmes closer together.
❖ Community mobilisation will create a demand for FP. If demand is generated, facilities will need to look at innovative ways of staffing e.g. enrolled nurses can provide FP services if trained.
❖ Need to use the framework of available services and look at what staff members are available e.g. CHWs are a resource – they can include a discussion on FP/HIV in their contacts with clients.
❖ Integration pillars/links: build on this, instil that one can't do one without the other. Can't separate HIV and SRH.
❖ Minimum package in HIV care: should be based on client needs and provider and policy maker views. Concrete tools for providers are needed to help them with discussion and counselling on contraception, safe sex and safer contraception.
❖ Condom talk: health care providers need to counsel on both male and female condoms.
❖ Community engagement: tell people to use condoms. Focus on figures – we currently show how many condoms are distributed but not on how many are used.
❖ PMTCT: should be PPTCT (preventing parent to child transmission); change paradigms to include men.
❖ Monitoring, evaluation and record keeping practices: we need to have an efficient way of recording integrated consultations and efficient commodity monitoring if we are to know whether integration is actually happening and how successfully.
❖ Revitalise the School Health Programme as part of community engagement.
❖ Look at existing training: does HIV training include FP?
❖ Funders need to move beyond supporting focused vertical services to a broader integrated approach.
❖ Draw up algorithms/SOPs, to lead to a visit-based approach to help providers make decisions.
❖ Create flowcharts to ensure that all areas are covered when addressing clients.
❖ Monitoring and evaluation: need to monitor the number of clients falling pregnant on ART, how many MMC clients received FP etc.
❖ Integration should be explored from a community perspective: what do communities want? Also need to create demand for what has not yet been seen as beneficial.
❖ What services can we offer at high quality levels? A smaller number of services at a higher level is better than a large number of poor quality services.
❖ Data issues: Needs to be a better understanding of data that is collected at facility level, and how it is fed to higher levels, collated and passed back again. Staff need to understand how service statistics are used at higher levels and how they can use them at facility level to monitor changes in their services.
❖ A minimum care package should include quality care delivery.
❖ Special groups that may find it harder to access services, especially adolescents accessing FP, need hours outside school/college. FP services should be made available to factory staff to provide working women with on-site services (this used to be available but was discontinued).
❖ Fast queues for some services such as FP have their benefits but must be provided in the context of comprehensive services. Women may get what they want (when coming for only one specific service) but they may miss out on receiving other essential services. It should be highlighted that women should at some point be seen for a full appointment to discuss other SRH matters.
# Appendix 1: Programme

## Integration Symposium

**Integration of Sexual and Reproductive Health & HIV Services in South Africa: Progress and Challenges**

**Venue:** Durban Country Club  
**Date:** 20 - 21 September 2011

### Day One – Tuesday, 20th September 2011

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<thead>
<tr>
<th>Time</th>
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<tr>
<td><strong>Session 1</strong></td>
<td>Integration of RH and HIV/AIDS Services in South Africa: Where are we now?</td>
<td><strong>Session Chair:</strong> Mags Beksinska</td>
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<tr>
<td>9:30</td>
<td>Welcome &amp; Purpose of the Meeting</td>
<td>Zonke Mabude, MatCH</td>
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<tr>
<td>9:50</td>
<td>Integration of Reproductive Health and HIV/AIDS: An Overview</td>
<td>Jenni Smit, MatCH</td>
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<tr>
<td>10:05</td>
<td>Key lessons learnt that make FP/HIV integration worthwhile</td>
<td>Hloniphile Mabuza, FHI 360</td>
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<td>10:25</td>
<td>Reproductive Health and HIV Integration in KwaZulu-Natal</td>
<td>Jacqui Ngozo, KwaZulu-Natal Department of Health</td>
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<td>10:40</td>
<td>Questions and Discussion</td>
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### Session 2 – Experiences of Integration in South Africa

**Session Chair:** Zonke Mabude

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<tr>
<td>11:10</td>
<td>Experiences on integration of RH and HIV</td>
<td>Saiqa Mullick, Population Council</td>
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<td>11:30</td>
<td>A work in progress: The McCord experience with integrated SRH and HIV services</td>
<td>Tamaryn Crankshaw &amp; Christie Cloete, McCord Hospital</td>
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<td>11:50</td>
<td>Integration and comprehensive SRH – IBIS' experiences</td>
<td>Naomi Lince, IBIS Reproductive Health</td>
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<td>12:10</td>
<td>Using pregnancy support grants to optimise the utilisation of maternal and child health services in South Africa</td>
<td>Matthew Chersich, Centre for Health Policy, University of the Witwatersrand</td>
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<td>Lunch &amp; Poster Viewing</td>
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### Session 3 – The eThekwini Integration Perspective

**Session Chair:** Jenni Smit

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<td>14:00</td>
<td>Integration: The eThekwini project overview and progress to date</td>
<td>Cecilia Milford, MatCH</td>
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<td>14:20</td>
<td>Health Systems Navigation &amp; Adolescent Interventions</td>
<td>Letitia Rambally, MatCH</td>
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<td>14:40</td>
<td>Training &amp; Mentoring</td>
<td>Zonke Mabude, MatCH</td>
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<td>15:20</td>
<td>Integration: Are we getting there? Experiences from project sites</td>
<td>Tessa Beaunoir, eThekwini Municipality</td>
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<td>15:40</td>
<td>Integration: Integration of eThekwini HIV services</td>
<td>Arthi Ramkisson, MatCH</td>
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<td>16:00</td>
<td>Discussion</td>
<td>Jenni Smit, MatCH</td>
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<td>16:30</td>
<td>Closure – Day One</td>
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### Day Two – Wednesday, 21st September 2011

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<td>Status of Integration of Reproductive Health and HIV/AIDS in South Africa and KwaZulu-Natal</td>
<td>Precious Robinson, National Department of Health</td>
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<td>08:50</td>
<td>Overview of Day One – Feedback for Panel Discussion</td>
<td>Mags Beksinska, MatCH</td>
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<td>09:05</td>
<td>Panel Discussion – Developing a Integration Policy for KZN led by Mags Beksinska</td>
<td>Saiqa, Naomi, Victoria, Arthi, Fiona, Tamaryn, Jennifer (TBC)</td>
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<td>Break-away group discussions</td>
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<td>Tea</td>
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<tr>
<td>11:20</td>
<td>Feedback from group discussions</td>
<td>All</td>
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<tr>
<td>11:50</td>
<td>Recommendations and way forward</td>
<td>Mags Beksinska, MatCH</td>
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<tr>
<td>12:35</td>
<td>Closure</td>
<td>Jenni Smit, MatCH</td>
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<tr>
<td>12:50</td>
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Integration of Reproductive Health and HIV/AIDS: An Overview

Jenni Smit, MatCH (Maternal, Adolescent & Child Health)

Looking back on Global Initiatives Relevant to SRH/HIV Integration

- **Alma Ata 1978**: ‘Health for all by the year 2000’
  - Primary health care approach: comprehensive, accessible, affordable, appropriate health care for all.
- **District Health Systems (DHS) Approach, adopted by the WHO Global Programme, 1986**:
  - A fully comprehensive range of promotive, preventive, curative and rehabilitative health activities, based on equity, accessibility, inter-sectoral action, community involvement, decentralization, integration of health programmes, coordination of separate health activities.
- **International Conference on Population and Development, Cairo, 1994**: 180 countries pledge support for comprehensive SRH services, delivered through integrated systems rather than by separate vertical programmes.
- **United Nations Millennium Declaration, 2000**: Commits nations to a new global partnership to reduce extreme poverty. The 8 MDGs include call for universal access to RH and halving the spread of HIV/AIDS by 2015.
- **Glion Call to Action, 2004**: Reflects the consensus of the first global consultation focusing on the linkage between FP and PMTCT.
- **Maputo Plan of Action 2006**: Calls for (among other things) “integration of sexual and reproductive health services into PHC” on the continent.
- **WHO Health Strategy on HIV and AIDS 2011-2015**: Guides health sector’s response to HIV; proposes 4 strategic directions, 1 of which is to “Leverage broader health outcomes through HIV responses: Strengthen links between HIV programmes and other health programmes”.

Have these Global Initiatives been Adopted in South Africa?

- **PHC approach** to service delivery adopted in 1994
  - Formerly vertically delivered FP services incorporated into PHC.
- **DHS put in place with primary care clinics as first point of access, and referral systems to secondary and tertiary care**.
- **MDGs guide many policies and strategic plans including HIV National Strategic Plan and many SRH policies**.

In the Pipeline

- **National Contraception Policy Revision Expert Working Group**, constituted in 2010 to update the **South African National Contraception Policy and Guidelines**, taking into account the HIV prevalence in South Africa. New policy scheduled to be released later this year.
- **KwaZulu-Natal Provincal 5-Point Contraceptive Strategy 2011-2016**: Key Priority: Promote Integration of Contraceptive Services with other Services.
- **Draft NSP 2012-2016**: Mentions service integration only in relation to: 1) HIV, TB and STI co-infection & need for prevention and treatment of all 3 to be integrated; and 2) Importance of promoting combination prevention - including: male & female condoms (in multiple settings), MMC for men on demand, PMTCT, STI treatment, regular HCT, PrEP, microbicides, ARVs as prevention.

However……

- **At PHC level, although SRH services should be comprehensive, in reality they are limited**.
- **Difficult to ensure an integrated approach within decentralized health services that are supported by vertical national health programmes and subject to widespread human resource shortages and skills**.
- **Rapid (but necessary) implementation of vertical HIV services paradoxically may have reinstated the very same vertical, fragmented approach to health that the country strived to eliminate in 1990s**.
- **Vertical fast track roll-out of MMC is a major focus of current prevention efforts**.
- **FP and other SRH services consequently overshadowed**.
### The Importance of Integrating RH/HIV Services

- Importance is widely acknowledged in the literature
- Strong and logical rationale to integrate care: majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding
- Growing recognition of the importance of contraception for HIV/AIDS prevention efforts
  - Repeated calls to strengthen links between FP & PMTCT
  - Addressing the SRH needs of PLWHA enables a more comprehensive response to the HIV epidemic
- Integration of SRH & HIV services especially relevant in SA:  
  - the highest number of people living with HIV in the world
  - high maternal mortality
  - high contraceptive prevalence, but many unplanned pregnancies and teenage pregnancies.

### What is Integration?

A key obstacle to evaluating the effectiveness of integrated services is the ambiguity around the term ‘integration’.

- Integration means different things to different stakeholders; in many settings, may take a diversity of forms (Lush et al. 1999; Maharaj & Cleland 2005; French et al. 2006).
- Study conducted in the UK (lit review and IDIs): no consensus about what it means to have integrated services, which services should be integrated or where integration should occur (French et al. 2008)
- Little agreement about the most effective methods of integration or how best to achieve them (Maharaj & Cleland 2005).
- At the service level, definitions of integration have ranged from:
  - **Supermarket** approach (‘one-stop-shop’) -- single provider for all RH needs on a single visit at a single delivery site
  - **Teamwork** approach -- provider refers clients to separate services at the same delivery site or another site (Lush et al. 1999).

### One Size Doesn’t Fit All

**Consensus: Integration implies different models depending on the need and context**

- Could be: One provider, internal or external referral
  - “there is no one size fits all”
  - ‘the best way for one facility may not be the best way for another, depending on client load, and the availability of staff, and the availability of ...you know, supplies and equipment. So, I don’t think there’s necessarily one best way’
- However, need minimum std of care and principles for consistency
- Some services still require specialisation (e.g. ToP & violence)
- Range in perceptions of complexity of integration: From simple and “self evident” to the need for a “paradigm shift” in the organisation of care

### Challenges & Opportunities to Delivering Integrated SRH and HIV Care: Findings from Key Informant Interviews *

- Consensus among key informants on the need for more integrated systems of SRH and HIV care in South Africa.
- A range of inter-related systems factors, at policy and service-delivery levels identified as challenges to delivering integrated care.

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*Findings from eThekwini RH/HIV services integration project

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### Policy level challenges

- Organisational structures in own guidelines, policies (e.g. GIPA, 1996)
- Understanding, and lack of attention to RH issues within sex, gender, cultural orientation
- Poor coordination between different policy needs
- Treatment and care programs remain separate, guided by current guidelines

### Service level challenges

- Drafting strategies and high client load
- Poor high level decision-making and low sustainability
- Resistance to change and being evident among providers (e.g. midwives)
- Lack of political will to use RH services to decrease disease
- Lack of technical skills in SRH
- Infrequent training methodologies
- Lack of integration education and referral
- Lack of integration in performance appraisal
- Lack of integration in performance appraisal and coordination processes and job descriptions
- Ineffective referral systems and poor coordination
- Ineffective referral systems
- Infrastructure (space shortages)

### Consequences of Integrating SRH & HIV Care

- Failure to address SRH in the context of HIV care (including FP, cervical cancer, STI, positive prevention, access to reproductive choice and family planning)
- Care focused on management of the HIV disease
- Fragmentation of care between different service levels
- Patients to reverse referrals

### Opportunities

- Recognition of the need to integrate
  - International support for different models
  - Support for demonstration of RH services
  - Implementation of wide-ranging models
  - Promotion of a ‘provider initiated’ approach

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*Findings from eThekwini RH/HIV services integration project
Session 1:
Integration of RH and HIV/AIDS Services in South Africa: Where are we now?

RH and HIV Service Integration: What Lies Ahead?

- Context increasingly complex, many new HIV prevention approaches imminent:
  - MMC, microbicides, oral PrEP, treatment for prevention, HPV vaccines
  - What are the distribution channels?
  - Where are the resources?
  - How will this impact on existing RH services?
- Combination prevention approaches advocated
- Implications for counselling, training, human resources
- Increasing calls for couple counselling
  Focus on sero-discordance; Preconception counselling

What we hope to learn and achieve to-day

- Experiences from researchers and practitioners in the field
- Some clarity on what is required
- Feasible models for delivering integrated RH/HIV services
- Progress in integrating services
- Recommendations for an RH/HIV integration policy

Selected References

- Smit JA, Church, KA, Milford, C, Harrison A, Beksinska, M. Key informant perspectives on the policy- and service-level challenges and opportunities for delivering integrated sexual and reproductive health and HIV care in South Africa. BMC Health Services Research, responses to reviewers in progress.
Key Lessons Learnt From FP/HIV Integration

Hloniphile Mabuza, FHI 360/SA

**Benefits of family planning**
- Delays first births
- Lengthens birth intervals
- Reduces the total number of children born to one woman
- Prevents high-risk and unintended pregnancies
- Reduces the need for unsafe abortion

**Family planning is HIV prevention**
- Women’s right to family planning
  - “To decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”
  - Source: Convention on the Elimination of All Discrimination against Women

**Women with HIV have unintended pregnancies**
- 70% unintended repeat pregnancies among women with HIV in India (2008)
- 74% unintended pregnancies among women in an ART program in Rwanda (2007)
- 3 different studies by FHI found high levels of unintended pregnancies among PMTCT clients: 50% in Kenya, 60% in Rwanda, 70% in SA (2010)

**Impact of family planning on PMTCT**
- **ARVs (over 1 year)**
  - # infants spared HIV infection: 735
- **Contraception (over 1 year)**
  - # unintended births prevented: 220
  - Sources: PEPFAR (2009), Reynolds (2008)
Session 1:
Integration of RH and HIV/AIDS Services in South Africa: Where are we now?

Impact of family planning on PMTCT – South Africa, 2008

- In 2008 researchers estimated the number of HIV-positive births currently prevented by contraceptive use in PEPFAR focus countries, and estimated the first year cost savings to each country if unintended and unwanted HIV-positive births were prevented via FP use rather than providing ART for HIV-positive pregnant women (*traditional PMTCT services*)

- South Africa’s CPR (50.6%, 2003), adult HIV prevalence (18.8%, 2005), and annual #s of unintended and unwanted HIV+ births (46,774, combined) were used to produce estimates

Source: Reynolds 2008

Impact of family planning on PMTCT- South Africa, 2008

- Over 400,000 unintended pregnancies are currently prevented among HIV-positive women in SA via contraceptive use, resulting in the prevention of over 120,000 HIV-positive births

- By preventing just the unwanted HIV-positive births via FP rather than providing ART for HIV-positive pregnant women, the minimum annual cost savings in SA alone would be over $2.2 million

Source: Reynolds 2008

FP for PMTCT can be integrated into all HIV services, not just PMTCT sites

Reduce missed opportunities

Share common needs:

- often both sexually active and fertile
- are at risk of HIV infection or might be infected
- need access to contraceptives
- need to know how HIV affects contraceptive options and vice versa

Lessons from: Nigeria

- Referral-based model of integration implemented in 71 facilities
  - Training and job aids for VCT, ART, PMTCT, and FP providers
  - Integration coordinator identified at each facility
  - Referral system between FP and HIV clinics formalized
  - Clinic registers, monthly summary forms modified

- Evaluation findings
  - Major improvements in FP clinic attendance, FP uptake
  - Proportion of men attending FP clinic significantly higher among referred clients
  - Routinely collected data can be used for evaluation

Source: Chabikuli (2009)

Lessons from: Coast and Rift Valley, Kenya

- FP integration rolled out to 148 ART facilities
  - Sensitization meetings with facility staff
  - Training and job aids for ART providers on offering FP services
  - Supportive supervision
  - Some FP methods available on-site, depending on facility

- Evaluation findings:
  - FP use among female clients increased from 36% to 52%
  - Providers more likely to report provision of non-condom modern methods post-intervention (38% to 59%); condom provision stayed constant

Source: FHI (2010)
Session 1:
Integration of RH and HIV/AIDS Services in South Africa: Where are we now?

Serving the Family Planning Needs of PMTCT Clients in South Africa

Research partner: Women’s Health Research Unit, University of Cape Town

Study purpose: Test an intervention to expand range of contraceptive method choices—including long acting and permanent methods—offered to PMTCT clients

Sites: Four public sector primary care facilities in Khayelitsha and one clinic in Mitchell’s Plain in the greater Cape Town area

Design: Pre- and post-intervention cross-sectional surveys conducted with PMTCT clients intercepted at child health services

Intervention Components

- Provider training on FP for HIV-positive women
- IUD insertion training
- Clinical supplies for IUD services
- Strengthened mechanism for referrals to female sterilization services
- Coaching to encourage FP counselling on full range of FP methods
- Counselling aids

Main Findings and Conclusions

- Use of female sterilization and the IUD by HIV positive women was low at baseline and remained low following intervention.
- Knowledge and attitudes toward LAPMs remained largely unchanged and were not conducive to uptake of the methods.
- Challenges with commodities, supervision and district oversight
- Integration interventions must include broader system strengthening.

Mobile services unit (MSUs)

- FHI 360 runs 5 MSUs in the four rural Provinces of South Africa (Limpopo, Mpumalanga, Kwa-Zulu-Natal and the Eastern Cape)

Objectives are:

- To increase access to integrated FP/HIV services
- To strengthen referral/linkages between HBC, FP and HCT services and health facilities
- To provide IPHC services focusing on FP/HIV/TB integrated services

Lessons learnt

- MSUs provide a viable option for the expansion of integrated FP/HIV services into remote, rural and underserved areas
- Proper and systematic counseling significantly increases the acceptance of FP and HIV testing
- Adherence to FP program is achievable as long as services are accessible to the people, clients state FP as a reason for visiting the MSU
- Positive trends in the acceptance of FP in HCT clients and vice versa indicates the unmet need for both services
- Bundling services could have unintended programmatic effects

Summary: What have we learned?

- Missed opportunities to deliver FP services to HIV service clients, even when policies indicate integrated services
- No “one-size-fits-all” approach
  - Different levels of integration depending on physical, human, financial, and technical capacity
- Various operational considerations
  - Training is a necessary but insufficient outcome measure to change service delivery practices
Session 1: Integration of RH and HIV/AIDS Services in South Africa: Where are we now?

Health systems strengthening is key

- Range of interventions needed across different levels of the health system
  - policy environment
  - technical capacity of providers, supervisors, and other health workers
  - facility set-up and referral systems
  - reporting/information management
  - commodity supply
  - community involvement

Obstacles to FP/HIV integration

- Funding constraints
- Lack of infrastructure/capacity at facility level
  - Staff shortages, high turnover or inadequate training
  - Poor program management and supervision
  - Inadequate equipment and commodity supply
- Lack of political will
- Traditional PMTCT focus on prophylaxis for HIV+ pregnant women
- Limited “how to” evidence

Sources: Kennedy 2010; Petruney 2010; Wilcher 2008; Wilcher & Cates 2009

Looking towards the future

- Develop efficient, scalable, generalizable models of FP/HIV integration
- Enhance measurement through routine M&E
  - “what gets measured gets done”
- Increase attention to gender-related constraints

Application to South Africa priorities

- Strengthened linkages between family planning and HIV in South Africa could contribute to several key deliverables aligned to the National Strategic Plan 2009-2014
  - < child mortality
  - < maternal mortality
  - < PMTCT
  - Strengthened primary health care approach
  - Strengthened HIS
  - Improved services for youth
  - Improved physical infrastructure for service delivery

Thank you
**Why is this integration crucial in this province?**

- Improve access to and use of key HIV and SRH services (current couple protection rate ~ 25%, Delivery rate for women under 16 years ~ 10%)
- For better access of PLWHA to SRH services tailored to their needs
- Reduction in HIV-related stigma and discrimination
- Improve coverage of underserved/vulnerable/key populations
- Greater support for "dual protection" (correct and consistent condom use to prevent HIV and unintended pregnancy)
- Improve quality of care and offer package of care for different focus groups
- Decrease duplication of efforts and competition for resources
- Better understand and protect individuals' rights
- Mutually reinforce complementarities in legal and policy frameworks
- Enhance program effectiveness and efficiency
- Better utilize scarce human resources for health.

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**HIV Prevalence by district: 2007-2010**

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<td>35.8</td>
<td>35.2</td>
<td>37.2</td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>36.2</td>
<td>36.8</td>
<td>46.4</td>
<td>38.9</td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>35.9</td>
<td>36.1</td>
<td>37.7</td>
<td>36.7</td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>31.6</td>
<td>29.2</td>
<td>28.2</td>
<td>31.1</td>
</tr>
</tbody>
</table>

*Note: Districts with prevalence above 40%: iLembe & uMgungundlovu 41.3%, Umhlangane 40.9%. Ugu & uMgungundlovu 41.7%.*

---

**Trend in Age related prev. from 2007 – 2009**

- There is an increase in prevalence in younger ages. This shows there is still a high rate of new infections which go with high teenage pregnancy rate.
**Session 1:**
Integration of RH and HIV/AIDS Services in South Africa: Where are we now?

### Prevention of Mother To Child Transmission of HIV

**Data elements**

- **ANC 1st Visit:** 251,395
- **Number of ANC clients HIV 1st test:** 245,040
- **Number of ANC clients positive for HIV:** 60,105
- **Number of ANC clients initiated on life-long ART:** 58,940
- **Number of babies given Nevirapine within 72 hours after birth:** 18,000
- **Number of babies given Nevirapine within 72 hours after birth:** 58,000
- **Number of babies PCR tested around 6 weeks:** 52,000
- **Proportion of PCR positive:** 7%

### Antiretroviral Treatment Programme

**District**

- **Ethekwini:** 139,969
- **Sisonke:** 51,395
- **Umkhanyakude:** 49,296
- **Zululand:** 36,708
- **Amagqoba:** 36,990
- **Uthungulu:** 35,813
- **Umkhanyakude:** 36,708
- **Zululand:** 36,990
- **Amagqoba:** 36,990
- **Uthungulu:** 40,729
- **Uthungulu:** 52,000

**Patients on ART at the end of March 2011**

<table>
<thead>
<tr>
<th>District</th>
<th>Patients on ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethekwini</td>
<td>139,969</td>
</tr>
<tr>
<td>Sisonke</td>
<td>51,395</td>
</tr>
<tr>
<td>Umkhanyakude</td>
<td>49,296</td>
</tr>
<tr>
<td>Zululand</td>
<td>36,708</td>
</tr>
<tr>
<td>Amagqoba</td>
<td>36,990</td>
</tr>
<tr>
<td>Uthungulu</td>
<td>40,729</td>
</tr>
<tr>
<td>Uthungulu</td>
<td>52,000</td>
</tr>
</tbody>
</table>

### Delivery of an integrated package of PHC centered service

Focal groups: youth/ women / male

### Challenges and Remedial Action

**Challenges**

- Lack of commitment from stakeholders
- Non-sustainable funding
- Clinics understaffed (low morale/high turnover/ inadequate training)
- Inadequate infrastructure, equipment, and commodities
- Lack of male partner participation
- Women not sufficiently empowered to make SHI decisions
- Cultural and literacy issues
- Poor program management and supervision
- Stigma preventing clients from utilizing services
- Adverse social events/domestic violence incidence

**Remedial Action**

- Enhance positive attitudes and good practices among providers and staff involvement of the community and government during planning and implementation
- Simple, easily applied additional services which add no costs to existing services
- Engagement in community dialogues on such issues and Non-stigmatizing services
- Male partner inclusion
- Engagement in community dialogues on such issues and Non-stigmatizing services
Progress in Interaction of PMTCT into MCYWH

Precious Robinson, National Department of Health

Session 1:
Integration of RH and HIV/AIDS Services in South Africa: Where are we now?

Background & Rationale

- SA PMTCT started in 2001 - pilot-18 sites
- Mainly focusing on PMTCT/subRVVP
- Vertical with pilot sites having specific personnel HIV/AIDS seconded
- Implementation and policies also as well
- 2004 need for integration NGOH-realization of neg impact of vertical prog
  Realization:
  - PMTCT is a strategy implemented to prevent and manage HIV and AIDS in HIV
    positive women and thus reduce morbidity & mortality in Women and Children
  - It is to be implemented across the MCWH cascade, from Family planning to Post
    natal care, EPL/COMT and back to SH
  - Its main goal is to prevent MTCT & keep the mothers alive
  - Forms the cornerstone and pillars for better maternal and child outcomes
  - Reality=all the above happen differ policies and guidelines, managers, implementation
  - Partners and donors also verticalizing programs and moving parallel on the "free way"

Package of services prong 1

- Information and counseling (safer sex, vertical transmission, risk of sero-conversion during pregnancy/ breastfeeding, services, ARVs as prevention)
- HIV T & C (couples, retesting, intensified post test counseling for HIV negative pregnant women)
- ART for prevention (decreases viral load)
- Condoms (including negotiating use)
- STI management
- Blood safety (universal precautions; anemia)
- Gender-based violence

Women living with HIV

Pregnant women living with HIV

Children living with HIV

Focus of this Framework

Contribution of Prongs 1 and 2 to MTCT Elimination

Prong 1: Primary prevention of HIV among women of child bearing age

Prong 2: Prevention of unintended pregnancies among women living with HIV

Prong 3: Prevention of HIV from a woman living with HIV to her infant

Prong 4: Provision of appropriate treatment, care and support to women living with HIV and their children and families

WHO operational definition of integration

"Integration of health services involves the organization, coordination and management of multiple activities and resources to ensure the delivery of more efficient and coherent services in relation to cost, output, impact and use (acceptability)."

PROGRESS IN INTEGRATION OF PMTCT/ INTO MCYWH

Match integration workshop
Durban; S A
21/09/2011
P A Robinson
Deputy Director –PMTCT-NDoH

Session 1:
Integration of RH and HIV/AIDS Services in South Africa: Where are we now?
**Session 1:**
**Integration of RH and HIV/AIDS Services in South Africa: Where are we now?**

### Family planning needs of women living with HIV of child bearing age
- Increased emphasis on rights-based counselling (full range of contraceptives; no coerced sterilization / abortion; right to be sexually active and have children)
- Information on drug interactions between some ARVs and some hormonal contraceptives
- Treatment for infertility
- STI management
- Serodiscordance, including conception
- CD4 and pregnancy
- Presently all the above is happening in different corners, silo’d

### 5 Key Strategies
- **Strategy 1:** Link SRH and HIV at the policy, systems and service delivery levels
- **Strategy 2:** Strengthen community engagement
- **Strategy 3:** Promote greater involvement of men
- **Strategy 4:** Engage organizations of people living with HIV
- **Strategy 5:** Ensure non-discriminatory service provision in stigma-free settings

### Health and Community Actors and Systems:
Defining effective points of overlap, synergy, cooperation and joint action: strategic result areas
SA and the multifaceted approaches

- Too much done, but not collaborative
- Every corner doing a bit of what needs to make the “patch work”
- Policy level grossly verticalised
- MCWH and HIV and Aids moving parallel
- No interdepartmental collaboration, DSD, DE, DOJ etc
- Govt and implementing partners, one song many tunes

Possible contributory factors to VPs

- Nationally different policy docs with diff managers
- No collaborative guidance to provinces, hence downward verticalization
- Partners supporting dept providing clear dissection to system through specialised support
- Inequity in resource allocation and priorities

Global initiative to Emtct-2015

- Global agreement to eliminate MTCT and keep mothers alive by 2015
- PMTCT Action Framework towards elimination
- Comprehensive approach involving partners and other stakeholders
- Action framework aiming to address all causes of maternal and child mortality across the cascade

Comprehensive approach to elimination

Call to action, joint move towards elimination

"Together we can do more.........."

- Serious need to integrate HIV into SRH
- Need to jointly address prong 1 & 2 to improve MCYH
- Put focus on Community health including youth
- Create platform for linkages with ACSM-SANAC /Partners
- Move from “theirs, they, them to I and client”
Session 1:
Integration of RH and HIV/AIDS Services in South Africa: Where are we now?

“YES WE CAN!”

ASANTE SANA

NGIYA BONGA

Have you already got a kiss, today?

No?

Go on, click immediately...
Feasibility and Effectiveness of Integrating HIV Prevention and Testing into Family Planning Services in South Africa. Results of a Cluster Randomized Trial.

Saiqa Mullick, Population Council

Context: South Africa

- High HIV prevalence
  - Pregnant women 29% (DOH, 2009)
  - Between 15 and 49 years 16.2% (DOH, 2005)
  - VCT rolled out in 2000
  - PMTCT in 2001
  - ARVs in 2003
- High rates of unwanted pregnancy 34% in women < 20 years, 35% women 40-44 years (DHS 2003)

Why FP services?

- High utilization CPR 65.3% (SADHS 2003)
- Opportunity to reach large population of sexually active women and their partners
- Prevalence of STIs amongst FP clients is high (Coetzee D, 1996; Wilkinson D, 1999)
- Opportunity to discuss prevention
- Opportunity for early referral for treatment
- Opportunity for early discussion of PMTCT before pregnancy occurs (prevention, early treatment and reduction of unwanted pregnancies)

What opportunities exist?

- Supportive policy and guideline environment
  - National HIV & AIDS Strategic Plan (2007-11)
  - National policy and guidelines for PMTCT
- Family Planning services are the highest utilized public sector service
- Emphasis on HCT
- Despite studies showing FP to be a cost effective PMTCT strategy – underutilized.

Systematic Review

(Spaulding A. et al, 2009)

- To examine the effectiveness, optimal circumstances, and best practices for strengthening linkages between FP and HIV services
- Methods: Systematic review of 16 peer-reviewed post intervention evaluation results from interventions linking FP and HIV (1990-2007)
- Interventions linking FP and HIV services were generally considered feasible and effective, though overall evaluation rigor was low

Acknowledgements

- The study is supported by the President’s Emergency Plan for AIDS Relief through the U.S. Agency for International Development’s South Africa Mission
- Provincial Department of Health North West Province South Africa
- Clinic staff and clients that participated in the study
**Session 2: Experiences of Integration in South Africa**

**Overall study objective**
- The general aim of the study is to evaluate the effectiveness of an acceptable and feasible model of integrating HIV into FP services compared with standard practice.

**Specific study objectives**
- To evaluate a model of integrated services against standard FP services in terms of the following:
  - **Study Outcomes:**
    - Dual protection – measured by condom use at last sex
    - Testing for HIV in the last year
    - Quality of care outcomes: assessing HIV and FP service provision by providers

**Study design**
- Cluster Randomized Trial (6 intervention and 6 comparison clinics in North West Province)
- Pre and post intervention cross sectional evaluation conducted at one year interval
- Target population: all FP clients over 16 years of age attending the selected study clinics

**Sample size calculations**
- A two-sided type I error of 0.05 and a power of 80 percent was assumed to detect a 100% change in % of HIV testing and a 50% change in ever use of condoms from an estimated baseline value of 5% and 30-40% respectively
- The coefficient of variation (k) was assumed to be 0.25
- A required sample size of 100 per cluster was calculated

**Facility selection criteria**
- Clinics with >100 FP clients a month
- Clinics with at least 2 professional nurses
- Providing HCT, STI and FP services

**Data collection**
- Client provider observation (pre N=1,111 & post intervention N=1,225)
- Client exit interview (pre N=1,111 & post intervention N=1,264)
- Anonymous self-administered HIV disclosure questionnaire (pre & post intervention)
- Facility Inventory (pre intervention only)
Implemented at clinic (cluster) level

Family planning services were standardized and strengthened through training providers in the “Balanced Counseling Strategy” (BCS plus) approach to family planning

HIV/STI prevention, dual protection and C&T awareness information were integrated into FP services in line with South African protocols

Description of Interventions

Balanced Counseling Strategy Plus

http://www.popcouncil.org/frontiers/bestpractices/BCSPlus_102008.html

Outcomes at follow up (N=1,264)

Socio-demographics

Average age was 28 years with a similar distribution

Approximately one in five women had not completed primary education, the vast majority of them had completed primary education

A quarter of women reported being married, almost a third cohabiting and the rest divorced, widowed or single

One in ten women had no children, over half had one or two

These characteristics were similar at follow up

Quality of care scores

<table>
<thead>
<tr>
<th>Quality of care scores (range of scores)</th>
<th>Mean Intervention (sd)</th>
<th>Mean Control (sd)</th>
<th>Difference</th>
<th>CI value</th>
</tr>
</thead>
<tbody>
<tr>
<td>General/FP History Taking (0-4)</td>
<td>2.23 (1.11)</td>
<td>1.03 (1.41)</td>
<td>1.20</td>
<td>(0.43, 2.93)</td>
</tr>
<tr>
<td>Client Provider Rapport (0-4)</td>
<td>2.09 (1.06)</td>
<td>2.41 (0.94)</td>
<td>0.32</td>
<td>(0.24, 0.49)</td>
</tr>
<tr>
<td>Number of FP Methods (5-7)</td>
<td>2.47 (1.45)</td>
<td>1.58 (1.70)</td>
<td>0.89</td>
<td>(0.52, 1.26)</td>
</tr>
<tr>
<td>STI/HIV History Taking (0-3)</td>
<td>1.07 (0.55)</td>
<td>0.33 (0.71)</td>
<td>0.74</td>
<td>(-0.31, 1.79)</td>
</tr>
<tr>
<td>STI Information Score (0-6)</td>
<td>3.17 (1.09)</td>
<td>2.87 (1.32)</td>
<td>0.30</td>
<td>(-0.01, 0.60)</td>
</tr>
<tr>
<td>DP and Condom Counseling (0-7)</td>
<td>3.02 (2.10)</td>
<td>1.41 (2.66)</td>
<td>1.61</td>
<td>(1.17, 4.08)</td>
</tr>
<tr>
<td>HIV Test Counseling (0-6)</td>
<td>1.93 (1.33)</td>
<td>1.01 (1.51)</td>
<td>0.92</td>
<td>(-0.93, 2.76)</td>
</tr>
<tr>
<td>Total quality (0-33)</td>
<td>16.52 (8.65)</td>
<td>9.82 (9.62)</td>
<td>6.70</td>
<td>(-4.50, 18.90)</td>
</tr>
</tbody>
</table>
Exposure analysis

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>SE</th>
<th>Regression Coefficient</th>
<th>95% CI</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing for HIV</td>
<td>0.69</td>
<td>0.48</td>
<td>0.64</td>
<td>(1.12, 0.80)</td>
<td>0.12</td>
</tr>
<tr>
<td>Condom use</td>
<td>0.38</td>
<td>0.15</td>
<td>0.72</td>
<td>(1.06, 0.79)</td>
<td>0.46</td>
</tr>
<tr>
<td>Total Quality Score</td>
<td>0.83</td>
<td>0.69</td>
<td>0.05</td>
<td>(0.50, 0.08)</td>
<td>0.24</td>
</tr>
<tr>
<td>History Taking Score</td>
<td>0.92</td>
<td>0.85</td>
<td>0.30</td>
<td>(0.13, 0.68)</td>
<td>0.01</td>
</tr>
<tr>
<td>STI Information Score</td>
<td>0.85</td>
<td>0.72</td>
<td>0.08</td>
<td>(0.50, 0.03)</td>
<td>0.00</td>
</tr>
<tr>
<td>Client Rapport Score</td>
<td>0.55</td>
<td>0.30</td>
<td>0.19</td>
<td>(0.31, 0.09)</td>
<td>0.06</td>
</tr>
<tr>
<td>Dual Protection Score</td>
<td>0.77</td>
<td>0.60</td>
<td>0.13</td>
<td>(0.02, 0.29)</td>
<td>0.07</td>
</tr>
<tr>
<td>VCT Counselling Score</td>
<td>0.87</td>
<td>0.76</td>
<td>0.24</td>
<td>(0.50, 0.42)</td>
<td>0.00</td>
</tr>
<tr>
<td>STI History taking Score</td>
<td>0.77</td>
<td>0.59</td>
<td>0.19</td>
<td>(0.50, 0.42)</td>
<td>0.00</td>
</tr>
<tr>
<td>Number of methods Score</td>
<td>0.77</td>
<td>0.59</td>
<td>0.19</td>
<td>(0.50, 0.42)</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Summary

- Strong evidence (p=0.01) that FP clients at intervention clinics were more likely to have tested for HIV in past year (RR = 1.56)
- Also trend towards higher condom use at last sex (RR = 1.20) but not significant
- All quality of care scores were higher in intervention clinics, but substantial variation across clinics and these differences were not significant.
- Exposure analysis showed impact of the tool on quality of care and HIV testing

Discussion

- This study is one of the few rigorously conducted studies assessing the impact of integrated services on behavioural outcomes and the first study assessing impact on HIV testing in a FP population
- A high degree of variability was seen across clusters
- There are a number of factors outside of the scope of the evaluation that may be responsible for the variation.
- Intervention could be adapted further to test expansion of spectrum of HIV services provided in FP settings (retesting, CD4, ART initiation, retention and follow up)

Priority areas of future research

- Cost effectiveness of linkages/integration
- How do different models of linkages function?
- Integration of services: MSM/SW/IDU/elderly/institutionalized/IDP/migrants
- Client satisfaction
- What mechanisms for referral systems are effective?
- How can SRH/HIV linkages reduce stigma and discrimination?
- How to Monitor and Evaluate integrated services what indicators to use?

Conclusion

- Need to acknowledge the role of SRH services in HIV prevention and care
- Still don’t have enough evidence of what works, where, how it works and its impact on health and health services, to make it more effective, how to scale up
- Significant gaps still remain
A Work in Progress: The McCord Experience with Integrated SRH and HIV Services
Tamaryn Crankshaw and Christie Cloete, McCord Hospital

A work in progress: the McCord Experience with Integrated SRH and HIV services
T. Crankshaw, PhD  
(PMTCT Programme Manager)  
C. Cloete, MBChB, HIV Dip Man  
(Adult ARV Programme Manager)

PMTCT ANC Programme Services
- Model: PMTCT Clinic + HIV Rx Clinic
- PMTCT rx options: dual therapy, HAART for PMTCT, HAART for Life
- Routine Pap smears (<36 weeks)
- “Look and See” colposcopies
- TB screening, IPT
- FP discussions
- Infant feeding support, psychosocial support, depression screening, ARV adherence training

PMTCT PNC Programme Services
- Mamanengane Clinic: HIV-positive woman and their infants (0-18months)
- Women:
  - Wellness programme (CD4>350)
  - Treatment programme (CD4<350)
  - Family planning and contraception provision
  - Pap smears (annual)
  - STI rx
  - Colposcopy service available
  - Specialist O&G referrals

PMTCT PNC Programme Services
- Other services:
  - TB screening and treatment
  - PHC
  - Well baby clinic
  - Immunizations
  - HIV testing for infants at 6 weeks and 18 months
  - Infant feeding monitoring
  - Psychosocial support

Clinical Staff
- Professional nurses – all registered midwives with PHC experience/qualification
- Lay counsellors trained in PMTCT
- Clinician available as required

Session 2:
Experiences of Integration in South Africa
### Session 2:
Experiences of Integration in South Africa

#### Current Challenges
- PMTCT department physically separate from ANC
- PMTCT nurses rotate in ANC but see PMTCT clients in PMTCT department (privacy concerns)
- ANC only nurses – no HIV management experience – resistance
- Fully integrate current PMTCT programme into ANC – rationalise and reallocate staff, in service training.

#### Current Challenges
- Substantial training, supervision, coordination and investment – skilled staff
- Supervising counsellors and psychosocial aspects – NB an often neglected area

#### Sinikithemba

**Adult ARV Treatment Programme**

#### Adult ARV Programme Services
- Model: ARV service integrating SRH
- Care integrated in one consultation
- ART, Routine paps (annual), Family planning and contraception provision, RPR at baseline
- On site colposcopy referrals
- Strong links with PMTCT programme
- Other: TB screening and Rx, IPT, PHC, psychosocial

#### Questions we have been asking ourselves
- Two models of integrated care – which is best?
- Do we integrate care into one consultation (“room-level” integration)?
- Do we integrate care under same roof, same day but separate services (“facility-level” integration)?

#### Finding the Balance
- Patient-centered approach BUT longer consultations, more time consuming, ?more expensive, more intensive, skilled staff
- Patients may not want integrated care – too much in one consultation for patient
Finding the Balance

- Additional waiting times and user cost fees
- Substantial training, supervision and investment
- Integrated electronic patients record system across services = increased admin
- Staff turnover
- High level of staff functioning to deal with varied processes
- ? Psychosocial aspects, FP, RH – priority given to clinical condition

Finding the Balance

- What is better for the patient?
  - Lab monitoring vs clinical monitoring?
  - Consultations vs labs
- ? Symptom based lab monitoring
- ? Patient responsibility to come in if symptoms
- Task shifting – how much needs to be done by clinician?
- Need for triaging (avoid unnecessary consults)

Finding the Balance

- Distinction between holistic care vs integrated care
- Impact of integration on quality of clinical care?
- Strong central programme management

Thank you
Comprehensive HIV and SRH Linkages: Progress and Next Steps

Naomi Lince, Ibis Reproductive Health

Overview

- Ibis's integration/linkages priorities
- Brief history and progression of linkages/integration discourse
- Ibis's experiences
  - Kenya
  - South Africa
- Reflections/priorities for future work

Organizational overview

- We accomplish our mission by:
  - Conducting original clinical and social science research,
  - Leveraging existing research, producing educational resources, and
  - Promoting policies and practices that support SRHR.
- We work closely with advocates to conceptualize our research questions and to ensure the results lead to positive change in women's lives.

Terminology

- According to UNAIDS (2010):
  - Linkages: The bi-directional synergies in policy, programs, services and advocacy between SRH and HIV. It refers to a broader human rights based approach, of which service integration is a subset.
  - Integration: Different kinds of sexual and reproductive health and HIV services or operational programs that can be joined together to ensure and perhaps maximize collective outcomes. This would include referrals from one service to another, for example. It is based on the need to offer comprehensive and integrated services.
Integration/linkages timeline

- 2004
  - Glion Call to Action on Family Planning and HIV/AIDS in Women and Children.
  - New York Call to Commitment: Linking HIV/AIDS and SRH
- 2005
  - Intensifying HIV prevention: UNAIDS policy position paper.
  - UNGASS World Summit Outcome
  - High Level Global Partners Forum, Call to Action: Towards an HIV-Free and AIDS-Free Generation
- 2006 - UNGASS Political Declaration on HIV/AIDS
- 2007
  - reproductive Health Matters. Ensuring SRH for PLHIV
  - Consensus Statement: Achieving Universal Access to Comprehensive PMTCT Services
  - Global Consultation on SRH and Rights of PLHIV
- 2008 - World Association for Sexual Health. Sexual Health for the Millennium

Source: UNAIDS 2010

Evolution of the discourse

Time

Perspective

Health systems (including providers)

Women PLWHAs

Communities (Men)

Decreasing emphasis

Services/Issues

Prevention/dual protection

HIV and STIs

HIV and TB, GBV

Prevention/dual protection

VCT and FP, MCH

SRH for PLWHAs

HIV testing or treatment and FP, MCH (PMTCT)

HIV and other SRH

Research agenda

- Feasibility
- Acceptability
- Effectiveness
- Cost and cost effectiveness

Systematic review

- Systematic review by WHO/UNFPA/UNAIDS/UCSF (2009) - A total of 58 studies (35 peer-reviewed studies and 23 promising practices) published between 1990-2007 met the inclusion criteria for further analysis.

Systematic review (2)

What's included?

- Peer reviewed – Most often linking with only one service
- Promising practice – Often linked 5 or more services
- Services/approach in “Other SRH” – Integration of HIV services and:
  - Cervical cytology
  - Pre-conception/fertility counseling
  - Post-abortion care services, and
  - Adolescent SRH.

Systematic review (3)

What's missing/limited?

- Empirical evidence
- According to systematic review
  - HIV and SRH for men and boys
  - HIV and GBV
  - Stigma discrimination
  - Comprehensive SRH for PLWHAs, especially unintended pregnancy services and fertility counseling/services
Session 2:
Experiences of Integration in South Africa

Systematic review (4)

What's missing/limited? (cont)
- Other
- Interventions targeting structural determinants
- HIV and SRH for adolescents, especially HIV+ adolescents
- Linking HIV and abortion services
- Cost effectiveness of linking HIV and comprehensive SRH

Ibis’s projects: Kenya

- Aim: To measure the impact of a comprehensive program that integrates family planning counseling and services into existing HIV care and treatment programs in southern Nyanza Province, Kenya.
- Design: Cluster randomized trial
- Perspectives: Health system, providers, women, men
- Outcomes:
  - Primary - Contraceptive prevalence
  - Secondary – Unintended pregnancy rate, contraception-related KAP, acceptability/feasibility, and cost.
- Timeline: 2007-Ongoing

Ibis’s projects: Kenya (2)

Challenges documented:
- Staffing challenges, including staff turnover and maintaining trained staff, avoiding staff burnout/feeling overworked
- Space/equipment limitations
- Demand creation—even if services are available and there is an interest in limiting/spacing childbirth, the same challenges to uptake exist, such as:
  - Gender power dynamics, lack of male involvement in contraceptive services
  - Lack of knowledge about methods, myths and misperceptions, as well as true concerns about side effects

Ibis’s projects: South Africa (1)

- Aim: To explore the root causes of teen pregnancy and HIV in communities and facilitate community mobilization regarding causes
- Design: Participatory research, community mobilization
- Perspectives: Young women, communities, health care providers
- Outcomes:
  - Young women’s and communities’ reports of root causes of teen pregnancy and HIV and prioritized solutions to address the causes, including service availability and organization
  - Health care providers’ attitudes towards adolescent sexuality and comfort providing SRH counseling
- Timeline: 2007-Ongoing

Ibis’s projects: South Africa (2)

- Aim:
  - To elicit feedback from communities on how best to integrate SRH and HIV service provision to meet their needs,
  - To gain insight as to how best to support HIV-positive men and women as they strive to realize SRHR goals, and
  - To obtain health providers’ perspective regarding the reproductive intentions of HIV-positive people.
- Design: Community-based, participatory assessments, in-depth interviews
- Perspectives: Communities, men, women, health providers
- Timeline: Postponed/planned

Ibis’s projects: Literature review

- Aim – To explore integration literature for coverage of:
  - HIV and abortion
  - HIV and long-acting and reversible contraceptives (LARCs)
- Timeline: June 2011 - present
- Methods: Major search engines, organization websites, individual correspondence
- Intended outcomes:
  - Briefs, blogs, research proposals, etc.
**Preliminary results: HIV and abortion**

- **Search terms:** integration, linkages, HIV, AIDS, gender-based violence, abortion, termination of pregnancy, post abortion care
- **Preliminary results**
  - Most were explorations of decision making, acceptability.
  - A few were rights-based or opinion pieces.
  - Very few were operations research or clinical investigations.

**Preliminary results: HIV and LARC**s

- **Search terms:** integration, linkages, HIV, AIDS, contraceptives, family planning, long-acting reversible contraceptives, IUD, Depo, injectable contraceptives, implant, IUD, LARC
- **Preliminary results**
  - Most were about HIV and hormonal contraceptives.
  - Very few covered IUDs and HIV; however the evidence was sufficient to produce a consensus that IUDs are an appropriate method for HIV+ women.

**Recommendations/Closure**

- Need to expand understanding of integration/linkages to include comprehensive SRH services, including abortion services
- Need for further research on
  - HIV and SRH for men and boys
  - HIV and GBV
  - Stigma discrimination
  - Comprehensive SRH for PLWHAs, especially unintended pregnancy services and fertility counseling/services
  - HIV and SRH for adolescents, especially HIV+ adolescents
  - Linking HIV and abortion services
  - Cost effectiveness of linking HIV and comprehensive SRH

**Thank you!**

Naomi Lince
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Session 2:
Experiences of Integration in South Africa

Linking State Support for Pregnant Women to Maternal & Child Health

Matthew Chersich, Centre for Health Policy, University of the Witwatersrand and Fiona Scorgie, MatCH (Maternal, Adolescent and Child Health)

Linking state support for pregnant women to maternal & child health

Matthew Chersich
(Centre for Health Policy, Wits University)
Fiona Scorgie
(MatCH)

Pregnancy support grant

- Government tender to study feasibility of PSG
- Cash, food or other transfer to:
  - improve maternal nutrition (protein-energy and micro-nutrients)
  - reduce women’s vulnerability during pregnancy
  - improve pregnancy outcomes: newborn and infant health
  - opportunity for considerable indirect benefits: linkages with MCH services

Child Support Grant currently 0-18 years. An additional 6 months is a small cost...

Four methods

- Literature review, CSG and international
- Interviews with potential recipients
- Interviews with key informants
- Economic model

- Options appraisal for DSD and for a trial

This is feasibility assessment, NOT DSD policy

Linking PSG to MCH

- Opportunity missed with CSG and other grants

Linking PSG to MCH

- Opportunity missed with CSG and other grants

Formal conditionalities
Session 2: Experiences of Integration in South Africa

**Linking PSG to MCH**
- Opportunity missed with CSG and other grants
  
  Formal conditionalities
  OR
  Implicit incentives for health-promoting behaviours

**Potential conditionalities**
- ANC and skilled birth attendants coverage good, but not everywhere
- Postnatal services weak...opportunities here?
- HIV testing?
- Male involvement?
- Based on evidence of what causes maternal infant deaths
- Higher transaction costs – some drawbacks, hard to monitor

**Implicit linkages between PSG & MCH**
- Register of vulnerable women, with info about them, contact details
- Could fit within PHC revitalisation, CHW program
- Interaction with a person who facilitates PSG becoming a CSG – could use this interaction?
- “The earlier you come the more support you get”: encourages both women & services to begin ANC earlier... marked impact on vertical transmission
- If grant-collection was at health services...?
Integration: The eThekwini Project Overview and Progress to Date

Cecilia Milford, MatCH (Maternal, Adolescent & Child Health)

Project outline

- **Aim:** To develop, implement and evaluate a service delivery model which structurally links family planning and barrier method services with HIV/AIDS services in eThekwini district

- **Project sites:** Wentworth Hospital and feeder clinics
  - Municipal: Lamontville, Bluff, Austerville, and Merebank
  - Provincial/Municipal: Chesterville, Cato Manor

- **Time frame:** 4 year project (2008-2011)

Background

- **Baseline research to inform model:**
  - Key informant interviews:
    - On understandings of integration and current integration practices
    - With DoH (national, provincial, local), NGOs, academics (local and international)
  - Facility inventory, Provider interviews, Client interviews:
    - Baseline data on facilities, services offered, and degree of integration in practice
  - Focus group discussions:
    - On understandings and current integration practices
    - With health care providers and community members

Background, cont’d

- After baseline research:
  - Feedback provided to each site on data collected at that site
  - Discussion and interpretation of findings
  - What do findings mean for integration at that site?
  - Integration presentation
  - Scenario of integration to stimulate discussion about integration models

Background, cont’d

- Various groups were established to inform model development:
  - District Working Forum:
    - Senior staff from facilities, providing on-the-ground support and experiential advice
  - Scientific Advisory Board:
    - Scientific/technical advice and input
  - Community Advisory Board:
    - To facilitate community involvement and support

Integration model at a glance

- Seven inter-connected intervention areas
- Staggered implementation
- Addresses health systems challenges
- Strengthens existing RH services (e.g. expanded FP method choice)
- Innovative methods to strengthen referrals in context of under-staffing
- Extends benefit of training through ongoing mentorship of providers
- Strong community and facility level involvement
Intervention activities

1. Capacity building
2. Strengthening existing RH services
3. Supporting integration of FP into HIV services
4. Strengthening patient & commodity monitoring
5. Strengthening referral & linkage systems
6. Community involvement
7. Policy contributions and dissemination

Integration activities

1. **Capacity building:**
   - On-site training on various integration & SRH topics:
     - Tools and principles for integration
     - Dual protection (including EC and FC)
     - Expanding FP method choice
     - Strengthening referral systems
     - M&E and record keeping
   - Post-training mentorship:
     - Pilot at one site
     - Provision of job aids

2. **Strengthening existing RH services:**
   - Health promotion talks;
   - Promotion of FC, EC, MMC;
   - Strengthening FC supply, monitoring & distribution;
   - Pilot dedicated adolescent clinic;
   - Pilot EC provision on weekends.

3. **Integration of FP into HIV services:**
   - Train counsellors, ARV providers, and postnatal PMTCT providers;
   - Implement WHO Reproductive Choices Flip-chart;
   - Support introduction of FP in Wentworth Wellness Centre.

4. **Strengthening patient & commodity monitoring:**
   - Review registers & patient-held cards;
   - Train providers (record keeping).

5. **Strengthening referral & linkage systems:**
   - Review referral protocols and practice;
   - Pilot a Health Systems Navigation (HSN) intervention.

6. **Community involvement:**
   - Train CAB members;
   - Map & train NGOs and involve in clinic activities;
   - Support CHWs & Navigators in community outreach.

7. **Policy contributions & dissemination:**
   - Overall policy recommendations;
   - Dissemination at conferences & DoH/eThekwini fora;
   - Publication in peer-reviewed journals.
Next steps
- Continue with M&E of activities implemented
- Awaiting ethics approval for some activities
- Endline assessment at facilities
- Evaluation of usefulness of WHO Reproductive Choices Flip Chart
- Record and write-up all data

Challenges
- Concerns about integration increasing providers’ workload, and the waiting times for clients
- Buy-in and approvals for some partners have been difficult to secure
- Nurses not confident to counsel clients and need further training and support
- Frequent stock-outs of female condoms
- Not possible to get full attendance of providers at training sessions

Essential elements for integration success
- Community engagement (through CAB involvement and NGO mapping)
- Strong partnerships with Department of Health
- Continual feedback to participating facility staff – through the District Working Forum
- Monitoring integration activities

Acknowledgements
- The funders: The William & Flora Hewlett Foundation
- HIP team:
  - Jenni Smit, Mags Beksinska, Claudia Ngoloyi, Cecilia Milford, Zonke Mabude, Fiona Scorgie, Jacqui Plenaar, Letitia Rambally, Ross Greener, Kedibone Molefe, Gloria Rasi, Abigail Harrison
- Providers and clients at participating facilities
- DoH (Provincial & District), and eThekwini Municipality
Health Systems Navigation and Adolescent Interventions

Letitia Rambally, MatCH (Maternal, Adolescent & Child Health)

Introduction
- The Health Systems Navigation (HSN) and Adolescent are pilots within the Integration project:
  - Structurally linking HIV/AIDS and family planning services in Kwa-Zulu Natal, South Africa: The eThekweni reproductive health and service integration model
  - Both pilots focus on:
    - Community outreach
    - Client level interventions

Background:
- Health systems navigation is a combined peer support and outreach activity that aims to assist patients in navigating complex health-care arrangements
- HSN programs have expanded recently into the realm of HIV/AIDS and have been shown to have:
  - success in increasing engagement and retention in HIV health care

Aims and Rationale: Health Systems Navigation (HSN) Pilot
- The HSN pilot aims to work at the client level to assist with barriers such as:
  - staff shortages
  - high client loads
  - weak or non-existent formal referral and follow up systems
  - The pilot was designed to link RH needs as well as HIV/AIDS services more effectively

Who are the Navigators?
- Four Community Health Worker level individuals recruited from local communities in the facility areas
- Who were trained in:
  - Monitoring referrals
  - Building rapport with clients
  - Client confidentiality
  - Giving health talks and record-keeping
  - Female condom demonstration
- Launch day with t-shirts and posters to advertise the Navigators and the services they offer
Session 3:
The eThekwini Integration Perspective

What do the Navigators do?
- As ‘service extenders’, navigators strengthen referral systems and minimise situations where clients are lost between RH and HIV services
- **Phase 1:**
  - Navigators were based primarily at their facility. Stationed at ANC, Top, OPD and ARV clinics in a District Hospital
  - promote the uptake of integrated services through health talks
  - Distribute IEC material
  - Assist clients with directions, information or by escorting them
  - Following up referrals
- **Phase 2:**
  - Navigators will link up with Community Health Workers and NGO’s in the surrounding area in order to:
    - Participate in community activities conducted by NGO’s
    - Conduct Health Promotion talks
    - Distribute IEC material
    - Promote Health facility services by word of mouth

Monitoring and evaluation
- Pre and post tests based on the curriculum were completed by the Navigators during training
- Focus Group Discussions with facility staff
- The Navigators use:
  - Monitoring log books
  - Client follow-up logs
  - Diaries
  - IEC material distribution logs
  - Logs of their health education talks
- An Endline assessment will be conducted with clients
Session 3:
The eThekwini Integration Perspective

Challenges
- Initially, poor communication between facility staff and navigators
- Clients phone at inappropriate times to schedule appointments
- In some facilities, clients are frustrated and impatient and some may be aggressive
- Navigators often tasked with other duties that detract from their navigator duties

Successes
- Continual feedback with participating facility staff through the District Working Forum (DWF)
- Positive response from providers...
  - "nurses are able to do their filing for the first time in a long time"
  - "this is starting to look like a hospital now"
- Community engagement – through Community Advisory Board (CAB) involvement and NGO mapping
- Monitoring and evaluation activities regularly and consistently completed

Preliminary findings
- Clients assisted: 2714 (22 May 2011 – 31 August 2011)
- Health Promotion talks: 339 (1 – 4 per day)
- Navigator diaries
  - Clients often approach Navigators for peer support or encouragement. Most often witnessed with clients accessing TOP and ARV/HIV services
- Future goals: to pilot this concept in smaller facilities

Adolescent pilot

Background
- Numerous SRH challenges faced by pre-adolescents (up to 12 years) and adolescents (13-19 years):
  - Early pregnancy
  - Unsafe abortion
  - High rates of STIs
  - Vulnerability to HIV
  - Inadequate medically accurate knowledge of how pregnancy occurs, STIs and HIV risk
  - Judgemental provider attitudes
  - Stigma associated with adolescent sexuality

  Adolescent-friendly services are essential for addressing these barriers

Proposed activities
- Situational analysis of the facility’s ability to provide adolescent-friendly services
- Training providers in adolescent-friendly service provision
- Extending facility hours once a week to enable adolescents and working mothers to access FP
- Displaying IEC material relevant to adolescent health; posters to advertise services on offer
- Community outreach in schools, dance and soccer clubs and other areas where adolescents congregate
Session 3: The eThekwini Integration Perspective

Services to be offered

- Family planning and counselling
- Emergency contraception
- HIV information, counselling and testing
- Counselling on and provision of male and female condoms
- STI information, screening and treatment
- Information on MMC
- Referrals for Termination of Pregnancy services
- Where sexual abuse is identified, referrals to local Support Centres

Monitoring and evaluation

- Regular review of registers over the duration of the project:
  - timing of services
  - service uptake
  - age of clients
  - services most in demand
- A brief anonymous checklist completed by providers at the end of each consultation with adolescent clients
- An anonymous checklist completed by all clients assessing the services that they received during their consultation
- Focus Group Discussions with providers to capture their experiences of implementing the pilot

Acknowledgements

- The funders: William & Flora Hewlett Foundation
- HIP team:
  - Jenni Smit, Mags Bekinska, Zonke Mabude, Claudia Ngoloyi, Cecilia Milford, Fiona Scorgie, Jacqui Pienaar, Gloria Rasi, Abigail Harrison, Kedibone Sithole, Ross Greener
- Providers and clients at participating facilities
- DoH (Provincial & District), and eThekwini Municipality

Selected References

Senderovich, J. (1997). Health Facility Programs on Reproductive Health for Young Adults. Focus on Young Adults Series. May 1997.
Introduction

- The integration model has seven inter-connected areas with capacity building as the foundation for all.
- Differential service needs were identified during baseline assessment at all sites.
- In preparation for the implementation of the model, a training curriculum, training schedule, and the post-training mentorship pilot programme were developed.
- Training activities undertaken between June 2010 & June 2011.
- In this presentation we share our training and mentorship programme.

Who were the Trainees?

- Health care professionals in all study sites.
- Lay counsellors, Community Health Workers/volunteers, and CAB members.
- Others:
  - Clinic Security Guards, Clerks, Porters, Marshals, etc.

Approach

- Participatory/interactive training sessions with:
  - Case studies/scenarios.
  - Small group discussions.
  - Role plays: spontaneous or scripted.
  - Pre- and post-course questionnaire.
  - On site training.
- Site and content specific.
- Participants’ handouts/manuals.
- Attendance register.

Key Capacity Building Activities

- Large-group training at each site.
- Smaller group training on specific SRH/HIV topics.
- Post training mentorship of providers.
- Distribution of job aids to each site (flip chart, FC pelvic models, WHO contraceptive eligibility criteria etc.)

Training Modules

| Module 1: Integrated FC Training/Barrier Methods |
| Module 2: Integrating RH/HIV & HIV/RH |
| Module 3: Referral System |
| Module 4: Monitoring & Evaluation |

Special Module:
Training commenced in June 2010 and ended in June 2011.

**Number of Providers Trained**

- Getting suitable training times for the majority of staff
- Postponement of sessions due to work pressures
- Staff missing training sessions
- Having new attendees at each training event
- Delays in obtaining approval for the adolescent pilot

**Post-training Mentorship Pilot**

- Evidence indicates that most providers once trained, don’t apply learned skills and new knowledge
- Lack of support at facility level is also a problem
- Staff are at times overwhelmed by heavy patient loads and understaffing
- Lack of or little access to experienced providers to call upon for consulting, reviewing cases, etc.

→ These problems were also identified in the eThekwini Integration Project, hence this activity

**WHO (2006:8) defines clinical mentorship as:**

"... a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes. Clinical mentors need to be experienced, practicing clinicians in their own right, with strong teaching skills”.

- Mentorship in a health service context focuses largely on the concept of "clinical mentorship”.
- Mentorship has seldom been used in interventions to promote integration of services (e.g. FP & HIV)

**Mentorship in the eThekwini Integration Project**

- Focuses less on reinforcing clinical skills per se, and more on building skills relating to the integration of services
- Mentorship itself is offered by a trained health provider from MatCH
- Involves follow-up immediately after training on FP & HIV integration
- Focus is mainly on reinforcing skills and knowledge to ensure quality integrated services
Objectives of the Pilot Mentorship Programme

- To support the application of formal learning to clinical care offered in FP, reproductive health (RH) and HIV services
- To build the capacity of providers to integrate FP, RH and HIV services in their daily practice
- To improve the quality of care provided in health services
- To improve the motivation of health care workers by providing effective technical support

Objectives cont.

- To strengthen accountability of providers within their facilities by deepening commitment to offering quality care
- To ensure capacity building activities are sustained beyond the life of the project through engagement of facility supervisors

Implementation

- Pilot implemented at Bluff Clinic
- Duration of mentorship: six months from July 2011
- Led by the MatCH Mentor who works closely with the Clinic Mentor/Supervisor and the Mentees

How is the mentorship pilot programme structured?

- A MatCH member is responsible for monthly mentorship support
- The MatCH member is also responsible for monthly group support
- The Clinic Supervisor provides day to day support and supervision
- Clinic Supervisor conducts one on one support and assessment of staff
- MatCH Mentor supports the Clinic Supervisor in mentoring staff
- Mentorship schedule developed jointly with staff

Issues covered during mentorship interaction

- Provider feedback on their experience of applying new skills in general
- Provider feedback on successes, problems and stumbling blocks encountered when trying to apply skills using case-base learning
- Joint review of registers and other recording tools to identify gaps or challenges
- Feedback on task-shifting if any
- Usefulness of job aids and other supportive material

Mentoring tools used

1. Checklist for one-on-one support
   - Used by MatCH Mentor and facility Supervisor to track and monitor progress in RH and HIV integration activities
   - Assists in identification of providers needing additional assistance and offer this support
   - Identifies input and specific areas commonly missed by providers in their daily practice
   - Checklists are completed, reviewed and captured
Mentoring tools cont’d.

2. Supervisor support checklist

Used by MatCH Mentor to:
- Offer support to the Facility Supervisor/ Mentor
- Assist in identification and addressing gaps and challenges in the process
- Track overall progress

Monitoring indicators

These measure how well the mentoring system is functioning and not the effectiveness of mentoring on quality of care.

- Number of providers displaying competency in learnt skills (e.g. counseling, referral, recording etc.)
- Number of providers correctly performing tasks as learnt from training
- Number of mentorship interactions over a specified period of time
- Regularity of provider's attendance at mentorship group meetings
- General mentee feedback after each mentorship group meeting

Acknowledgements

- The funders: The William & Flora Hewlett Foundation
- The eThekwini Integration Project team: Jenni Smit, Mags Beksinska, Claudia Ngoloyi, Cecilia Milford, Zonke Mabude, Fiona Scorgie, Jacqui Pienaar, Letitia Rambally, Ross Greener, Kedibone Molefe, Gloria Rasi, Abigail Harrison
- Providers and clients at participating facilities
- DoH (Provincial & District), and eThekwini Municipality

THANK YOU
Integration: Are we getting there? Experiences from project sites

Integration Symposium: Experiences of Integration in South Africa
20 September 2011
Sr. Tessa Beaunoir

Background: Local Government

- 46 Provincial, and 58 local Government Clinics in eThekwini
- First level of entry into health care system
  - Designed to reduce client loads of hospitals
- Primary health care focused
  - Services offered: FP, ANC, PHC (minor ailments), immunization for babies, HCT, mental health, TB, chronic conditions (e.g. hypertension and diabetes)
  - Services are free
  - Nurse driven system
    - Trained to diagnose and treat minor ailments
    - Refer cases that cannot be handled, to feeder hospital

Integration

- First introduction to integration and our relationship with MatCH began in 2008
  - Strong focus on integration of RH and HIV services
  - Subsequently the DoH has focused on the integration of FP, HIV and TB services
- In the current system one is like a hamster running in a wheel - Until MatCH introduced us to another dimension of how we could function
  - Integration focuses on:
    - Maximizing and effectively making use of staff and limited resources/equipment at our facilities

Experiences

- Initially there was concern about how to implement this within our limited capacity
- The concept of integration required us to think about service delivery in a different way
- But through participation in the project we realized that it was possible to do this
  - Through training individual staff so that they can provide more than one service to clients.
  - Training on FC promotion allowed us to offer this service to all our clients
  - Through training we were able to update our knowledge on ARVs which improved our service to our clients
  - We began looking at clients holistically rather than as either a TB or a HCT client
  - Posters and visual aids have also helped, as pictures tell a better story

Successes

Facility, services and staff level:
- We want to strive for quality rather than quantity
- Our service delivery is now more efficient because we have combined 2 or 3 services
- Staff are more aware of clients as a whole and hence more aware of clients’ overall needs
- Time management improved – the number of queues have been reduced and waiting time has decreased
- Strengthened RH services – through health promotion and learning about MMC
  - HIV and FP services strengthened
  - Referral system working well with Wentworth, our mother hospital
- We explore alternatives to service delivery more readily
### Successes (cont.)

**Client and community level:**
- Community involvement has increased:
  - 2 outreach programs per month (HCT & TB integrated for companies, with the help of NGOs)
  - Outreach also focuses on chronic clients (hypertension and diabetes)
  - Through outreach clients and community members know where our facility is and how we function
- Clients are happy – greater customer satisfaction – more compliments than complaints
- Improved access to services by clients

### Challenges

- People are resistant to change, but once we tried it and it worked we found it easy to change.
- There is a need for ongoing training
- To update our current medical knowledge
- And to improve service delivery
- We need to keep channels of communication open between all levels of health and colleagues

### Way forward

- Integration is an ongoing journey, we must not stagnate at any point but always strive to improve and to always do better
- In order to sustain integration we must continually motivate providers and promote the concept
Integration of eThekwini HIV Services
Arthi Ramkissoon, MatCH

**Integration of eThekwini HIV services**
Integration Symposium
20th September 2011

**eThekwini District**
- 3.5 million people, >1 million HIV
- 112 health facilities
- 70 supported by MatCH [10 hospitals & ref clinics]
- 100km radius of DBN, 2200sq km
- 2 functional areas [S, N/W]
- R8,800 ave per capita annual income
- District health service jointly run by province and LA 60:40

**Demographic Profile**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>eThekwini</th>
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<tbody>
<tr>
<td>% of KZN Provincial Population (average 2002-2006)</td>
<td>32.4%</td>
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<tr>
<td>Total District Population 2009</td>
<td>3,403,195</td>
</tr>
<tr>
<td>Male Population</td>
<td>49.0%</td>
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<tr>
<td>15-64 Year Age Group</td>
<td>68.4%</td>
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<tr>
<td>0-14 Year Age Group</td>
<td>27.0%</td>
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<tr>
<td>Population Density (persons/km)</td>
<td>997.9</td>
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<tr>
<td>Average Poverty Rate (2006)</td>
<td>29.9%</td>
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<tr>
<td>Unemployment</td>
<td>38.2%</td>
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<tr>
<td>Incidence of STI Treated-New</td>
<td>6.7%</td>
</tr>
<tr>
<td>HIV Prevalence among ANC Clients Tested (Survey) 2010</td>
<td>41.1%</td>
</tr>
</tbody>
</table>

**History of HIV Services**

2002       PMTCT –single dose NVP
2004       HCT, SRH @ PHC, CHC
            ART @ Hospitals
            TB @ TB clinics
            CD4s 200, mostly women
2006       Down-referral to PHC
            Up-referral to ART @ Hospitals, CHCs
2008       Dual therapy
**Session 3:**
The eThekwini Integration Perspective

**History of HIV Services**

- **2010**
  - PHC ART / NIMART
  - HCT campaign, TB/HIV integration, IPT
  - MMC
  - CD4 ≤ 350 pregnant women, TB/HIV

- **2011**
  - PHC re-engineering
  - TB ICF campaign
  - CD4 ≤ 250 ART for all

- **2012**
  - CD4 ≤ 350 ART for all

**INCREASED DECENTRALISATION = INCREASED INTEGRATION**

**eThekwini ART 2006**
- 4 Hospitals

**eThekwini ART 2007**
- 7 Hospitals & 2 CHC

**eThekwini ART 2008**
- 8 Hospitals & 2 CHC

**eThekwini ART 2009**
- 8 Hospitals & 3 CHC
What has the HCT campaign meant for Integration in eThekwini?

- More men accessing HCT
- More HIV+ men linked into care
- Improved HCT for TB clients, TB screening for HIV+ clients & increase in IPT
- Expanded MCWH services including ART for pregnant women
- Better access to FP, Pap smears, PEP

What has MMC meant for Integration in eThekwini?
Session 3:
The eThekwini Integration Perspective

MMC in eThekwini

Community Mobilisation

Risk Reduction
Dual Protection

HCT
STI
Risk Reduction
Dual Protection

Next Steps

- FP - more and more methods
- Couples/Partners/Youth friendly
- PHC outreach teams
- School health teams
- District MCWH clinical specialist teams
- One district health plan
- Training, Task shifting + sharing
- One MER Plan
- One Patient Information System
- One QA/GI Plan
- Synchronise appts – MCWH, FP, Immunisation

NGIYABONGA kaKHULU
THANK YOU
## Appendix 3: List of Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Email</th>
</tr>
</thead>
<tbody>
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<td>Khakhe, TV</td>
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<tr>
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