



# The Swaziland Linking HIV and SRH Programme Best Practice Series

A model of Integrated Services  
Integrating Family Planning into ART Services:  
The Case of Siphofaneni Clinic

December 2013





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# Acronyms

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Antiretroviral Therapy
<b>ARV</b>	Antiretroviral medicines
<b>eSystem</b>	Electronic System
<b>EU</b>	European Union
<b>FP</b>	Family Planning
<b>HIV</b>	Human Immunodeficiency Virus
<b>IPPF</b>	International Planned Parenthood Federation
<b>MCH</b>	Maternal and Child Health
<b>MDG</b>	Millennium Development Goal
<b>MER</b>	Monitoring, Evaluation and Reporting
<b>PLHIV</b>	People Living with HIV
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission of HIV
<b>RH</b>	Reproductive Health
<b>SADC</b>	Southern African Development Community
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>SRH</b>	Sexual and Reproductive Health
<b>STI</b>	Sexually Transmitted Infections
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>WHO</b>	World Health Organization

# Glossary of Terms

**Integration** - refers specifically to a continuum of health service delivery of organised tasks that need to be performed in order to provide a population with good quality health services at facility level

**Linkages** - refer to health systems (co-ordination mechanism, partnership, monitoring and evaluation and logistics systems) and policies (protocols, funding mechanism, legal issues)

**SRH and HIV Centre of Excellence** - is a model health facility that promotes collaboration and use of best practice in the provision of a comprehensive package of integrated SRH and HIV services.

**Best Practice** – is defined by SADC as being, ‘a practical instrument that facilitates sharing within and between Member States in order to assist stakeholders to scale-up interventions based on what is known to work’. The status of a Best Practice is attained through:

- Documenting, understanding and appreciating good experiences.
- Facilitating learning of what works and what does not.
- Sharing experiences.
- Proving replicability of small and successful interventions on a larger scale.



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# 1. Introduction

This booklet is a compilation of a Swaziland Best Practice in integrated SRH and HIV services, using the integration of family planning (FP) into antiretroviral therapy (ART) services as an entry point. Siphofaneni Clinic is one of five SRH and HIV facilities in Swaziland selected as Centres of Excellence, which are being strengthened to serve as models for integrated, interlinked SRH and HIV services. These facilities are of different levels in the country and include:

- Family Life Association Swaziland Manzini Clinic.
- Mankayane Government Hospital
- Matsanjeni Health Centre
- Mbabane Public Health Unit
- Siphofaneni Clinic.

Of these five, Siphofaneni Clinic has made significant progress towards integration of FP into ART services, the subject of this documentation. This presents an opportunity for other service providers to learn from this particular aspect of the facility's service intervention. This booklet outlines:

- The background to the project.
- Methodology of the documentation.
- Details of the integration of family planning into ART services best practices and key success factors.
- Lessons learnt challenges and recommendations.

## Siphofaneni Clinic Profile

Siphofaneni Clinic was established by the Government of Swaziland in 1967, to serve a mainly sugar producing farming area. It is served by a good road network linking it to other major centres, including the capital city. Following its official launch in 1981, it has expanded in terms of both size and the range of services offered. The clinic is a primary healthcare facility offering diverse services including: mother and child health, family planning, HIV testing and counselling (HTC), antiretroviral therapy (ART) and emergency delivery, among others. The clinic serves its community from Monday to Friday - 08:00 am to 16:45pm. On Saturdays and Sundays, the clinic opens from 08:00am to 13:00pm. In order to respond to emergencies, it also has an on-call nurse during the weekend.

Prior to the integration of FP and ART, the clinic had a core staff complement of four nurses and one expert client; now, it has a core staff complement of five nurses, two expert clients and two mother-to-mother supporters. Other staff members include officers responsible for TB screening, an Option B+ Data Capture clerk, a security guard and an orderly.

Previously, the health facility served on average 150 clients (120 women and 30 men). Following integration the clinic now serves on average 250 clients, the majority of whom are women.

## Regional overview of integrating SRH and HIV services: The case for integration

In southern Africa, where the HIV epidemic is generalised and the majority of HIV infections are either sexually transmitted or associated with pregnancy, childbirth and breastfeeding, the case for integration of SRH and HIV is very strong. Further evidence demonstrates that economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and social marginalisation of the most vulnerable populations, account for both sexual and reproductive ill-health and HIV<sup>1</sup>. There is general consensus among key stakeholders that it will be difficult to achieve the Millennium Development Goals (MDGs) without systematically addressing issues of universal access to SRH and HIV prevention, treatment, care and support. In order to achieve the targeted universal access goals health systems strengthening, linking of HIV and SRH policies and the provision of related integrated services should be prioritised<sup>2</sup>. Recent evidence citing HIV as a leading cause of death amongst women of reproductive age as well as contributing significantly towards maternal mortality<sup>3</sup> further demonstrates the interconnectedness of MDGs 3, 4, 5, and 6. This therefore strengthens the case for linking HIV and SRH interventions and for adopting united, harmonised and co-ordinated approaches to achieving the MDGs.

## Background to linking HIV and sexual and reproductive health and rights in Swaziland'

The Government of Swaziland is being supported by the European Union as part of a seven-country regional intervention targeted at supporting a co-ordinated approach to integration of SRH and HIV services. This follows the increased need for policy and programming to jointly address SRH, HIV and AIDS, particularly in the context of the commitment to universal access to health care services and the Maputo Plan of Action. A rapid assessment was conducted in Swaziland, and the findings indicated that there exist considerable strengths and opportunities for the linkage of SRH and HIV services. The National Health Policy (2007) and National Health Sector Strategy (2008-2013) allude to the need for integrated, collaborative and mainstreamed activities for provision of quality services and effective use of resources. This is further collaborated by the extended National Strategic Framework (2013-2018).

The overall aim of the project is to support the Swaziland Ministry of Health in addressing barriers to efficient and effective linkages between HIV and SRHR (sexual and reproductive health and rights) policies and services. It is aimed at strengthening health systems, increasing access to a variety of health care through the use of a broad range of quality services, and achieving the goals of universal access to reproductive health (MDGs 3, 4 and 5) and HIV prevention, treatment, care and support (MDG 6) by 2015, while implementing relevant mainstreaming and mitigation strategies within the education, gender and legal sectors.

Through the EU supported project 'Linking HIV and Sexual and Reproductive Health and Rights in Swaziland', the Government of Swaziland upgraded five health facilities of different levels to Centres of Excellence that will serve as models for integrated, interlinked SRH and HIV services. One of these clinics – Siphofaneni Clinic – has achieved significant success in integrating family planning into ART services and is thus the focus of this best practice documentation.

1 WHO, UNFPA, UNAIDS & IPPF 2005, A framework for priority linkages

2 IPPF, UCSF, UNAIDS, UNFPA, WHO (2009) Linkages: Evidence Review and Recommendations

3 Women and Health: Today's Evidence, Tomorrow's Agenda, WHO, 2009

The Siphofaneni Clinic documentation sought to highlight the effective strategies employed by the clinic in integrating family planning into ART services, as an entry point. The main focus areas for the documentation include the five features of a centre of excellence:

- i. **Provision of services:** Current integrated SRH and HIV services which should provide improved levels of quality and a better range of services.
- ii. **Systems strengthening:** Existing operational standards for integrated service provision and strengths in the referral systems to track client uptake of services.
- iii. **Leading by example:** Current management systems in place and whether it caters for integrated services such as planning, client flow, logistics, supplies etc.
- iv. **Monitoring performance:** Availability and use of data recording and reporting tools for integrated services.
- v. **Sharing learning:** Systems in place to ensure staff are capacitated and remain competently skilled to provide integrated SRH and HIV services.

## Rational for documenting SRH and HIV best practices in Swaziland

Although there is general consensus amongst stakeholders on the rational for linking SRH and HIV, different perceptions and familiarity with principles that are fundamental to each field still exist. These include limited knowledge and skills to link and integrate, which form a key barrier to efficiently moving the agenda forward. This also demonstrates a need to create and support multidimensional learning opportunities in support of integration, which include sharing practical interventions that significantly contribute to achieving linkages and integration goals.

The sharing of documented lessons and experiences amongst the different health facilities will contribute significantly towards achieving universal access to SRH and HIV prevention, treatment, care and support goals. Resources being invested in the five SRH and HIV centres of excellence are targeted at transforming them into effective integrated and interlinked SRH/HIV services that can serve as learning centres for best practice. Sharing documentation on linking and integration of SRH/HIV services through models and practices will harness the wealth of experience amongst facilities, which will, in turn, promote a co-ordinated and coherent response that contributes towards raising standards, appropriateness and effective service delivery.

Best practices support a continuous process of learning, feedback, reflection and analysis of what works, what does not work and reasons why it doesn't work. Best practices contribute towards, and inspire improved programming and service delivery. They:

- Widen the base of knowledge and available literature by establishing good implementing programmes within the continuum of care.
- Avail examples of 'what works' to programmers and policy makers, that will guide them in improved and meaningful decision-making on programme policies and management.
- Avoid repeating errors in programming. Best practice documents share lessons learnt with an aim to guide programmes towards a lower margin of error, and to enhance greater effectiveness of outputs.
- Encourage health care providers to maintain optimal service intervention standards.

# 2. Methodology

The methodology applied for this documentation was based on the SADC Framework for HIV and AIDS Best Practices, which defines the primary purposes of a best practice as being a practical instrument that facilitates sharing within and between Member States, in order to assist stakeholders to scale-up interventions based on what is known to work. This is achieved through documenting, understanding and appreciating good experiences; facilitating learning of what works and what does not; sharing experiences; and assisting replication of small and successful interventions on a larger scale. The methodology seeks to determine and confirm the five essentials for the identified best practice.

The following data collection methods were employed, using a triangulation approach:

- Focus group discussions (FGDs) – five FGDs conducted with groups of different beneficiaries.
- Key informant interviews (15 policy makers, project implementers) and stakeholders.
- Service implementer interviews (eight interviews were held with service implementers and relevant government departments).
- Literature review (programme and national records and documents).
- Observation data (site visits).

Annex I outlines the methods of data collection, data collection instruments, target groups, the sample size and the method of analysis. The criteria used are explained in detail below:

## A. Effectiveness

A best practice must have clear objectives, guided by identified community needs established through a baseline study, and must show that it is achieving these objectives. The community participates from project inception to implementation, monitoring and evaluation of the project.

## B. Ethical soundness

An ethical practice is one that upholds social principles and professional conduct. An intervention is a best practice if it does not violate human rights, respects confidentiality as a principle, embraces the concept of informed consent, applies the 'do no harm' principle, and works towards the protection of the interests of various vulnerable groups.

## **C. Cost effectiveness**

Cost of delivery for a cost effective programme is proportionate to available resources, that is: “the capacity to produce desired results with a minimum expenditure of energy, time or resources”. The intervention should have in place cost saving and reduction systems. The programme should provide a standard package of HIV prevention, treatment or care products and services at a reasonable cost. This should result in an increased number of community members whose quality of life has improved through programme products and services. Efficiency measures the capacity of the programme to produce desired results with minimum expenditure of energy, time and resources.

## **D. Relevance**

All HIV interventions need to take cognisance of the specific context in which they take place and take into account cultural, religious and other norms, political systems and socio-economic environment insofar as they affect vulnerability, risk behaviour, or the successful implementation of a response.

## **E. Innovativeness**

A best practice may show a unique way of implementing a programme that is more effective or saves resources.

## **F. Sustainability**

Sustainability is the ability of a programme or project to continue effectively over the medium to long term. This can be strengthened through community ownership of the project and when skills transfer takes place. Sustainability should take into cognisance financial sustainability, marketing and awareness building of the project.

# 3. From Policy to Action:

## Providing Integrated, Collaborative and Mainstreamed ART and Family Planning Services

*“Whilst many stakeholders have been caught up in the continuous debate to unpack what integration is all about, the Government of Swaziland has moved forward to provide integrated services starting at very low levels, allowing themselves to learn practically and build on existing knowledge on how best to integrate HIV and SRH services”*

A stakeholder supporting the Government’s integration programme

### 3.1 Programme Start-up

Of the five health facilities identified by the Government of Swaziland as centres of excellence to be supported to serve as models for integrated, interlinked SRH and HIV services, Siphofaneni Clinic demonstrated competence and leadership in integrating ART into FP services as an entry point to linking SRH and HIV. Their successful integration efforts in this area have resulted in their intervention being made the subject of this documentation of best practice and is articulated here from the perspectives of both the national and facility level.

#### Overview of key programme start up steps

The Government of Swaziland, with support from UNFPA and UNAIDS and other partners, underwent a systematic process to effectively prepare for implementation of the HIV and SRH service provision linkages that is being implemented through the five model centres of excellence.

The key steps are as outlined below:

- **Creating a supportive policy framework for integration**  
The Swaziland Government had already committed to linking SRH and related HIV integration services through local, regional and global policy instruments, such as the Africa Union’s Maputo Plan of Action (2007) and the UN’s Political Declaration on HIV/AIDS (2006), the Swaziland National Health Policy (2007) and Health Sector Strategy (2008-2013) make a strong case for integrating HIV and SRH services.
- **A rapid assessment of HIV and SRHR services**  
Through the EU support, the Government of Swaziland took the opportunity to fulfill these policy commitments as well as responding to identified gaps in policy and programming that jointly address SRH (sexual and reproductive health) and HIV. Gaps identified through a rapid assessment demonstrated that significant opportunities existed for linking SRH and HIV services.

- **Supporting and strengthening models for integrated, interlinked SRH and HIV services**

To systematically initiate an integrated, collaborative and mainstreamed intervention that would result in the provision of quality services and effective use of resources, the Government of Swaziland selected five facilities as models for Centers of Excellence that would pilot the integration of HIV and sexual and reproductive health and rights services. This was strategic, given the existence of different perceptions and levels of familiarity with SRH and HIV principles amongst the facilities and provided an opportunity to consistently support the targeted sites and inform the scale up to others based on Best Practice.

- **Building a common understanding**

The centres of excellence were defined in order to promote a common understanding of integration, types of integration and the reasons for integration. Building this common understanding of the centres of excellence was important to promote co-ordinated efforts among the key stakeholders towards a common goal. They are defined as “a model health facility that promotes collaboration and uses best practice in the provision of a comprehensive care package of integrated SRH and HIV services for other health facilities to follow”.

- **Injecting an evidence-based site-specific support package for the centres of excellence to become role models**

In order to systematically support the identified facilities as models for other health facilities in the provision of integrated, interlinked HIV and SRH services, a baseline assessment was conducted to further inform the planned support towards strengthening them. Each of the facilities was assessed by focusing on three primary objectives.

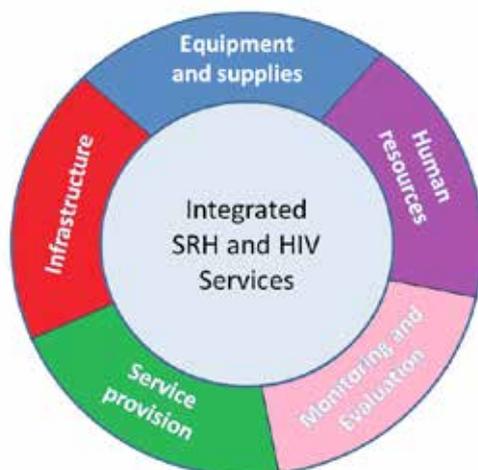
1. To **provide a baseline** across the five features of a centre of excellence

- **Assess services being provided:** Current integrated SRH and HIV services provided level of quality and number of services provided.
- **Assess strength of systems:** Existing operational standards for integrated service provision and the strength of referral systems to track client uptake of services.
- **Leads by example:** How current management systems cater for integrated services such as planning, client flow, logistics and supplies etc.
- **Assess MER system:** Availability and use of data recording and reporting tools for integrated services.
- **Assess capacity building system:** Systems in place to ensure continuous staff competency for the provision of integrated SRH and HIV services.

2. To **assess staff competency and capacity building needs** for effective delivery of integrated SRH and HIV services and information.

3. To enhance **the existing capacity** of the facility around integrating SRH and HIV services.

The facility assessment focused on the following six strategic areas guided by the three objectives, as shown in the diagram below:



The results of the facility assessment informed the package of support to be provided to each of the five centres of excellence to strengthen them to provide integrated and interlinked HIV and SRH services. Siphofaneni Clinic has taken lead in the integration of family planning services into ART services.

## 3.2 Programme Description

### **Siphofaneni Clinic: A model for the provision of integrated family planning into ART services**

Findings from the selected five centres of excellence demonstrated that the purpose, nature, speed, and extent of integration varies considerably and is determined by the complexities of the necessary intervention. Siphofaneni Clinic scored a significant success in using family planning and ART services integration as an entry point for linking HIV and SRH interventions. Integration of FP and ART is of particular significance to the HIV prevention, treatment, care and support agenda and also addresses the Maputo Plan of Action thrust to provide universal access to family planning services.

Provision of FP as a separate service is associated with missed opportunities, while resulting in increasing numbers of unintended pregnancies amongst people living with HIV (PLHIV). Siphofaneni Clinic is using FP as an entry point in providing integrated ART services, which in turn acts as a pedestal for the integration of HIV and SRH services.

### **Integrating FP into ART services in practice: A supermarket approach.**

Siphofaneni Clinic adopted the supermarket approach to the integration of FP and ART services, by providing both services in the same building, although in different rooms. During the health talk sessions that precede service provision, clients are oriented on the supermarket approach, to acquaint them with the set up of the facility. A consultation/prescription sheet is used by the nurse and assists them to identify other client needs beyond FP and ART. During the consultation, a client receives ART monitoring information and, where applicable, a CD4 count is recorded, any clinical issues are addressed and treatment within the nurse's scope is offered. Issues beyond the scope of a nurse are referred to other facilities for further management. Expert Clients working alongside the clinical staff provide complementary care by assisting clients on an individual level, prior to the client's consultation with the nurse.

## **Creating structures for supporting integration and enhanced co-ordination**

The Ministry of Health, through the sexual reproductive health and Swaziland National AIDS (SNAP) programmes, provides overall leadership, co-ordination and management of the integrated services. UNFPA and UNAIDS jointly provide technical support to the Ministry of Health in the implementation and linking of HIV and SRH services. A multi stakeholder national technical working group chaired by the ministry, with a sub-technical working group on monitoring, evaluation and reporting (MER) has been put in place to further provide technical support for the linked services. The TWG meets periodically to review progress, address bottlenecks and make recommendations on the centers of excellence.

## **Building capacity for service provision**

The programme is anchored in enhancing the skills competence and knowledge of programme managers and service providers to effectively implement integrated HIV and SRH services. At Siphofaneni Clinic, service providers received basic training on the integration of FP into ART as part of addressing the capacity needs of the centres of excellence. Facility staff, through the support of the Lubombo Regional Health Office (Supervision and Mentorship Department) also conduct in-house mentoring/capacity building sessions, depending on what courses have been updated. This approach to capacity building has contributed towards the creation of a service provider who is competent in service integration and able to provide integrated ART and FP services. The collaboration between the nurses and the Expert Clients helps prepare clients and identify any potential integrated service issues before they reach the consultation room.

## **Reproductive health and HIV equipment and supplies**

To effectively support integration and augment existing equipment and supplies, the EU project fund complemented Siphofaneni Clinic with additional equipment and supplies in an effort to improve on integration of service delivery.

## **Monitoring and evaluation**

Monitoring and evaluation is a key component of the programme since integration of HIV and SRH requires that indicators be reviewed and new indicators developed that are responsive to integration. This poses additional challenges relating to the review of existing tools, as well as orienting of services providers. The Ministry of Health's Management Information Services department works closely with the centres of excellence TWG and provides oversight to define the MER framework for the project and build ownership.

## **Linking community to health facility - building structures to enhance accountability**

Like other health facilities in Swaziland, Siphofaneni Clinic has a Clinic Committee, whose composition includes healthcare staff and community representatives. This committee has been oriented on the integrated approach and provides a platform for feedback to the clinic on the services provided. It is also used in community mobilisation to create demand for the services that are being provided at the clinic and contribute towards community ownership of the services provided.

## **Addressing gender issues - reaching out to men**

Men play an important role in determining a family's health seeking behaviours and it is strategic that they are engaged in order to address barriers to access, as well as influencing social change. In response to identified gaps and barriers to women's access to integrated ART and FP services and in line with universal integration principles of addressing structural determinants, human rights and gender issues, the health facility, in collaboration with traditional leadership, strategically mobilises and engages men. Once a month, the clinic conducts a facility-based 'Phila Uphephe' 'Live and Be Safe' session exclusively for men. This is an opportunity to engage men on the services provided at the facility, as well providing HIV and SRHR

information. Targeting men with accurate information has the potential to yield positive results for women's access to and utilisation of FP services, as well as reducing sexual and gender-based violence (GBV).

### **Adopting a family centred approach to integrated FP and ART services**

*“If a mother walks in to obtain her ART resupply and has an infant with her, we always ask about the child's HIV status. If DBS [dried blood spot] sample has not been taken, we do that, after explaining to the mother. So we are not just focusing on this mother who has come for her ARV re-supply but the baby as well. If the partner has not been tested we also discuss and encourage the partner to come. This is part of our discussions with men when we meet with them in their own sessions. If the child is confirmed positive then a pre-ART register is opened and referrals are made for further services”*

Service provider sharing how integrated services are provided

Although Siphofaneni Clinic is known for successfully integrating FP into ART services, it has also made significant in-roads to providing a family centred approach and this has been incorporated into the provision of integrated services.

### **3.3 Elements of a best practice**

*“Before this programme was introduced, we were doing integration of some sort without knowing it, or in response to our own challenges of staff and space shortages but once oriented properly on integration we now do it for efficient delivery of services to our clients. Our clients at times express their surprise at the speed at which they would have been served, with some services often offered in one room or in the next room. Before this, they knew that in most cases they come to the clinic to receive one particular type of service and they will make another trip to be attended for another one. This was time consuming for both the client and us as the volumes kept on increasing, but attending to same clients on different days”*

A service provider sharing her perceptions on integration

The provision of integrated FP and ART services by Siphofaneni Clinic within the framework of a family centered approach, demonstrates its credible documentation as a best practice that can provide opportunities for learning. This approach will significantly contribute towards achieving the goals of HIV prevention, prevention of unintended pregnancies and reduction of mother-to-child transmission of HIV. The skills competency and knowledge of the service providers on the services they provide demonstrate the capacity to deliver services effectively and efficiently, reducing wasted time on the part of clients, who previously had to make multiple visits to have their FP and HIV needs met.

### **Effectiveness:**

The effectiveness of the Siphofaneni FP and ART integrated service is best described by the community's view of the service. The clinic has managed to reduce missed opportunities by extending FP services to the ART department instead of referring clients. The success of the integration of SRH interventions into HIV services is noted in client perceptions about receiving FP commodities whilst attending to their HIV related needs, without fear of stigmatisation. The capacity building of staff prior to the commencement of integrated service provision also seems to have created a positive attitude amongst the service providers, leading to the creation of a client-friendly environment and significantly reduced client waiting time and unnecessary queuing.

### **Ethical Soundness:**

Neither FP nor ART services are mandatory, allowing clients to express their human rights to access treatment or not. The integration of FP and ART services targets PLHIV and their families by expanding access to the services they need on an individual basis. Family planning services may be either provider or client initiated, while ART services are provider initiated. Both services potentially impact on the client's human rights. Under the integrated service provision, clients are provided with information to make informed decisions, taking account of the ethical need for clients to be allowed to make an informed choice. The community mobilisation component has contributed towards raising awareness of the service and to creating demand, whilst taking account of the community's wishes and experiences.

*“At this clinic we have witnessed a new relationship between the clinic staff and the community. We have meetings where challenges that we face at the clinic are addressed. During these meetings the community and clinic staff reach an understanding of the other's problems and in the end problems are solved. I am not taking these pills because I was forced but because the advantages were discussed in a meeting at the clinic and I just said to myself this is good; I am going to be part of it”*

Siphofaneni Clinic FP client

### **Cost-effectiveness:**

There is a general belief that integrating services will be cost effective given that it involves sharing staff, facilities, equipment, and other administrative and overhead costs.

The integration at Siphofaneni clinic is regarded as a cost effective intervention by both service providers and clients; clients benefit from integration through reduced visits to the health facility, while the one-stop

shop approach means service providers' time is used more effectively and client visits and consultations are reduced. The facility indicated that following the integration and its coupling with a community mobilisation component, the number of clients they serve per day has increased as indicated in the table below.

Total number of clients/visitors per day before integration (average)	All <b>150</b>	Men <b>30</b>	Women <b>120</b>
Total number of clients/visitors in a day after introducing integrated services	All <b>250</b>	Men <b>50</b>	Women <b>200</b>

Although the average time spent with each client has increased following integration, the client waiting time has reduced as demonstrated in the table below. The integration was targeted at reaching a greater number of PLHIV and has been successful in achieving this, as the number of HIV positive clients now being reached with family planning services has increased. However, due to the numerous registers being used at the health facility it was not possible to aggregate the number of PLHIV reached with FP prior to integration.

Issue	Before integration	After integration
No. ART patients seen (average)	<b>40</b>	<b>60</b>
Length of waiting time	<b>1hr 30min</b>	<b>30 min</b>
No ART patients using FP	<i>(This was difficult to follow up since they had too many registers at that time)</i>	<b>25-30</b>

The fact that service providers spend more time with one client has created a demand for additional staff. However, reliable data on cost-effectiveness remains limited and further studies need to be undertaken to obtain a better understanding of the monetary benefits of linking services.

### Relevance:

Relevance of integration of FP and ART can be viewed from two angles; relevance to the community and to the Government of Swaziland.

*"I feel that the clinic has heard our pleas, I was tired of the many trips to the clinic to collect my ARV supplies, my family planning pills and other services, since these services were offered on different dates that I was often not aware of. This was draining financially too, but now if I am well I only go to the clinic once and the queues move much faster, since everyone is told in advance how the clinic is arranged".*

Siphofaneni Clinic client

This quote indicates that the clinic's clients feel ownership of the integrated services, as they respond to their expressed needs.

The Swaziland Government is a signatory to the Africa Union's Maputo Plan of Action (2007), as well as the UN's Universal access to HIV prevention, treatment, care and support declaration (2006), as a result of which it had

previously introduced service integration through the public health approach. However, this was not done in a co-ordinated fashion and the objectives it aimed to fulfill were different. Thus the EU supported interventions presented an opportunity for government to systematically translate this commitment to practice.

*“In Swaziland the HIV and SRH linkage programme provides an opportunity for health system strengthening and for us to fulfill an earlier commitment the government had made to integration. This programme did not impose a new way of doing things but it responded to our needs and is in line with our strategic direction for provision of quality and efficient services to our people”*

Views from a government representative

As a public health facility, Siphofaneni clinic had always provided integrated services. However, the structured approach to the integration of SRH and HIV services refined their approach to a single goal, i.e. to increase access to FP services to those already receiving ART services.

The community in general and the community of PLHIV in particular, were unanimous on the relevance of integration of FP and ART. The representatives of PLHIV engaged disclosed that both society and service providers have negative attitudes towards PLHIV's sexual and reproductive rights. Often PLHIV who seek FP services face stigma from some service providers. PLHIV expressed a desire to have HIV negative children but despite having knowledge on PMTCT, accessing FP services in order to derive maximum benefits from PMTCT services was difficult prior to the integrated service provision. Thus the provider initiated FP services provided by Siphofaneni under the integration programme have made it easy for PLHIV to access such services and to plan their pregnancies.

### **Replicability:**

The five centres of excellence have not been proscribed in terms of which entry point to integration they use; this has provided them with the flexibility to identify and pilot any entry point applicable to their level and context as a facility. At national level, the key milestones of integration are well documented, including baseline facility assessment reports and mid-term reviews.

Using FP and ART integration as an entry point has worked in Siphofaneni's setting. The steps taken to achieve integration are clearly documented and staff members, including expert clients, demonstrate high levels of understanding of the integration of FP into ART, making it easy to transfer these skills to others. The staff training carried out prior to the introduction of integrated service provision has played a significant role in the success of the integrated service provision and can easily be carried out elsewhere. The steps that Siphofaneni has taken to provide integrated FP and ART services are clear and can be replicated in facilities with different settings.

The monthly male dialogues and the involvement of traditional leaders are also a feature that can be readily replicated in other communities.

### **Innovativeness:**

Whilst the debate around unpacking integration and interlinkages has been a challenge for many countries in introducing systematic integration of HIV and SRH, Swaziland has focused on learning through doing. The country has not limited its integration intervention to one specific model, neither has it used only a

single entry point to integration. This has provided flexibility in the country's response to pilot, learn and innovate through its five centers of excellence.

Siphofaneni Clinic is using integration of FP and ART as its entry point to linking SRH and ART services and has innovated by adopting a family centered approach that allows it to address family members other than the client. This has increased the clinic's scope and created an avenue for the health facility to reach out beyond the present client.

The offering of DBS services to children of female ART clients is an innovation given the challenges recorded across the 22 high-burden countries in offering HIV testing and initiating children on ART. At Siphofaneni, due to the adoption of the family centered approach, the service provider initiated DBS is a commendable step that can be replicated elsewhere in Swaziland and the southern Africa region.

Another area where the Siphofaneni integration is showing innovation is in addressing the gender dynamics in service provision through the monthly male dialogue platforms, which are conducted in collaboration with traditional leaders at the facility.

*“Within this clinic, children are offered an HIV test. We have also tried to involve men in health issues. We have been having men's dialogues called “Sidla Inhloko”. These dialogues have helped men through information and educating them on how they can support their wives and children. Like you have seen for yourself, some of the men now accompany their wives and carry their children, supporting the wife throughout the clinical processes. This has shown that men are now getting involved”*

Women beneficiary of the service

### **Sustainability:**

*“From the beginning the Government of Swaziland understood that when the EU supported intervention ends, it will take over and expand them beyond the five centers of excellence. This has always been the plan, so we have used this support as a pilot to allow us to learn and eventually role out in a more informed and systematic manner”*

Comment by a Government representative

Siphofaneni clinic has not established new avenues in implementing SRH and ART integration strategies, but has added to an existing system that has simply broadened its goals and direction. This ensures the sustainability of the interventions once EU support ends.

*“This is our service and we are part of all decisions that are made by the clinic. We know that the clinic staff is here to help us but this facility is part of our assets hence we participate and support the staff to fulfill their mandate to the community.”*

A traditional leader and member of the Clinic Committee at Siphofaneni

### **Addressing structural determinants**

Key to the ethos of linking HIV and SRH is the issue of building a common understanding of the principles for each pillar, one of which is increasing community access to information and health education.

Siphofaneni Clinic collaborates with its clients at facility level by creating linkages with the community through the Clinic Committee. This assists in creating demand for the services it provides, as well as creating avenues to obtain feedback from the community. It has also enabled the health facility to continuously reflect on the services it provides and to improve in response to community feedback.



*“Men and women are represented in the Clinic Committee; this makes it easy for concerns of both parties to be heard. The meetings between men and the clinic staff help us as women since the nurses take up our issues with our partners at such meetings. It seems men listen to nurses more than to us and sometimes we see change when men begin to say this is what the nurses have said so we must do that”*

Comment by a woman client at the clinic.

# 4. Key Programme Successes

## 4.1 Responding to Community, National and Regional Priorities

*“This Siphofaneni integration of ART and FP services intervention has managed to reduce the number of visits a client makes to a health facility, but more importantly it is a strategic prevention intervention for both HIV and unintended pregnancies amongst PLHIV”*

A service provider

The integration and linkages intervention is anchored in high political and community commitment and support, given to its alignment with both the country’s and regional strategic direction in service provision. It has responded to the needs of the community as is demonstrated by the community’s perception of the intervention. Siphofaneni’s integration of ART and FP services is contributing towards the Government of Swaziland’s thrust to fulfill its regional and local SRH and HIV integration priorities and is in line with the Extended National Strategic Framework on HIV and AIDS (2013-2018), which promotes access to family planning in the context of HIV.

The Siphofaneni integration has contributed towards the systematic monitoring of ART and family planning, and therefore also to the strengthening of the monitoring, evaluation and reporting (MER) framework. Some of the data collection tools used at Siphofaneni under the integration of FP and ART programme include FP/ART Registers, ART prescriptions and Chronic Care file. The number of clients reached following integration has increased significantly, as demonstrated in table below.

Total number of clients/visitors per day before integration (average)	All <b>150</b>	Men <b>30</b>	Women <b>120</b>
Total number of clients/visitors in a day after introducing integrated services	All <b>250</b>	Men <b>50</b>	Women <b>200</b>

The health facility enters data on a daily basis; monthly data summaries are then shared with regional mentors as part of monthly clinic report from the different departments

The comprehensive approach adopted in addressing human resources, equipment and commodities, service quality, monitoring and evaluation and infrastructure, will result in overall health systems strengthening.

## 4.2 Efficient Use of Resources

In Swaziland, the Siphofaneni's integration of FP and ART services has demonstrated efficiency in both client, financial and human resource use. Given the acute shortage of nurses, the intervention has demonstrated that effective utilisation of human resources can be achieved through increased integration, since nurses are now multi-skilled and competent to deliver both FP and ART services. This approach demonstrates the commitment at this level to address the challenges created by vertical programme design and will eventually contribute towards reduction in duplication of efforts and competition for scarce resources amongst partners and entities. The use of Patient Experts frees highly skilled nurses for other tasks.

## 4.3 Stigma Reduction

*"This intervention has assisted to address stigma amongst HIV positive women. Now I am able to plan my pregnancies because the services are accessible. When you are HIV positive and you fall pregnant, people just don't like it especially the nurses"*

Sentiments of a client

The flexibility of the integration interventions has allowed services to be aligned to the local context from the national to facility specific contexts. The approach to integration is not proscriptive but provides room for the design of an integrated service intervention approach that is responsive to and informed by the local context. This has created ownership of the services amongst beneficiaries, service providers and political leadership.

## 4.4 Existence of Multi-level Support for Intervention

The Siphofaneni ART and FP service integration is not implemented in isolation, as it is part of a national intervention strategy with a multi-stakeholder approach that enables support at different levels to maximise health outcomes. The national and regional teams support the health facility with skills competency, capacity building and mentoring. The presence of a champion at facility level fosters co-ordination of the integration within the facility and has contributed to the high visibility of the intervention. Integrating FP and ART services will eventually contribute towards the reduction of maternal mortality, as unintended pregnancies in women living with HIV are reduced and their other SRH needs are also met while obtaining ART services.

## 4.5 Expanding FP services that are tailor-made for PLHIV and their needs

Increasing access to family planning for PLHIV strengthens the response to the four pillars of PMTCT by reducing unintended pregnancies in women living with HIV. Integrated SRH and HIV services provide information on family planning and it is promoted as a strategy to eliminate new HIV infections in children and reduce unplanned pregnancies in PLHIV by 2015. PLHIV are accessing tailor made FP services which are critical for improved access, elimination of missed opportunities and increased acceptance of services.

The Siphofaneni integration of FP and ART services records significant successes and creates an entry point for linking HIV and SRH services. However, a number of challenges still need to be addressed in order to meet set targets.

# 5. Challenges

## 5.1 Strengthening the Programme Monitoring and Reporting System

Although structures have been put in place to support monitoring at various levels, significant gaps still exist.

- There is need to identify indicators aligned to the integrated interventions and develop appropriate and efficient tools that do not add to the burden of data collection and recording for healthcare workers. This will also reduce double counting.
- The staff rotation practiced at Siphofaneni could have unintended negative results, as healthcare workers have to be competent in more than one area and may not have adequate time to spend at one station so that they become efficient in data collection and management for that station. Continuous supportive supervision and mentorship remain of essence in ensuring the success of the FP/ART integration.

## 5.2 Promote a Co-ordinated and Coherent Response

The Siphofaneni integration project promotes an integrated family centered approach where HIV is not a stand-alone service but is embedded into other services, such as maternal and newborn health, infant nutrition and non-communicable diseases amongst others. This systematically contributes towards a co-ordinated and coherent response to HIV that builds upon the principles of one national SRH/HIV framework, one broad-based multi-sectoral SRH/HIV co-ordinating body, and one agreed country level monitoring and evaluation system (the Three Ones Principles).

## 5.3 Addressing Supply Chain Management Issues

Siphofaneni clinic experienced stock outs of key commodities such as HIV testing kits and some family planning commodities. This was due mostly to:

- Widespread stock outs that still need to be addressed at national level.
- Poor documentation, resulting in poor forecasting in line with increased client demand.
- Limited skills and capacity in the ordering and projection of commodity needs as determined by client volume and increased demand.

## 5.4 Infrastructure to Provide Integrated Services

Although Siphofaneni has adopted the supermarket approach to integration that entails providing services in different rooms under one roof, the existing infrastructure is inadequate, given that this is a high volume site.

# 6. Lessons Learnt

Key lessons have been learnt at various levels through the implementation of integrated FP and ART at Siphofaneni clinic. These lessons learnt serve to inform both the ministry and programmes on strategies that can be used to adopt integrated services in similar facilities.

## 6.1 Integration of FP and ART is a Strategic Intervention for HIV Prevention and Reduction of Unintended Pregnancies

Integration of FP and ART services is seen as promoting dual protection amongst people living with HIV. Use of condoms with another hormonal contraceptive is promoted at the clinic and there is a deliberate effort to ensure that the integrated ART and FP service approach contributes towards obtaining better outcomes of PMTCT interventions. This is a strategic move whose benefits will help realise the general HIV elimination strategies. Provision of family planning services for PLHIV alongside ART services has minimised missed opportunities for FP and increased access to FP for PLHIV.

## 6.2 Integration Leads to Client Satisfaction

Provision of ART and FP services under one roof has resulted in improved client satisfaction as it has reduced the number of visits that clients make to health facilities. The integration interventions thrust to collaborate with traditional leaders has created linkages between the health facility and the community, enabling the community to contribute towards ensuring that services are structured in a way that responds to their needs and lifestyles.

## 6.3 Building Capacity of Service Providers Builds Ownership and Confidence

The systematic efforts made by the programme to prepare service providers for the provision of integrated services have resulted in greater ownership and appreciation of the services being provided, by health care workers. Inadequate knowledge and skills amongst service providers often result in loss of confidence to provide services, which results in missed opportunities for clients to access services.

# 7. The Way Forward

## Strengthening the Monitoring, Evaluation and Reporting Framework for Effective Integration

Although some integration indicators have been developed so far, there is need to develop additional measurable integration indicators to track strategic areas such as quality of service, client satisfaction, cost effectiveness and process efficiencies. Harmonisation of data collection tools for SRH and HIV need to be strengthened at national level to support the commendable efforts towards integration at Siphofaneni Clinic.

Whilst service providers at facility level have demonstrated high knowledge levels and skills to implement integrated FP and ART, the shortage of healthcare workers will need to be addressed, together with other factors that motivate them.

The existence of numerous data collection tools at the health facility results in a burden of records, taking staff away from service delivery. Despite the importance of recording, more efficient data collection methods should be identified in order to provide more time to service delivery. The use of data clerks that has been piloted in some countries in southern Africa could be a commendable move to address this challenge

## 8. Conclusion

There is strong evidence that integration of ART and FP services is an entry point to linking SRH and HIV services at Siphofaneni Clinic. At facility level, healthcare workers share a common definition and understanding of the purpose of the integration. Through the rotation system, nurses at Siphofaneni have learnt that comprehensive training (in-service, mentorship, and supportive supervision) is required in order to provide HIV services.

Through the integration, immediate health goals are being realised. These include stigma reduction, increased access to FP services, prevention of unintended pregnancies in PLHIV, and joint delivery of FP commodities and ARVs. Broader health goals that will be impacted upon include strengthening of health systems, as well as HIV prevention amongst the general population in the long term.

The relevance of this intervention has been demonstrated beyond doubt through the commitment of leadership at different levels, including service providers. The country has invested significantly in building capacity for the delivery of integrated services; this pool of highly skilled individuals must be retained for the future sustainability of the programme.

# References

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4. UNFPA/UNAIDS Centres of Excellence Baseline Survey Facility Report
5. UNFPA, UNAIDS, Mid-Term Review of the Project “Linking HIV and Sexual and Reproductive Health and Rights in Southern Africa”
6. WHO, UNFPA, UNAIDS & IPPF (2005) *A framework for priority linkages*
7. [www.integrainitiative.org](http://www.integrainitiative.org)

# Annexes

- Annex I : Methodology matrix
- Annex II : Data Collection Tools
- Annex II : Best Practice Score Card
- Annex IV : Peer Review Guide
- Annex V : Siphofaneni Clinic Facility Assessment Report

# Methodology Matrix

## Siphofaneni Clinic – Integration of ART and Family Planning Best Practice Documentation

Five data collection methods were applied during the documentation process, with the following five population samples: programme implementers; managers and senior officials; key stakeholders; community groups and beneficiaries. Precise dates, times and persons for each sample method were informed by UNFPA and the COE, during the field planning process.

Data Collection Method	Data Collection Tools	Data Type	Samples	Numbers
Key Informant Interviews (KII)	KII Questionnaire for implementers	Qualitative and quantitative	Programme Implementers	15-20 in total
	KII Questionnaire for managers and senior officials	Qualitative and quantitative	Managers and senior officials (Matron, Clinic CEO/Administrator etc , MOH SRH Unit, MOH HIV unit, PS, etc )	
	KII Questionnaire for stakeholders	Qualitative	MOH, UNFPA, UNAIDS, other, Community Stakeholders (Chief, Headman, )	
Focus Group Discussions (FGD)	FGD Guide for beneficiaries	Qualitative and quantitative	Beneficiaries (women who have accessed services)	3
	FGD Guide for community members	Qualitative and quantitative	Community members (PLHIV groups, other)	2
Client Exit Interview (CEI)	CEI Guide	Qualitative	Beneficiaries (women on site leaving clinic)	10-15
Observation	Camera / photography		Onsite	
Desk Review	Checklist	Qualitative and quantitative	<ul style="list-style-type: none"> <li>– SADC regional documents</li> <li>– UN agency documents</li> <li>– Continental and global documents</li> <li>– Swaziland national documents –</li> <li>– National reports, statistics, SRH &amp; HIV policies, strategies and related docs</li> <li>– ART and FP integrated programme documents (workplans, strategies, M&amp;E plans, reports, evaluations)</li> </ul>	

# Tool 1: Interview Guide for Key Informants

## EFFECTIVENESS

1. What is the purpose or aim of the project/programme?
2. How does the project/programme goal or aim relate or fit into the national HIV and AIDS and SRHR strategic plan?
3. What are the strategies to achieve the goal? (*Probe for implementation plans, services rendered and defined target groups – geographic and demographic catchments*)
4. How are the project/programme services accessed by beneficiaries? (*Probe for clarity on community outreach plan or disbursement / distribution plan,*)
5. What systems are in place to ensure effective implementation? (*Probe financial, programming, procurement, human resource allocation, equipment, staff development, skills transfer and project sustainability*)
6. How does the project/programme approach integrate into other programs i.e. inclusion of other services, multitasking? (*To see if or not programme is vertical and assess multiplier effect- does one stone kill many birds?*)
7. How were project/programme priorities determined? (*Probe for information on needs assessments, community and other stakeholders involvement, project addressing urgent needs of community*)
8. How is the community involved in the project/programme? (*Participation in planning, monitoring, implementation and evaluation - probe for information on mechanisms put in place to solicit for feedback from community groups – probe for other ways that community contributes to the project, assess project acceptability – social, political, cultural and religious*)
9. How does the project/programme take into cognisance gender dynamics at community level (*probe for composition of structures, participation and beneficiaries*)
10. How is the project/programme monitored? (*Ask for monitoring tools if any and frequency e.g. coverage, reporting forms, tally sheets, monitoring committees, quality assurance or quality bench marks*)
11. How is the project/programme evaluated? (*Measurement of impact – probe for knowledge of main indicators and baseline information, frequency of conducting evaluations*)
12. Who are the implementers of the project/program? (*Probe for information on sectoral expertise among staff, volunteers, out sourcing as necessary, adequacy of staff, roles and responsibility*)

## ETHICAL SOUNDNESS

13. How does the project/programme ensure inclusion of vulnerable groups? *(Probe for value statement on how interests of young people, women, children living with disabilities and children living with HIV are taken care of)*
14. What policies are in place to ensure that the project/programme upholds and respects human rights? *(Probe for policy or consideration of confidentiality, informed consent and safety issues)*
15. What policies are in place to ensure continuity of services? *(Probe for systematic weaning or phase out strategies, skills transfer)*
16. What policies are in place to ensure equitable distribution of services? *(Those with greatest need access the service)*
17. How is the project/programme audited and who does the auditing? *(Probe for transparency i.e. project allowing for both internal and external programme and financial audits, frequency of audits)*

## REPLICABILITY

18. What are some of the success stories that can be shared?
19. What are some of the project/programme challenges?
20. What are some of the lessons learnt? And how have these learning points been used to strengthen the project/programme?
21. What plans are in place to scale up the project/programme? *(to reach more beneficiaries or to have more impact on currently reached beneficiaries)*

## SUSTAINABILITY

22. How is the project/programme vision aligned to current trends? *(National and regional trends, epidemic, economic, developmental - political correctness- MDGs, Universal access etc)*
23. What is the funding pattern of donors? *(Basket funding, % of funding from local sources and donors,)*
24. How does the project/programme strategy ensure financial sustainability? *(Probe for information on fundraising strategies, user fee, community initiatives)*
25. What do you see as the future of the project/programme?

## INNOVATIVENESS

26. What do you think is the most unique aspect of this project/programme?
27. Ask for any other additional information deemed relevant but not covered in the questions

**THANK YOU FOR YOUR TIME, SUPPORT AND PATIENCE**

# Tool 2: Focus Group Discussion Guide (FGD) for Communities/Beneficiaries

*\*Introduce the purpose of the FGD, and get verbal consent. Assure FGD members that the information they shall share shall be treated anonymously.*

## EFFECTIVENESS

1. What is the purpose or aim of the project? (goal, objectives)
2. How were you involved in the establishment of the project/programme? (conceptualisation, consultations, needs assessment, prioritization of needs, relevance to needs, usefulness, timeliness of project/programme, planning)
3. What do you think are the benefits of this project/programme for you as women /men /children, young people and your communities?
4. How do you view this project/programme? (Is this YOURS - ownership, or imposed, or donor driven, or neutrally accepted because they don't have a choice)
5. How do project/programme services/activities cater for the needs of different age-groups, sexes, and social classes within your community?
6. How does the project/programme take into cognisance gender dynamics in your community? (Probe for composition of structures, participation and beneficiaries – girls, boys, women and men), benefits
7. How has access to project/programme services/activities been influenced by the economic or political trends in your community?
8. How are project/programme implementers working with you to determine project/programme needs to meet your needs?
9. How are you participating in the project/programme implementation and checking that the project/programme is progressing well (monitoring and evaluation processes)?
10. How do you share your feedback or feelings about the services/activities you are receiving, with project/programme implementers? How often?
12. How does your community contribute towards the services/activities that this project/programme offers? (cash, kind, other support, e.g. advice and networking)
13. Describe the process that takes place for community members to access the services activities provided by the project/programme? (probe specific to the good practice you are documenting , this will measure how implementers are 'doing things' e.g. are human rights being adhered to etc)
14. What factors hinder children from accessing the services, or engaging in the activities that this project/programme is offering?
15. What would you like to be done in this project/programme, to be of greater benefit to your community?

## **COST EFFECTIVENESS**

16. Are services provided in a timely manner?
17. Is there an increase in the number of children and families in this community whose lives have been changed as a result of benefiting from the programme?
18. Is there a positive life story that you can share with us?
19. The way the service is provided, is it cost effective? How can it be improved?
20. Do you find that the project has adequate personnel providing the service? (numbers and skills.)

## **RELEVANCE**

21. What are the views of your traditional and religious leaders on this project/programme? (project was introduced to traditional systems, consensus sought, part of consultative process, commitment, support offered by traditional systems)
22. Are all the services provided necessary? If not which ones

## **ETHICAL SOUNDNESS**

23. Are your rights and others respected in this programme, why?
24. In your opinion is the distribution of services between men and women, rich and poor, married and unmarried, adults and children fair?
25. Is there transparency in the operations of this organisation?
26. Do you feel that the organisation and its staff are accountable to beneficiaries?
27. Are people treated with respect, and their opinions listened to by programme staff?

## **INNOVATION**

28. In your opinion, is this programme creative and innovative, different from other projects?
29. Can you share with us a story that demonstrated this innovation?

## **SUSTAINABILITY**

30. In the absence of donor support, do you think this programme should continue? Why (are there skills in the community? Is community contributing to the programme cash or kind?)
31. Is the programme well known to the community?
32. What are some of the challenges faced by yourselves in this programme and how have these challenges been addressed by yourself and the NGO?

**THANK YOU FOR YOUR TIME, SUPPORT AND PATIENCE**

# Tool 3: Interview Guide for Project/Programme Implementers

*\*After adequate introduction and explanation of purpose of exercise, point out that interview may take up to one hour. There may be need to have some documents handy to clarify issues during or after the interview.*

## EFFECTIVENESS

1. What is the purpose or aim of the project/programme?
2. How does the project/programme goal (or aim) relate to, or fit into, the Swaziland National HIV and AIDS and SRHR strategic plan
3. What are the strategies to achieve the goal? *(Probe for implementation plans, services rendered and defined target groups – geographic and demographic catchments)*
4. How are project/programme services accessed by beneficiaries? *(Probe for clarity on community outreach plan or disbursement / distribution plan)*
5. What systems are in place to ensure effective implementation? *(Probe financial, programming, procurement, human resource allocation, equipment, staff development, skills transfer and project sustainability)*
6. How does the approach of the project/programme integrate with other programs i.e. inclusion of other services such as family planning, multitasking? *(To see whether programme is vertical, assess multiplier effect- 'does one stone kill many birds?')*
7. How were project/programme priorities determined? *(Probe for information on needs assessments, community and other stakeholders involvement, project addressing urgent needs of community)*
8. How is the community involved in the project/programme? *(Participation in planning, monitoring, implementation and evaluation- probe for information on mechanisms put in place to solicit for feedback from community groups – probe for other ways that community contributes to the project, assess project acceptability – social, political, cultural and religious)*
9. How does the project/programme take into cognisance gender dynamics at community level? *(Probe for composition of structures, participation and beneficiaries)*
10. How is the project/programme monitored? *(Ask for monitoring tools if any, and frequency e.g. coverage, reporting forms, tally sheets, monitoring committees, quality assurance mechanisms or quality bench marks)*
11. How is the project/programme evaluated? *(measurement of impact – probe for knowledge of main indicators and baseline information, frequency of conducting evaluations)*
12. How is monitoring and evaluation data used? *(frequency of use for project review, timely dissemination to relevant stake holders)*
13. Who are the implementers of the project/programme? *(Probe for information on sectoral expertise amongst staff, volunteers, out-sourcing as necessary, adequacy of staff, roles and responsibility)*

## ETHICAL SOUNDNESS

14. How does the project/programme ensure inclusion of vulnerable groups? *(Probe for value statement on how interests of young people, women, children living with disabilities and children living with HIV)*
15. How are human rights upheld or respected during establishment and implementation of the project/programme? *(Probe for policy, consideration of confidentiality, informed consent and safety issues)*
16. How is continuity of services, support or care ensured after end of current funding cycle? *(Probe for systematic weaning or phase-out strategies, skills transfer mechanisms)*
17. How is equitable distribution of services ensured? *(Those with greatest need access the service)*
18. How is the project/programme audited and who does the auditing? *(Probe for transparency i.e. project allowing for both internal and external programme and financial audits, frequency of audits)*

## COST EFFECTIVENESS

19. How are project/programme resources distributed? *(Admin versus programme costs)*
20. How is the service-cost measured within this project/programme? *(Probe for methods of tracking inputs, outputs in relation to outcomes so as to enable calculation of cost per client)*
21. To what extent are available resources adequate to support delivery of project/programme services? *(Probe for adequacy of human and financial resources, equipment and supplies)*
22. What are the cost saving and cost reduction measures of the project/programme? *(use of low cost, improvised substitute, engaging volunteers for some of the services, does it have an increased financial burden on beneficiaries)*
23. To what extent does cost sharing take place in the project/programme? *(user fees, payment of some of the services like training, transport)*
24. What is included in the minimum package of the service/s provided by the project/programme? *(compare with the standard package policy for the country, procedure guides)*
25. How timely is the delivery of services?

## REPLICABILITY

26. How are project/programme activities and processes documented? *(get copies of reports, case studies collected, documentaries, manuals, books etc)*
27. What are some of the success stories that can be shared to depict positive impact or influence of the project/programme services on beneficiaries?
28. What are some of the project/programme challenges?
29. What are some of the lessons learnt from this project/programme, and how have these been used to strengthen the project/programme?
30. What plans are in place to scale-up the project/programme? *(to reach more beneficiaries or to have more impact on currently reached beneficiaries, quality & quantity)*

## INNOVATIVENESS

31. What do you think is the most unique aspect of this project?
32. Ask for any other additional information deemed relevant but not covered in the questions above.
33. Share with us a success story that demonstrates the success of your program.

## SUSTAINABILITY

34. How is the project/programme vision aligned to current trends? *(national and regional trends, epidemic, economic, developmental - political correctness- MDGs, Universal access etc)*
35. How is the project/programme marketed to stakeholders? *(assess for active education and awareness building amongst stakeholders, language and medium used, are you getting the expected responses)*
36. How does the project/programme strategy ensure financial sustainability? *(probe for information on fundraising strategies, user fee, community initiatives)*
37. What do you see as the future of the project/programme?

**THANK YOU FOR YOUR TIME, SUPPORT AND PATIENCE**

# Tool 4 – Key Assessment/Analysis Tool – Score Card

\* This Score card is measured from a total of 100

Variable	Data Source	n/a	0	1	2	3	4
<b>1. EFFECTIVENESS (25 points)</b>							
<b>1.1 Project/Programme Design/Structure (10 marks )</b>							
Goal/s is/are clearly articulated and well understood by beneficiaries and implementers.	Interviews/ FGDs/ Lit review						
Project/programme is in line with the National HIV and AIDS and SRHR strategic plan	Lit. review / Interviews						
Strategies are in place and clearly articulate how the goal can be achieved/supported by clear implementation plan.	Lit. review/ Interviews						
Clear strategies are in place to evaluate impact of the project	Lit. review/ Interviews						
Project/programme has clear results as defined by implementers, beneficiaries and stakeholders and in line with original objectives	Lit. review/ Interviews						
Project's /programme's services/activities are clearly defined.	Lit. review						
Project/programme has clear systems in place (financial, community outreach, distribution/disbursement, equipment).	Lit. review/ Interviews						
Baseline/assessment ground-work was undertaken prior to project's /programme's commencement.	Lit. review						
Project/programme has clearly defined targets.	Lit. review						
Project's/programme's objectives are SMART.	Lit. review						
Project/programme embraces an integrated approach (vs. vertical).	Lit. review/ Interviews						
There is sectoral expertise to manage and implement the project/programme.	Interviews						
<b>1.2 Community Involvement (10 marks)</b>							
Project's/programme's priorities are based on actual needs of the community – evidence of needs assessment done.	Lit. review/ Interviews/ FGDs						
Community knows and understands the objectives of the project/programme.	Interviews/ FGDs						

Community participated in the initiation/conceptualisation of the project/programme, setting priorities.	Lit. review/ Interviews/ FGDs								
Community participates in the project's/programme's planning, monitoring and evaluation.	Lit. review/ Interviews/ FGDs								
Community participates in the project's/programme's implementation, as volunteers or paid staff.	Lit. review/ Interviews/ FGDs								
There is a sense of ownership of the project/programme, among communities. Community feels the project and its outcomes belong to them.	Lit. review/ Interviews/ FGDs/ Observation								
Community contributes in cash or in kind towards project's/ programme's activities.	Lit. review/ Interviews/ FGDs								
There is gender sensitivity in community participation. (both men and women are involved equally).	Interviews / FGDs Observation								
Community is satisfied with the project's/programme's services. (both men and women)	Interviews / FGDs/ Observation								
<b>1.3 Monitoring and Evaluation (M&amp;E) (5 marks)</b>									
Systematic methods of tracking inputs and outputs are in place.	Lit. review/ Interviews								
Key stakeholders, including the community, participated in the development of the project/programme's indicators.	Lit. review/ Interviews/ FGDs								
Project/programme's activities are periodically monitored and evaluated including coverage.	Lit. review/ Interviews								
Quality assurance/quality benchmarks are in place and are being followed.	Lit. review/ Interviews								
Participatory monitoring and evaluation methods are being used that include the community.	Lit. review/ Interviews/ FGDs								
M & E (impact, assessments, outputs) data are analysed periodically.	Lit. review/ Interviews								
Results of impact evaluations are used to make meaningful adjustments to the project/programme.	Interviews								
<b>2. ETHICAL SOUNDNESS (10 points)</b>									
Confidentiality, as a principle, is upheld in interactions with project/programme's service beneficiaries.	Lit. review/ Interviews/ FGDs								

The interests of vulnerable groups (young people, women, children living with disability and children living with HIV), are respected and protected.	Interviews/ FGDs								
Project/ programme does not directly or indirectly violate human rights.	Interviews/ FGDs								
Project/programme has a Value Statement for protection of the interests of various vulnerable groups.	Lit. review/ Interviews/ FGDs								
Project/programme always embraces the concept of informed consent when dealing with human beings as participants.	Lit. review/ Interviews/ FGDs								
There is evidence of equitable distribution of project's/ programme's resources (finances, geographic distribution, sex).	Lit. review/ Interviews/ FGDs								
The autonomy of beneficiaries is protected and respected during project/programme roll-out.	Lit. review/ Interviews/ Observations								
There is an ethical standard ("do no harm" principle) embedded in the project's/programme's policies.	Lit. review								
There is a minimum service provision package (clearly defined, access irrespective of colour, creed, sex, religion, political affiliation).	Lit. review/ Interviews								
Project/programme is transparent (allows for external and internal programmatic and financial audits).	Lit. review/ Interviews								
<b>3. COST EFFECTIVENESS (12 points)</b>									
Distribution of project/programme's resources is cost effective (administration versus programming) and is proportionate to available resources.	Lit. review/ Interviews								
There is evidence of increased number of children and community members whose quality of life has been improved by the project/programme's resources and services.	Lit. review/ Interviews								
There is evidence to enable calculation of 'cost per client' measure. (cost known)	Lit. review/ Interviews								
A standard package is provided at a reasonable cost.	Lit. review/ Interviews								
Services are delivered in a timely manner.	Interviews/ FGDs								
There are adequate human resources for programme's activities	Interviews								
The strategy used by the project/programme has resulted in multiplier effects (cost - benefit).	Lit. review/ Interviews/ FGDs								
Project/programme has introduced cost saving / reduction systems.	Interviews/ FGDs								

<b>4. RELEVANCE (12 points)</b>						
Project/ programme is socially and culturally acceptable.	Interviews / FGDs					
Project/programme takes cognisance of specific contexts (literacy, messaging, lifestyle, economic, political, approach, environmental factors, risk groups and areas).	Interviews / FGDs					
Project/programme does not conflict with the religious norms of the community and has support from political and traditional leadership.	Interviews / FGDs					
Beneficiaries perceive the project/programme as relevant and timely in addressing their most urgent needs.	Interviews / FGDs					
The project/programme is in line with demographic, social, political, and economic trends.	Interviews / FGDs					
Project/programme addresses gender dynamics.	Interviews / FGDs					
Project is appreciated by vulnerable groups.	Interviews / FGDs					
Project/programme is perceived as valuable and credible by the community.	Interviews / FGDs					
<b>5. REPLICABILITY (11 points)</b>						
Project/programme can be replicated in similar contexts.	Lit. review / Interviews					
Project/programme sets an example for similar programmes.	Interviews					
Project/ programme is adaptable in different contexts and levels using local resources.	Interviews / Observations					
Project/programme is replicable in part or in totality.	Lit. reviews/ Interviews					
Project/programme exhibits evidence of proper documentation in terms of goals, processes, evaluation, cost and resources.	Interviews / Observations					
Project can be scaled-up to reach more beneficiaries.	Interviews / Observations					
Project can be scaled-up to improve quality of service	Interviews / Observations					
<b>6. INNOVATIVENESS (10 points)</b>						
Project/programme is unique (different methodology from other organisations).	Interviews/ FGDs/ Observations					
Project/programme has a new way of reaching children.	Interviews/ FGDs					
The utilisation of available resources is done in a creative manner.	Interviews/ FGDs/ Observations					

The strategy of implementation, used by programme implementers, is innovative.	Interviews								
Project/programme concept is new to the community (as perceived by the community).	Interviews/ FGDs								
Project/programme is contributing to the base of knowledge.	Lit review/ interviews								
Project's/programme's approach and systems are scientifically/economically sound and safe.	Lit. review								
<b>7. SUSTAINABILITY (20 points)</b>									
<b>7.1 Programme sustainability (10marks)</b>									
Project/ programme is supported by men, women, young people, community ownership, contributions in cash and kind.	Lit. review/ FGDs/ Interviews								
The community expresses confidence that the programme will continue without donor support.	FGDs								
Skills transfer takes place in relation to the project/ programme.	Lit. rev/ Interviews								
Project/programme's vision is in line with the development patterns of HIV and AIDS, SRHR and national trends (social, economic & cultural)	Lit. review/ Interviews/ FGDs								
Project/programme's vision is in line with national trends (social, economic and cultural)	Lit. review/ Interviews								
Planning and implementation takes into account the issue of sustainability. (sustainability plan)	Lit. review/ Interviews								
<b>7.2 Financial sustainability (7marks)</b>									
Project/programme implementers are aware of potential donors (local and international).	Interviews								
There exists a positive attitude and willingness to achieve sustainability.	Interviews/ Observations								
Project/programme has the ability to access diversified resources to contribute to its services/activities. (fundraising plan in place)	Interviews								
Cost sharing mechanisms are built into service delivery where appropriate.	Lit. review/ Interviews								
A percentage of financial support comes from the community; organisation has had stable funding over time.	Lit. review								
<b>7.3 Marketing and Awareness Building (3 marks)</b>									
Project/programme is actively marketed to stakeholders and funders.	Lit. review/ Interviews								
Project/programme actively educates and builds awareness amongst stakeholders about its own services/ activities.	Lit. review/ Interviews								
Appropriate language is being used in information, education and implementation programmes.	Lit. review/ FGDs								
<b>TOTAL</b>									

# Peer Review Guide

## *'SRH & HIV Integration' Good Practice Documentation: The Case of Siphofaneni*

The Government of Swaziland received EU funding to support a co-ordinated approach to integration of SRH and HIV services and information following the increased need for policy and programming to jointly address SRH, HIV and AIDS, particularly in the context of the commitment to universal access to prevention, treatment, care and support and the Maputo Plan of Action. A rapid assessment was conducted in Swaziland and findings indicate that there exist considerable strengths and opportunities for the linkage of SRH and HIV services. The National Health Policy and Health Sector Strategy allude to the need for integrated, collaborative and mainstreamed activities for provision of quality services and effective use of resources.

Through the EU project "Linking HIV and Sexual and Reproductive Health and Rights in Swaziland", government is looking at strengthened five centres of excellence that will serve as models for integrated, interlinked SRH and HIV services. One of the centres is Siphofaneni Clinic. The definition of a SRH and HIV centre of excellence is "a leading health facility that promotes collaboration and uses best practice in the provision of a comprehensive package of integrated SRH and HIV services as a model for other health facilities to follow".

The documentation sought to highlight the effective strategies employed by the organisation in integrating SRH and HIV. The main focus areas for the documentation that include five features of a centre of excellence were:

- i. Provision of services:** Current integrated SRH and HIV services provided, level of quality and number of services provided.
- ii. Systems strengthening:** Existing operational standards for integrated service provision and strength of referral systems to track client uptake of services.
- iii. Leading by example:** Current management systems in place and whether caters for integrated services such as planning, client flow, logistics and supplies etc.
- iv. Monitoring performance:** Availability and use of data recording and reporting tools for integrated services.
- v. Sharing learning:** Systems in place to ensure staff are up skilled and remain skilled to provide integrated SRH and HIV services

The documentation resulted in the collation and production of a report which, following this peer review process and finalisation, will be disseminated as both an informative tool and a tool to facilitate national learning.

UNFPA considers peer review of this report to be an essential step in the finalisation of this report; Peer Reviewers should focus on providing meaningful suggestions to support the writers in improving the report before finalisation and publication. This guide sheet is meant to merely be a guide as you review and provide feedback and recommendations on the report.

**Objective of Peer Review:** To offer meaningful and constructive feedback on the report so as to guide the authors in improving and finalising the report.

**Title of Document:** *'SRH & HIV Integration' Good Practice Documentation: The Case of Siphofaneni*

**Name of peer Reviewer:**

**Date Submitted:**

	<b>Question</b>	<b>Comments/ Recommendations/ Observations</b>
1	Does the report provide a good description of the strategies employed by Siphofaneni?	
2	Does the document provide adequate descriptions of the <b>five features of a centre of excellence</b>	
3	Is the report strong in the use of creative methods of data sharing (e.g. pictures, illustrations, maps, illustrations etc)	
4	Is the report accurate and credible?	
5	Is the described process of Siphofaneni, as well as the articulation of the various conditions, processes and activities that have made implementation of the project in these communities valuable to other organisations working on similar projects in Swaziland	
6	Does the report provide enough detail to make replication easy?	
7	Are there any gaps that need to be filled in the report to ensure that the end product is a comprehensive report on lessons learnt and to ensure that the report is accurate and credible? Please expand.	
8	Please provide other recommendations on how to strengthen the document	

# Siphofaneni Clinic Facility Assessment Report

*Date of assessment:* Friday 16<sup>th</sup> December 2013

*Assessment team:*

- Nozipho Motsa (SRHU)
- Gcinile Nyoni (MoH)
- Sister Cordella (Lobombo Regional Supervising Officer) – Champion
- Jon Hopkins (UNFPA)

*Results by area:*

Key area	Key components
<b>Integrated service provision</b>	<ul style="list-style-type: none"> <li>• As this is a small clinic, VCT is integrated into <b>all</b> the services the clinic provides</li> <li>• <i>MNCH services:</i> As well as SRH services, a full range of HIV services are also available in the same room with the same provider.</li> <li>• <i>HIV services:</i> PMTCT is integrated into HIV services and FP and STI services are referred internally. Physically, ART is next to the maternity ward and just down the hall from the FP/ANC room, so referral between rooms is simple and facilitated by an expert client or mentor mother.</li> </ul>
 <b>Human resource capacity</b>	<ul style="list-style-type: none"> <li>• <i>Staff rotation:</i> takes place on a monthly basis, requiring all staff to know how to provide the full range of services, as well as having time to settle into each department/rotation.</li> <li>• <i>Staff complement:</i> Lacking a doctor.</li> <li>• <i>Training systems:</i> Most training is in-service and provided by ICAP and EGPAF. Staff occasionally attend external workshops.</li> <li>• <i>Training needs:</i> Identified training needs were: NARTIS, family planning, emergency maternal and neonatal care, cervical cancer screening using VIA, STIs and documentation.</li> <li>• <i>Management of human resources:</i> Staff meetings happen once a month. The senior nurse at the facility oversees all the services and the integration between them. The current staff rotation system, together with an effective internal referral system, supports the delivery of integrated services. The facility also receives frequent visits from external supervisors to check records, discuss problems, discuss technical practice and conduct staff observations.</li> </ul>

## M&E systems

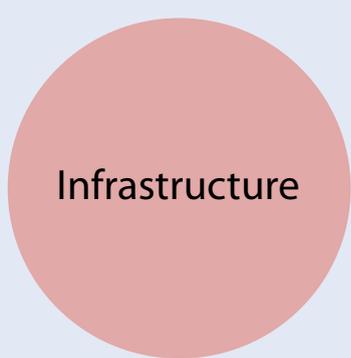
- *Data collection tools:*
  - *SRH:* The facility records whether SRH clients are receiving HIV services. More copies of some data collection tools are required, e.g. the new family planning cards and ANC cards.
  - *HIV:* The facility does not currently record whether HIV clients receive SRH services, but there is a referral form for VCT clients who are HIV-positive.
- *Referral systems:*
  - *Internal:* An informal internal referral system is in place. If a patient requires a referral to another service within the facility an expert client is buzzed to come and take the patient to the other service.
  - *External:* Standard referral forms are used for referrals to other facilities.

## Commodities, equipment and supplies

- *Commodity supply systems:*
  - *Stock-outs:* There have been no stock outs of FP commodities over the past year, but there have been some stock outs of reagents such as those for CD4, syphilis and HBV.
  - *Ordering system:* Monthly orders are placed using stock cards but FP and ART stocks ordered from two different places – FP stocks from Siteki and ART stocks from Sithobela Health Centre. Also two stocks of CTX currently are used – CTX for HIV use is free from CMS but CTX for curative use needs to be paid for.
- *Commodities available:*
  - *MNCH:* Full range of FP commodities, as well as HIV testing kits and general supplies.
  - *HIV:* In ART clinic, only male and female condoms available. Reagents for HIV related tests found in the lab. HIV testing is done throughout the facility.
- *Equipment available:* Equipment needs highlighted in previous assessment (see attachment). The key areas of need are sterilisation equipment and blood pressure apparatus.

## Quality of care

- *Quality of care system:* There is a quality improvement team at the facility made up of both facility and regional staff. The team is not currently functioning.
- *Client feedback system:* A suggestion box for clients exists and some changes have been made due to suggestions, such as spending less time on health education and the clinic gate being opened earlier in the morning for clients to start queuing.
- *Client waiting times:* Reported as being 15 minutes for STI services and 30 minutes for ANC/PNC and FP services, due to one nurse providing all these services. VCT is done in every consultation room at the same time as providing other services. ART services have the longest waiting times at over 30 minutes, as no nurse is scheduled for this so clients have to wait until a service provider is available.
- *Guidelines, policies and standards:* Generally short on up to date guidelines, policies and standards, especially HIV counselling and testing guidelines, up to date ANC guidelines and Essential Obstetric Care guidelines.
- *IEC materials:* There were not many posters displayed throughout the facility, as the facility were recently told to take down any that were not laminated for infection control reasons. There were no printed IEC materials available for clients to take away with them.



## Infrastructure

- *Physical space:*
  - Client waiting areas: Shaded with seats.
  - Signage: Clear signage outside the facility but little signage within the facility.
  - Consultation rooms: there are enough consultation rooms for SRH services but not for HIV services. For example, the ART clinic is held in the dental hygienists old office.
- *Utilities that enable provision of services:*
  - Water: Clean water is available from a bore hole with a backup water tank.
  - Electricity: Power generally reliable but there is no backup generator to ensure fridges/equipment can be used when there is a power cut.
- *Infection prevention:* No sinks available in ART and consultation rooms – they use alcohol gel. For decontaminating, cleaning and drying instruments, there is a jig but no decontamination buckets or sterilisation available. Linen washed in cold water.
- *Waste management:* There is a waste management protocol in place, which includes systems to separate waste, sharps boxes and a functioning incinerator.
- *Allows for dignified care for clients:* Whist space is limited, there are currently enough consultation rooms for confidential examinations to take place. Client toilets are available.

### *Facility perspectives on SRH and HIV integration:*

#### Constraints to offering integrated SRH and HIV services at the facility:

- *Large constraints:* Shortage of equipment; shortage of space; shortage of supplies
- *Medium constraints:* Shortage of staff training
- *Small constraints:* Shortage of staff time; insufficient staff supervision; low staff motivation
- *Not a constraint:* None

#### Impact of linking SRH and HIV services at the facility:

- *Increase:* Efficiency of services; time spent per client; need for equipment, supplies and drugs
- *Decrease:* Stigmatising of clients
- *No change:* Cost of services to facility and client; Workload for providers; space and privacy

### **Next steps**

Of the six areas that were looked at as part of the survey it was found that SRH and HIV services are well integrated within the facility, with VCT being offered in all of the consultation rooms; a referral system that meant that clients were taken between service delivery points within the facility; and strong management of human resources with a functioning staff rotation system.

The key areas that should be focused on to strengthen SRH and HIV services in the centre of excellence are:

**1. Infrastructure/equipment, commodities and supplies:**

- a. Provide sterilising equipment and other essential equipment and supplies requested.
- b. Align procurement systems for SRH and HIV supplies to reduce the time it takes to order SRH and HIV commodities from separate places.

**2. Quality of care:**

- a. Provide copies of a full range of up to date SRH and HIV guidelines, policies and standards, as well as laminated posters and IEC materials on family planning, HIV, STIs, PMTCT, pregnancy and breastfeeding.
- b. Support clients living with HIV by reducing waiting times for the ART clinic. This could be achieved by offering ART services on certain days and dedicating one member of staff to provide these services at these times. Alternatively, ART services could be integrated into one/all of the other services being offered at the facility.

**3. Human resources:**

- a. Provide training and increase mentoring provision on NARTIS, family planning, emergency maternal and neonatal care, cervical cancer screening using the VIA, STIs, and documentation.

**4. M&E:**

- a. Supply the facility with more copies of data collection tools, especially the new family planning cards and ANC cards.
- b. Support the development of a system to record whether HIV clients receive SRH services.



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