



This summary highlights the experiences, results and actions from the implementation of the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages* in Lesotho<sup>1</sup>. The tool – developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives in 2009 – supports national assessments of the bi-directional linkages between sexual and reproductive health (SRH) and HIV at the policy, systems and services levels. Each country that has rolled out the tool has gathered and generated information that will help to determine priorities and shape national plans and frameworks for scaling up and intensifying linkages. Country experiences and best practices will also inform regional and global agendas.

## RECOMMENDATIONS

### What recommendations did the assessment produce?

#### Policy level:

- The National Technical Working Committee (NTWC) should more actively and consistently participate in committees of key stakeholders in non-health sectors, in order to facilitate the coordination of broader linkage issues of women's reproductive 'rights' rather than focusing only on health service integration.
- The Ministry of Health and Social Welfare (MOHSW) and its partners should agree on the core list of essential bi-directional sexual and reproductive health (SRH) and HIV services to be integrated.
- A clear implementation protocol for sexual and reproductive health rights (SRHR)/HIV service integration should be developed and disseminated, to bring all the integration elements in the different policy documents together in one operational document with clear follow-up mechanisms.

#### Systems level:

- Prioritizing securing adequate space for HIV and SRH services within the existing infrastructural development programme.
- Advocating and creating awareness among service providers on how SRH services can effectively accommodate clients with HIV needs, without necessarily increasing their workload.
- Increasing the SRHR and HIV competency of health providers beyond existing practice, e.g. strengthening training and supervision on implementation of prevention of mother-to-child transmission (PMTCT) Prongs 1 (Prevention of HIV infection among women

of childbearing age) and 2 (Prevention of unintended pregnancies among women living with HIV).

- Strengthening strategies to scale up condom provision, including routine communication of 'dual use' messages as a minimal intervention and investigating possible provider-level constraints to provision of male condoms, e.g. cultural barriers or (dis)comfort among providers.
- Relieving clinical staff of data collation duties, but building capacity to analyse data for service planning. Revision of the current staff establishment, including recruiting data collection personnel for the HIV and SRH units, should be considered.
- Training providers on customer care, with additional motivational mechanisms, e.g. awarding certificates.
- Identifying and regularly monitoring integration indicators.

#### Services level:

- Scaling up availability of integrated SRH/HIV services to adolescents through the roll-out of dedicated adolescent services in all facilities.
- Considering developing linked services targeting men and boys, which may provide opportunities to promote male circumcision, educate men on the rights of women to make SRH decisions, and the roles of men in reducing gender-based violence (GBV) and supporting PMTCT Prongs 1 and 2.
- Undertaking population awareness programme on reproductive rights to allay fears of compromised confidentiality if the same provider offers sexually transmitted infection (STI) and HIV services.

1. This summary is based upon:

- Ministry of Health and Social Welfare (2011). Report 1. *Rapid Assessment of the Status of HIV and Sexual and Reproductive Health Linkages and Integration in Lesotho*. Prepared by African Institute for Development Policy (AFIDEP).
- Ministry of Health and Social Welfare (June 2012). Report 2. *Rapid Assessment of Status of HIV and Sexual and Reproductive Health Linkages and Integration at the Level of Service Delivery in Lesotho: Areas for Strengthening of the Original Rapid Assessment*. Prepared by O.A. Ayo-Yusuf, MPH, PhD.

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# PROCESS

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## 1. Who managed and coordinated the assessment?

The initial assessment was managed and coordinated by the African Institute for Development Policy (AFIDEP) with the logistical support of the UNFPA Lesotho office. The follow-up assessment was undertaken by O.A. Ayo-Yusuf, with technical support from UNFPA and UNAIDS. The European Union (EU) provided financial support for both assessments.

## 2. Who was in the team that implemented the assessment?

The initial assessment team was made up of AFIDEP, accompanied by two research assistants who undertook data collection and transcription. The follow-up assessment team was led by the evaluation consultant, Ayo-Yusuf, and included a staff member of the Family Health Directorate of MOHSW, the UNFPA National Project Coordinator, and a research assistant.

## 3. Did the desk review cover documents relating to *both* SRH and HIV?

The assessment involved a broad review of literature consisting mainly of HIV and SRH policy and strategy documents, service delivery guidelines (e.g. PMTCT, HIV counselling and testing/HCT), Lesotho National Health and Social Welfare Policy (2011), Lesotho Demographic and Health Survey reports, Maputo Plan of Action (2006), HIV- and SRH-related reports, and relevant published and web-based articles. Documents on the legal environment affecting HIV and SRH were also reviewed. Other documents reviewed include Annual Planning Operational Plans and unpublished reports from stakeholders.

## 4. Was the assessment process gender-balanced?

No. All except one of the 13 service providers interviewed were female. Most of the clients interviewed were female (83.3%) and all male clients were from the HIV/HCT services.

## 5. What parts of the Rapid Assessment Tool did the assessment use?

The study used some of the structured questions from the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages* for the policy level interview process; however, in addition open-ended questions were asked. For the service provider and client exit interviews, the Rapid Assessment Generic Tool was also used, though it was modified to suit the local context for service delivery. In particular, extra explanations were added by interviewers.

## 6. What was the scope of the assessment?

The overall purpose of the initial study was to help the government of Lesotho identify policy, system and service delivery gaps in SRH and HIV linkages, and provide recommendations on ways to effectively address gaps. The specific objectives of the initial study included:

- assessing HIV and SRH bi-directional linkages at the policy, systems, and service-delivery levels;
- identifying current critical gaps and opportunities for improvement in policies, programmes and services; and
- synthesizing the data obtained into information that can be utilized in the development of country-specific action plans to forge and strengthen SRH and HIV programmes linkages.

The follow-up study had the objective of studying the NTWC's comments on the initial phase of the study, ascertaining their correctness and addressing them accordingly. Specific issues addressed included additional documents to strengthen the literature review, service provider and client interviews, and other methodology-related issues.

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**7. Did the assessment involve interviews with policy-makers from both SRH and HIV sectors?**

Yes. In total, 26 representatives were interviewed, including 9 government policy-makers from both SRH and HIV, 7 donor and development partners, including UN agencies, as well as 9 representatives of non-governmental organizations (NGOs) and 1 civil society organization representative.

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**8. Did the assessment involve interviews with service providers from both SRH and HIV services?**

Yes. In total, 13 service providers (e.g. nurses or midwives) were interviewed: 5 from HIV service sites, and 8 from SRH service sites. Sites included two government and two Christian Health Association of Lesotho health facilities located in Maseru (1), Berea (2) and Mafeteng (1) districts.

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**9. Did the assessment involve interviews with clients from both SRH and HIV services?**

Yes. In total, 36 clients – 25 SRH and 11 HIV clients – were interviewed from the same sites where the service provider interviews were located.

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**10. Did the assessment involve people living with HIV and key populations?**

The Lesotho Network of People Living with HIV and AIDS (LENEPWHA) was part of the policy-level interview process. Interviews were held with officials, rather than individual members that are people living with HIV (PLHIV), so the responses were on behalf of LENEPWHA as an organization.

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# FINDINGS

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**1. Policy level**

There is high-level political commitment (e.g. Know Your Status – KYS – was launched by His Majesty King Letsie III) for bi-directional SRH and HIV linkages as well as for health reform from government and partners, including the planned decentralization of health services that would provide linkage opportunities between home-based and facility-based care. Integration commitments are fragmented in various policy and strategy documents for HIV/AIDS and reproductive health, and Lesotho does not have a specific bi-directional SRH and HIV linkages strategy.

At the policy level, all health, SRH and HIV policies and strategies developed over the past five years stress bi-directional SRH and HIV linkages. These include:

- the 2011 National Health and Social Welfare Policy
- the 2006 HIV and AIDS Policies and Guidelines
- the National HIV Prevention Strategy for a Multi-sectoral Approach to the HIV Epidemic (undated)
- National Guidelines for HIV Testing and Counselling (2009)
- Health Sector Policy on Comprehensive HIV Prevention (2010)
- the Roadmap for the Acceleration of Reduction of Maternal Mortality (2011).

In addition, a number of policies are currently under review (e.g. National Condom Strategic Plan), providing opportunities to emphasize linkages.

There are no national integration service and supervision guidelines, except for the PMTCT policy and guidelines/strategic plan which integrates SRH and includes clear indicators. However, respondents noted a number of challenges with the Elimination of Mother to Child Transmission Strategic Plan (2011), including the need to improve implementation of Prongs 1 and 2 and programmes for psychological support for HIV-positive women, as well as the need for enhanced coordination when integrating HIV services into maternal and child health (MCH) or SRH services. As such, there is strong need to streamline policies and strategies and strengthen leadership on integration.

In relation to a supportive legislative framework, laws provide for the protection of the human rights of all individuals. Although there are no laws that prohibit same-sex relationships or sex work, cultural norms and beliefs of the Basotho people do not support these practices and may, to some extent, hamper the recognition and provision of services to these groups, who are recognized in government policies as vulnerable. Provision of abortion services is prohibited by law except in cases in which the mother's life is in danger. Other aspects of the legal framework include:

- The absence of laws to protect PLHIV against stigma and discrimination, except in the workplace: employers of more than 10 people are required to put in place HIV workplace policies that protect the rights of PLHIV.
- The Sexual Offences Act of 2003, which plays an effective role in responding to GBV. The provisions of the Act have been widely disseminated and the police department has established a Child and Gender Protection Unit (CGPU) specifically to focus on investigating GBV. Although the CGPU operates countrywide, its offices are based at the district level, which is a barrier to reaching communities.
- The Legal Capacity of Married Persons Act (2006), which provides for equality between women and their husbands. Some participants felt that the law had not been effectively disseminated, hampering implementation.

Interviewees noted that there were a number of legal requirements that were either confusing or hindering service delivery, including the following:

- For women to receive tubal ligation services, they require their husband's consent.
- For young people: there are different minimum legal ages for marriage (16 years of age for girls and 18 for boys), for voting (18), for receiving HIV testing and counselling (12), and for providing consent to undergo medical procedures (21).

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## 2. Systems level

### Successes

- Improved supply of commodities, even though there is still room for improvement.
- Existing close links within medical services facilitate clinical referral.

### Gaps

- Limited supervision and monitoring of integration progress.
- Uncoordinated data requests from several donors are thought to be time-consuming and limit the time for supervision by supervisors who are required to collate this data.
- Non-sustainable reliance on donor-funded staff, e.g. mothers to mothers/m2m staff etc. The MOHSW staff establishment list was reported to have remained fixed and has not formally provided for expanding services related to increasing workload over time.

In addition, the study found that existing systems for planning, funding, human resource capacity and development, procurement, supplies and logistics for commodities, and monitoring and evaluation (M&E) do not effectively support integration, as they are primarily programme or sector specific. Significant equipment and infrastructure challenges, particularly for facilitating integration in remote areas, include:

- Lack of accessible laboratory services
- Lack of storage facilities
- Substandard examination and delivery rooms, poor lighting, and rundown facilities.

The integration experience revealed a number of systems and operational challenges that need to be addressed in order to strengthen integration, including staff shortages and inadequate skills, poor infrastructure, weak referral systems, logistical challenges in ensuring consistent availability of SRH and HIV commodities, and weak M&E systems overlaid with numerous parallel monitoring tools to be filled out.

Overall, and as captured in this quote from a UN respondent:

*"[t]he system level, as it is, is inadequate in bringing about SRH and HIV integration. It has to be strengthened for this purpose with coordination of the effort owned by MoH and backed by an efficient M&E system."*

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### 3. Services level

This study found that a significant level of integration of HIV and SRH services is occurring, but there is limited bi-directionality, with HIV services more likely to be integrated with SRH services than vice versa.

#### Successes

- Universal access to HCT (free services widely available) and rapid scale-up of HCT.
- HIV service currently well integrated with STI services.
- PMTCT is housed and well operationalized within the MCH unit.
- Adolescent health services/corners that integrate SRH with HIV services were available in at least one of the four facilities.
- Even though not as comprehensive as they should be, existing integrated services are offered at the same facility and mostly on the same day.

#### Challenges

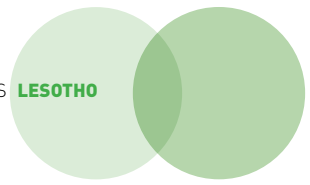
- Missed opportunities for condom provision and to communicate information on dual prevention. The influence of provider/institutional religious orientation cannot be ruled out.
- Inadequate physical space to add on new services such as HCT at some MCH services sites, thus necessitating referral to another site within the same facility.
- Lack of male participation in SRH services, particularly family planning (FP).
- Despite progress with PMTCT, there is still limited practice of comprehensive PMTCT strategies, with the current focus mainly on Prong 3 (Prevention of transmission of HIV from mothers living with HIV to their infants).

#### HIV integration into SRH

- HIV services most commonly offered with FP within SRH sites were HCT and PMTCT Prong 3.
- Maternal, newborn and child services were most likely to offer HCT, PMTCT, prevention for PLHIV and prevention information for the general population.
- Condom provision was least often offered within other SRH services, including FP.

#### SRH integration into HIV

- HIV treatment services were more likely to offer STI prevention and management (100%) and FP (40%).
- Overall, HIV services were least likely to provide prevention of unsafe abortion, provision of post-abortion care, and GBV prevention and management.



### SERVICE PROVIDER PERSPECTIVES:

- SRH and HIV integrated services are most commonly provided at the same site within the facility, on the same day and by the same provider. The next most common situation is that integrated services are provided at the same site, but by different providers. There were few referrals out of the service site.
- There was limited staff appreciation of the importance of integration for HIV prevention. In particular, some staff were reluctant to engage with issues such as prevention of GBV and care for key populations.
- When asked how SRH services have been reoriented to accommodate clients living with HIV, the most cited was staff training, especially Integrated Management of Adolescent and Adult Illness – IMAI.
- When staff were asked to recall any protocol/guidelines that they thought support integrated service delivery, the two most cited were 'PMTCT guidelines' and the 'HIV/STI guideline'.
- The most commonly reported constraints were shortage of training, shortage of space and insufficient supervision. Some providers felt that supervisors spend too much time collating data instead of supervising.
- The majority of SRH and HIV services providers felt that integration would increase the efficiency of services, but felt it might increase workload and time spent per client.
- A few noted that the current infrastructural development of outpatient departments is perceived to have enhanced staff motivation and that the additional space may enhance the extent to which integrated services are offered.

### SERVICE USER PERSPECTIVES:

- There was generally a high level of satisfaction among clients (82.9%), with those primarily receiving SRH services being more satisfied (95.2%) than those who had primarily received HIV services (60%).
- Those who received both SRH- and HIV-related (integrated) services were also more satisfied (86.7%) than those who received only SRH- or HIV-related services (76.2%).
- 42% of the clients reported that they either received or the provider mentioned an issue related to both HIV and SRH during their consultation (i.e. integrated care), independent of whether an SRH or HIV issue was the primary reason for their visit.
- While the majority (58.3%) of respondents preferred to receive SRH and HIV services at the same site, only one-third preferred to receive both services from the same provider.
- The disadvantages cited of receiving both services from the same provider included increased waiting time, providers being too busy and fear of less confidentiality and/or stigma and discrimination.

# LESSONS LEARNED AND NEXT STEPS

## 1. What lessons were learned about how the assessment could have been done differently or better?

- Additional time could have been spent adapting and focusing the data collection tools to the specific needs at country level. In particular, the tool and approach could have been further adapted to introduce the subject with more clarity prior to the assessment process.
- Involving more facilities and in particular health centres in the assessment could have provided important input on issues affecting the service entry point closest to where people live. Findings from hospital facilities may be a better representation of what happens at health centres. Nevertheless, the issues raised by providers recurred, suggesting that information saturation might have been reached.
- Involving more male clients in the service users' interview could have provided important input on issues affecting men/boys and greater gender perspectives. However, the availability of only a few men is a reflection of the reality on the ground.
- To successfully broaden the integration of SRH and HIV services, it would be critical to continue to have the meaningful commitment of government and the resources of partners. It will be of great importance that integrated services maintain high quality of care through trained staff and reliable supplies.

## 2. What 'next steps' have been taken (or are planned) to follow up the assessment?

Next steps planned include:

- Holding a dissemination workshop to discuss findings and recommendations with MOHSW and partners at local, district and national levels, including National AIDS Commission.
- Reviewing the gaps noted in strategic issues in individual meetings with appropriate sector leaders, such as senior policy decision-makers in the SRH and HIV programmes and other ministries such as Ministry of Education, Gender etc.
- Discussing the implications of findings with personnel in charge of pre-service (nursing school) and in-service training for the health services in general and HIV programmes in particular. This might mean working with them to adjust curricula or institutional training policies to include creating linkages between SRH and HIV policies, systems and services.
- Reviewing findings with those responsible for behavioural change communication from both the HIV and SRH programmes to identify how linkages can be strengthened in mass communication and public education programmes (especially as there are limited posters and information, education and communication/ IEC materials available and clients expressed concerns regarding compromised quality of care that may result from integration, which need to be addressed using appropriate IEC).
- Accessing funding from partners to develop action plans and to operationalize recommendations and activities to broaden SRH and HIV integrated services.



## LESSONS LEARNED AND NEXT STEPS CONTINUED

### 3. What are the priority actions that are being taken forward as a result of the assessment, at the:

- policy level?
- systems level?
- services level?

#### Policy level:

- The National Condom Strategic Plan is currently being developed. Although the development of the Condom Strategy is not a direct result of the Rapid Assessment, the MOHSW felt compelled to integrate SRH and HIV for the dual purpose nature of the condom as a commodity. The Joint UNFPA/UNAIDS regional project on Linking SRHR and HIV in Southern Africa staff were vigorously consulted and they provided important information related to the strategy.
- The project has engaged the consultant, who is currently reviewing the integration and linkages of all SRH and HIV documents, tools and instruments to ascertain the bi-directional linkages.
- The project has reactivated the SRH National Technical Committee to oversee the project and other initiatives on both SRH and HIV themes.

#### Systems level:

- For the next budgeting year, it is intended to plan the SRH and HIV initiatives together to avoid duplication and competition between the two units.
- Procurement of SRH and HIV units is currently done jointly.
- Space constraints could be addressed with ongoing infrastructural development and proposed renovation of maternity wards.

#### Services level:

- Joint UNFPA /UNAIDS regional project on Linking SRHR and HIV in Southern Africa activities are to commence in August 2012, following discussions in July. The project is piloting integrated and/or ongoing initiatives in three districts, with a plan to focus vigorously on three facilities and document lessons for wider dissemination (part of Result Area 3 of the project).
- The three focus facilities are a government facility and two NGO facilities.
- There will be orientation of staff, purchase of equipment, development of key messages through IEC materials, testing the task shifting concept, study tours etc.
- There are specific outputs and areas for lessons to be documented.

### 4. What are the funding opportunities for the follow-up and further linkages work in the country?

- The main SRH programme funders are UNFPA and the Lesotho government. Others include Irish Aid, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), WHO, Population Services International and UNICEF.
- The main HIV programme funders include the Lesotho government, GFATM and the US President's Emergency Plan for AIDS Relief/US Agency for International Development, US Centers for Disease Control, German Agency for International Development and German Development Bank, World Bank, African Development Bank, Population Action International, Irish Aid, Pact, UK Department for International Development (up to March 2011), EU, Millennium Change Account and Millennium Change Compact, and UNESCO.

## Abbreviations

<b>AFIDEP</b>	African Institute for Development Policy
<b>AIDS</b>	acquired immune deficiency syndrome
<b>CGPU</b>	Child and Gender Protection Unit
<b>EU</b>	European Union
<b>FP</b>	family planning
<b>GBV</b>	gender-based violence
<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>GNP+</b>	Global Network of People Living with HIV/AIDS
<b>HCT</b>	HIV counselling and testing
<b>HIV</b>	human immunodeficiency virus
<b>ICW</b>	International Community of Women Living with HIV/AIDS
<b>IEC</b>	information, education and communication
<b>IPPF</b>	International Planned Parenthood Federation
<b>LENEPHWA</b>	Lesotho Network of People Living with HIV/AIDS
<b>M&amp;E</b>	monitoring and evaluation
<b>MCH</b>	maternal and child health
<b>MOHSW</b>	Ministry of Health and Social Welfare
<b>NGO</b>	non-governmental organization
<b>NTWC</b>	National Technical Working Committee
<b>PLHIV</b>	people living with HIV
<b>PMTCT</b>	prevention of mother-to-child transmission (of HIV)
<b>SRH</b>	sexual and reproductive health
<b>SRHR</b>	sexual and reproductive health rights
<b>STI</b>	sexually transmitted infection
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>VCT</b>	voluntary counselling and testing
<b>WHO</b>	World Health Organization

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