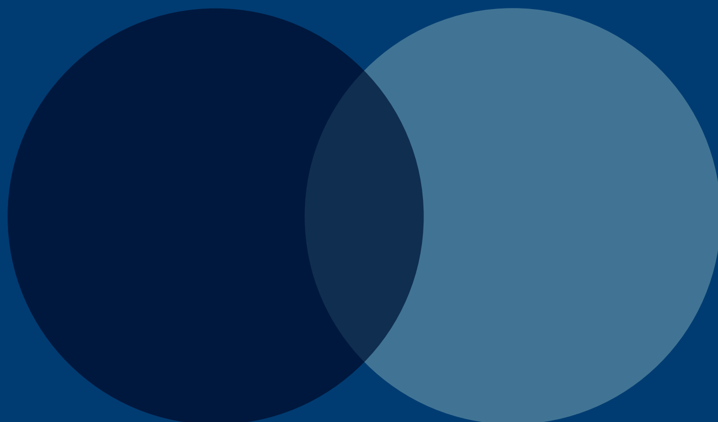
RAPID ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES



IPPF International Planned Parenthood Federation

UNFPA

World Health Organization

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
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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 Zambia[1]. 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:

- Developing one health policy which addresses issues of SRH and HIV integration and linkages comprehensively.
- Highlighting gender-based violence (GBV) prevention and management in all health and related policies.
- Strengthening the monitoring and evaluation (M&E) framework to include SRH and HIV integration.
- Promoting specific studies to inform policy-makers about the status of SRH and HIV linkages.

Systems level:

- Harmonizing the SRH and HIV planning and management processes at national level.
- Strengthening coordination among partners and donors on SRH and HIV.
- Recruiting more health workers.
- Giving special training to all health workers on the integration and linkages of SRH and HIV services. There is also need to strengthen counselling skills among physicians.
- Ensuring follow-up after staff training in facilities to ensure that staff adhere to recommended guidelines.
- Strengthening M&E structures from the policy to service delivery levels in order to improve service quality.
- Undertaking joint monitoring of SRH and HIV programmes by the Ministry of Health (MoH) and non-governmental organizations (NGOs).
- Allocating specific budgets for SRH and HIV integration, including implementation and monitoring.

Services level:

- Developing an SRH and HIV service integration strategy.
- Ensuring the availability of protocols and guidelines for SRH and HIV service integration in facilities.
- The government should ensure that there are appropriate family planning (FP) referrals for clients of Catholic Church-run facilities or set up special FP facilities nearby to enable clients' access to FP services.

1. This summary is based upon: *Nationwide Rapid Assessment of the Status of HIV and Sexual and Reproductive Health Integration and Linkages*, Zambian Ministry of Health and United Nations Population Fund, July 2011.

PROCESS

1. Who managed and coordinated the assessment?

The MoH, with technical and financial support from UNFPA.

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

The review was carried out by a team of consultants (Bushimbwa Tambatamba and Namuunda Mutombo), who undertook the document review, data collection and analysis. Two research teams were formed and trained by the consultants, with each team comprising one consultant and three research assistants (Dr Cheswa Vwalika, Ms Cherry Kashale, Ms Tamba Tambatamba, Ms Elizabeth Nyirenda, Ms Maluba Sikopo and Mr Lumamba Mubbunu).

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

Yes. A desk review was undertaken of 15 policies and/or plans that have implications for SRH and HIV.

4. Was the assessment process gender-balanced?

This was unclear, as the Rapid Assessment did not request gender disaggregation. There were:

- 2 consultants: 1 male and 1 female
- 6 research assistants: 1 male and 5 female
- 203 clients exiting services: 18% male and 82% female.

However, regarding the 4 policy-makers, 19 managers and 79 service providers, there was no gender disaggregation.

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

A cross-sectional study was undertaken in nine (9) of Zambia's districts using adapted questionnaires (A, B, C and D) from the Rapid Assessment Tool.

6. What was the scope of the assessment?

The objectives were to:

- Assess HIV and SRH bi-directional linkages at the policy, systems, and service delivery levels.
- Identify current critical gaps in policies, programmes and services.
- Synthesize the data obtained into information that can be utilized in the development of country-specific action plans to forge and strengthen SRH and HIV programme linkages.

Three hundred and five (305) interviews were conducted with selected policy-makers, programme managers, service providers and clients.

The service delivery sites were selected from 9 districts, including both provincial headquarters and rural, and from 5 provinces, including Lusaka, the capital. The 9 districts and 5 related provinces were: Chipata and Nyimba Districts (Eastern Province); Mansa and Samfya (Luapula); Lusaka (Lusaka); Kasempa and Solwezi (North-Western); and Mongu and Senanga (Western).

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

Yes.

- At the national level, in all, 12 institutions and organizations were identified for interviews; however, only 4 completed the questionnaire (Dr Malumo, National Programme Officer, Reproductive Health/RH, UNFPA; Dr Moyo Crispin, Antiretroviral Therapy/ART Coordinator, MoH; Dr Alex Simwanza, Director, Prevention and Mitigation, National AIDS Council/NAC; and Kunyima Banda, Programmes Manager, Network of Zambian People Living with HIV/NZP+).
- At the district and sub-district levels, 19 key informants, 80% of whom managed hospitals and provincial or district health offices, were interviewed.

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

Yes: interviews were conducted with 79 service providers from health facilities in which SRH and/or HIV services are being provided. Of these, 60% were from public health facilities, 15% each from private and faith-based organization (FBO) health facilities; and 10% from NGO health facilities.

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

Yes: 203 respondents were recruited from SRH and HIV facilities. In principle, 4 clients were interviewed per facility; however, in some cases fewer clients were interviewed, due to non-availability, while at some facilities more than 4 clients were interviewed.

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

Yes: one informant was interviewed from NZP+, which is an organization for people living with HIV. In addition, there could have been clients interviewed who were HIV positive but remained unidentified.

FINDINGS

1. Policy level

National policies, plans and guidelines:

The MoH aims to provide equity of access to cost-effective, quality health services as close to the family as possible. Policies are guided by the contents of the Sixth National Development Plan (2011–2015), in general, and the National Health Strategic Plan (2011–2015), in particular.

Based on these documents, various policies are in place to guide programming for HIV and SRH, including:

- **National Reproductive Health Policy (2008**). This aims to provide "high-level quality and affordable integrated reproductive health services" and states the need for FP integration with HIV and sexually transmitted infection (STI) services, enhancing male involvement, providing prevention of mother-to-child transmission (PMTCT) services to all pregnant women and their families, and training of service providers at all levels. The policy does not address the needs of key populations, including people living with HIV, and integration of the SRH care package with HIV.
- **National HIV/AIDS/STI/TB Policy (2005)**. This policy does not specifically discuss the importance of SRH and HIV linkages, though it does identify key populations including people living with HIV, young people, women with low socio-economic status, orphans and vulnerable children as needing special HIV-related services.
- **National AIDS Strategic Framework (2011–2015)**. The guiding principles of the strategic framework include HIV integration with other facility-based services, such as SRH. The framework provides for linkages and integration, although more emphasis should have been made on how this would be achieved.
- **NAC National Strategy for the Prevention of HIV and STIs (2009–2014)**. The strategy outlines comprehensive SRH and HIV linkages, including linking RH and HIV in school health programmes and integrating FP with STI and HIV services.

In addition, the **NZP+ Sexual Reproductive Health and HIV/AIDS Integration Strategy (2009–2012)** elaborates on implementation and funding gaps, outlining actions for integrated SRH and HIV programmes primarily for people living with HIV.

Most policies indicate a high level of SRH and HIV integration, though there are too many documents addressing similar issues. For example, the MoH has separate policies on adolescent health, RH and child health which could be combined into a comprehensive policy. Furthermore, most documents discussing integration are HIV- rather than SRH-based. Integration at the policy level is a gap that needs to be resolved.

Despite the low number of policy interviewees (4), there seems to be a lack of programme integration at the policy level. Policy-makers seem to have little information on linkages with other policies/programmes. For example, it was unclear whether respondents understood if HIV and SRH policies address social, legislative, policy and community attitudes towards key populations.

Legal framework:

Policy-makers were aware of laws criminalizing men who have sex with men, and drug use, as well as anti-discrimination laws, although interviews did not go into details about penalties.

2. Systems level

Partnerships:

- 40 organizations were mentioned as HIV and SRH programme development partners, with 50% being major development partners in both programmatic areas.
- Apart from the MoH, the Centre for Infectious Disease Research in Zambia (CIDRZ), Zambia Prevention, Care and Treatment (ZPCT) and World Vision are major champions of SRH and HIV linkages.
- The main SRH partners are UNFPA and MoH.
- There were more major development partners for HIV, with the most commonly mentioned being CIDRZ, ZPCT and Centers for Disease Control and Prevention (CDC).
- There is a general lack of coordination among SRH and HIV partners at the implementation level, resulting in duplication in some areas and under-service in others, affecting the flow of information from communities to the national level.
- The majority of systems level managers were certain that people living with HIV (80%) and young people (70%) were involved in both the SRH and HIV responses, although they were unsure about other key populations. Furthermore, over 50% said that young people were more involved in SRH and HIV situation analysis and implementation than in planning.

Coordination:

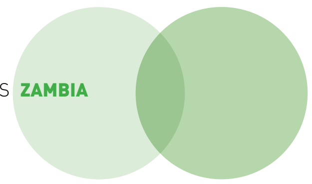
- Within the MoH, there is no joint SRH and HIV planning and budgeting for programmes. For example, RH and HIV prevention, care and support services are administered through the MoH's Public Health Department, while treatment and pharmaceutical services are under the Clinical Care Department. The RH unit is further subdivided into safe motherhood, FP and adolescent health, child health and PMTCT.
- The Interagency Coordinating Committee, chaired by the MoH and attended by all heads of UN and bilateral cooperating partners involved in SRH and child health services, plays a large role in advocacy for and creating financial commitment from government, NGOs and private partners.
- Coordination mechanisms for each programme need to be linked from the district to national levels.

Human resources and capacity building:

- There is a serious shortage of staff. Without more human resources, integrating HIV and SRH will create impossible workloads for health care providers managing programmes.
- Human resource distribution and retention schemes have been developed to facilitate relative equity in staff distribution.
- Other initiatives to address shortages include:
  - Training of lay counsellors, community health workers and traditional birth attendants.
  - Development by the MoH of fast-track training packages for nurses.
  - Opening of training institutions for doctors and nurses in the private and public sectors.
  - Reopening and refurbishment of nursing schools.
- All health personnel need some form of training. The most common skills needed are training in SRH and HIV integration, particularly for nurses, and training in counselling for physicians.
- Respondents cited workload and burnout (89.5%), and service quality (68.4%) as the greatest staff-related challenges. Others included recruitment, task shifting and retention.
- Solutions included:
  - additional incentives;
  - increased recruitment;
  - monitoring;
  - training in quality assurance;
  - involvement of community volunteers.
- SRH and HIV service delivery guidelines/protocols have been developed and distributed to health facilities. However, very few are being used. More HIV-related guidelines are being referred to than SRH guidelines, many of which are outdated.

Logistics and laboratory support:

- 95% of respondents stated that laboratory facilities were serving both SRH and HIV service needs.



- Support systems such as laboratory, transport, and M&E need to be reorganized in order to integrate SRH and HIV services, from planning and budgeting through to implementation.

Monitoring and evaluation:

- Weak M&E structures may compromise service quality: in particular, there is no M&E of client satisfaction.
- Fewer than half of respondents (47%) indicated that M&E captures SRH and HIV integration.
- Fewer than half of respondents (47%) stated that there were no tools for integrated supervision.
- 80% of data is disaggregated by age and sex, although only 53% is disaggregated by HIV status.

3. Services level

A. SERVICE PROVIDER PERSPECTIVES

- There are higher levels of SRH and HIV service integration at the service delivery level than at the policy and systems levels, particularly in rural facilities where limited space and staff have forced facilities to offer services using the same rooms and service providers.
- Services with high levels of bi-directional linkages include:
  - HIV counselling and testing (HCT), FP and STI prevention and management.
  - Psychosocial support and FP.
  - Prevention for and by people living with HIV, prevention of unsafe abortion, and management of post-abortion care.
- There are more linkages to SRH services for clients who access HIV services than vice versa.
- Over 80% of service providers indicated that SRH services have been reoriented to accommodate HIV.
- High levels of FP referrals are due to the number of Catholic Church-owned health facilities, which do not offer FP, although they do offer condoms for HIV-positive people, especially serodiscordant spouses.
- There are inadequate mechanisms for follow-up of referrals.
- Major constraints include staff time, space to offer private and confidential services, and low staff motivation.
- Most service providers stated that HIV and SRH service integration would enhance efficiency and reduce stigmatization but cited additional workload, increased demands for equipment, supplies and drugs, and increased costs and time per client as major concerns.

B. SERVICE USER PERSPECTIVES

- Clients interviewed sought various services, the most common being mother and child health (MCH) (45%), and HIV monitoring and/or treatment (31%). Approximately 25% received the services they were seeking on the day, due in large part to most health facilities, especially in rural areas, having assigned days for specific services. People who could not receive services were referred to other facilities.
- 88% of clients stated that they received all services sought. The main reason given for not receiving a service was its non-availability (68%).
- 77% of clients preferred receiving both SRH and HIV services at the same health facility, with this preference stronger in rural areas. Advantages cited were: reduced number of trips and transport costs, and improved efficiency. Disadvantages cited were: provider will be too busy, and increase in waiting time.
- 53% of clients did not want to be served by the same health care provider, as one provider may not have the necessary skills to deal with both SRH and HIV.
- 60% of clients were very satisfied with the services being provided, with rural clients indicating the highest levels of satisfaction.
- In terms of improving SRH and HIV service integration, suggestions included increased staffing and supply of antiretroviral (ARV) drugs, and opening laboratories in all facilities.

LESSONS LEARNED AND NEXT STEPS

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

- The response level of policy-makers could have been improved, e.g. by calling them to a meeting to answer the questionnaire.
- Two days were allocated per district, which was challenging when respondents were unavailable or busy.
- Data collection in Luapula Province was affected by riots.
- Sampling:
  - Purpose samples are prone to sampling errors.
  - The rapid assessment (RA) guidelines stipulate the inclusion of government, private, NGO and FBO facilities; however, there are districts without all these.

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

- The Adolescent Health Technical Working Group (TWG) reviewed the RA report and recommended:
  - linking RA findings to other similar SRH and HIV integration assessments;
  - developing advocacy materials;
  - developing a policy brief;
  - organizing a high-level RA dissemination meeting.

RA recommendations informed the development of the 2012 work plan.

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:

- Ensuring that SRH and HIV integration are included in the Health Policy.
- Developing policy briefs on SRH and HIV integration for policy-makers, UN agencies, community leaders and stakeholders.
- Advocating with NAC to participate in MoH's SRH and HIV TWG.
- Mapping and reviewing upcoming policies, and planning reviews to address linkage priorities.
- Advocating for the revision of the Sexuality Education Curriculum to include HIV.

Systems level:

Technical consultations

- Engaging stakeholders on bottlenecks and facilitating implementation of RA recommendations.
- Supporting full operationalization of the Adolescent Health TWG.
- Identifying operational research to support integration, e.g. access to integrated services for females of 15–24 years of age.
- Holding national consultations on age disparity for consensual sex and marriage.

LESSONS LEARNED AND NEXT STEPS
CONTINUED

Advocacy

- Advocating and supporting joint planning, budgeting, supportive supervision and joint annual reviews by the HIV and RH units, as well as between MoH and partners.
- Advocating and supporting the Ministry of Education (MoE) to deliver (age-appropriate) comprehensive sexuality education curricula in schools and in pre-service and in-service training curricula for teachers.

Strategy development

- Supporting the MoH and MoE to:
  - finalize the Adolescent Health Strategic Plan;
  - advocate with complementary projects (CIDA), EU grants on maternal, newborn and child health (MNCH), and World Bank on Results-Based Financing; and
  - support the adoption of the MNCH Roadmap.

Capacity building

- Collaborating with the USAID-funded Zambia Integrated Systems Strengthening Program and partners to support the MoH's SRH and HIV integration mentorship and supervision programmes.
- Strengthening the capacity of civil society organizations (CSOs), people living with HIV and key populations to meaningfully engage in consultations and advocate.

Services level:

- Refurbishing youth-friendly corners as a model of service delivery.
- Supporting capacity building of health workers to provide youth-friendly services.
- Creating demand for linked SRH and HIV services in communities.

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

- HIV funding: mostly by the government and donors (mainly GFATM and PEPFAR). Government funding covers drugs and supplies for clinical care units while the rest is covered through public health programmes.
- SRH funding: by the government and donors, including for commodities, e.g. FP, equipment and medical supplies. Commodities are funded through the MoH Directorate of Public Health and also the Directorate of Clinical Care and Diagnostic Services. UNFPA, WHO and bilateral partners support equipment and supplies, training and budgets.

Abbreviations

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
CIDA	Canadian International Development Agency
CIDRZ	Centre for Infectious Disease Research in Zambia
CSO	civil society organization
EU	European Union
FBO	faith-based organization
FP	family planning
GBV	gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+	Global Network of People Living with HIV/AIDS
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
M&E	monitoring and evaluation
MCH	maternal and child health
MNCH	maternal, newborn and child health
MoE	Ministry of Education
MoH	Ministry of Health
NAC	National AIDS Council
NGO	non-governmental organization
NZP+	Network of Zambian People Living with HIV
PEPFAR	US President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission (of HIV)
RA	rapid assessment
RH	reproductive health
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization
ZPCT	Zambia Prevention, Care and Treatment

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