

Amplifying Lessons Learnt from the Implementation of the Joint Programme to Strengthen Integrated SRHR, and HIV and SGBV Services

A Case Study in the Eastern Cape and KwaZulu-Natal Provinces



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Umthombo weMpilo Institute



Published by Human Sciences Research Council
Private Bag X9182, Cape Town 8000, South Africa
www.hsrc.ac.za

ISBN print 978-0-6397-2266-5

ISBN eBook 978-0-6397-2267-2

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Research conducted on behalf of UNFPA South Africa and East and the Southern African Regional Office

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Prepared by: Zungu NP, Naidoo I, Gumede T, Manzini-Matebula N, Babatunde S, Dana N, Ndlovu P, Vondo N, Takatshana S, and the 2gether 4 SRHR Team. (2022). Amplifying Lessons Learnt from the Implementation of the Joint Programme to Strengthen Integrated SRHR, and HIV and SGBV Services: A Case Study in the Eastern Cape and KwaZulu-Natal Provinces. Pretoria: Human Sciences Research Council.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adolescents Living with HIV
AGYW	Adolescent Girls and Young Women
ANC	Antenatal Care
ART	Antiretroviral Treatment
ARV	Antiretroviral
AYFS	Adolescent and Youth Friendly Services
CAC	Comprehensive Abortion Care
COVID-19	Coronavirus – 2019
CBOs	Community-based organisations
CCMDD	Central Chronic Medicines Dispensing and Distribution
CSE	Comprehensive Sexual Education
CTOP	Choice on Termination of Pregnancy
DHIS	District Health Information System
DHMT	District Health Management Team
DoH	Department of Health
EC	Eastern Cape Province
GBV	Gender-Based Violence
HCT	HIV Counselling and Testing
HCW	Healthcare Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HSRC	Human Sciences Research Council
HTS	HIV Testing Services
ICF	(Originally) Inner City Fund
ICM	Ideal Clinic Model
ICSM	Integrated Clinical Services Management
IUCD	Intra-uterine Contraceptive Device
IMCI	Integrated Management of Childhood Illness
KZN	KwaZulu-Natal Province
LARC	Long-Acting Reversible Contraception
LIVES	Listen, Inquire, Validate, Enhance Safety and Support
MTCT	Mother-to-Child Transmission
MCWH	Maternal, Child and Women's Health
NCD	Non-Communicable Disease
NDoH	National Department of Health
NGO	Non-Governmental Organisations

NHI	National Health Insurance
NICD	National Institute of Communicable Diseases
NIMART	Nurse Initiated Management of Antiretroviral Treatment
PDSA	Plan, Do, Study, Act cycle
PEP	Post-Exposure Prophylaxis
PHC	Primary Healthcare
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PoC	Package of Care
SADC	South African Development Community
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infection
SGBV	Sexual Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and reproductive health and rights (SRHR)
TB	Tuberculosis
TCC	Thuthuzela Care Centres
TOP	Termination of Pregnancy
TWG	Technical Working Group
UNAIDS	United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UWI	Umthombo weMpilo Institute
VCAT	Values Clarification and Attitude Transformation
WBOT	Ward-Based Outreach Team
WHO	World Health Organisation

ACKNOWLEDGEMENTS

Our sincere appreciation to colleagues from the HSRC who assisted in the finalisation of this report. We thank Dr Tawanda Makusha for reviewing and proof reading the report. We also want to thank Mr Frederick Tshitangano for designing the district maps used in the report, Ms Yolande Sean who assisted with the formatting as well as Ms Ilze Visagie and Ms Lindiwe Mashologu who designed the graphics used on the cover. We thank Mr Vernon Joshua and his team who assisted with copy editing and typesetting the final report.

Background and context

The United Nations Population Fund (UNFPA) has a long history of working with governments, communities, and partners to promote universal access to quality, integrated sexual and reproductive health (SRH) services. During the 2017 to 2022 period, and in collaboration with the South African National Department of Health (NDoH), the UNFPA partnered with Optidel Global and Umthombo weMpilo Institute (referred to as the implementers) to incorporate and implement integrated service delivery models in selected health facilities in the Eastern Cape and KwaZulu-Natal provinces. The three districts chosen were Alfred Nzo and OR Tambo in the Eastern Cape and uThukela in KwaZulu-Natal. The implementing partners documented the implementation processes and findings at different stages of the intervention.

The UNFPA commissioned the Human Sciences Research Council (HSRC) in 2021 to conduct a desktop review, synthesise the project data, and compile a report based on the UNFPA Guidelines for Documenting Promising Practices. Here we summarise the processes and results emanating from the implemented interventions. We highlight lessons learnt and emerging promising practices, and we conclude with recommendations for the scaling up of this project.

Intervention: Processes to deliver integrated services in selected health facilities in Eastern Cape and KwaZulu-Natal

The intervention was rolled out in three phases: baseline, pilot, inception and scale-up. Baseline assessments were conducted in 2017. Pilot studies were undertaken in six facilities in Alfred Nzo District, four facilities in OR Tambo District, and five facilities in uThukela District.

Once the baseline assessments were completed, inception activities commenced. These formed part of the rollout of the intervention in 2018. From 2019 to 2021, the scaling up of the interventions was rolled-out in 10 healthcare facilities in OR Tambo District, and 10 healthcare facilities in Alfred Nzo District. There were annual assessments of progress in implementing the intervention within the selected health facilities. Those facilities showing successes were handed over to the Eastern Cape Department of Health and new health facilities were added. In uThukela District, the intervention was first implemented in 12 health facilities from 2019 to 2020; and from 2021 to 2022, it was expanded to 53 health facilities across the three districts.

Intervention: Description of intervention models applied in selected health facilities in Eastern Cape and KwaZulu-Natal

The integration models were adapted from the policy guideline contained in the Ideal Clinic Model (ICM). Optidel Global used a quality improvement methodology based on the Plan, Do, Study, Act (PDSA) cycle – which is also referred to as the 2gether 4 SRHR Model.

Umthombo weMpilo Institute supported the implementation of two models: (1) the supermarket model, which offers all services during the same visit under the same roof; or (2) the one-stop-shop/kiosk approach, in which the health facility is structured to offer comprehensive health services during the same visit by one provider in the same consultation room.

In the next section, we describe baseline and end-line assessment results for selected sexual and reproductive health and rights (SRHR) indicators per district. The results are presented in terms of process (proportion of healthcare workers trained, and client exit interviews), the positive changes observed, and the impact of the interventions.

Results

Assessments of selected indicators at baseline and end-line phases: At baseline, implementers reported on selected SRHR, HIV, and Sexual Gender-Based Violence (SGBV) indicators to establish the status of SRHR/HIV integration at the facility level. In OR Tambo District, seven indicators were reported from four health facilities.

In Alfred Nzo District, nine indicators were reported from six health facilities, and in uThukela District, nine indicators were reported from 12 health facilities. Generally, the provision of services to clients seeking assistance for GBV (aligned with indicators 11¹ and 17²), cervical cancer screening (aligned with indicator six³), prevention of unsafe abortions, and post-abortion management, were low before the intervention. Overall, the results showed that in most health facilities only one SRHR service was received by clients at baseline assessment, and this increased to three services available to clients at the end-line assessment. For example, in 2021, OR Tambo District health facilities reported an improvement in the integration of SRHR and GBV services.

1 Indicator 11 is the total number of clients accessing SGBV services.

2 Indicator 17 is the percentage of clients who received two or more SRHR, HIV and SGBV services.

3 Indicator six is the percentage of clients accessing services at family planning service delivery points who were screened for cervical cancer.

Healthcare worker skills audit at baseline and end-line phases: Strengthening human resources for service provision was identified as a critical focus area needing appropriate intervention. For example, the facilities skills audit in five health facilities in Alfred Nzo and OR Tambo Districts found that less than 30% of healthcare workers were trained in all service areas reviewed by the implementers. In 2020, OR Tambo District reported that there was a gap in the training of healthcare workers in delivering SGBV services. By 2021, improvements were noted – particularly in using the listen, inquire, validate, enhance safety and support (LIVES) approach. Clients were offered emergency prophylactic treatments as well as referrals to other resources and services. Furthermore, healthcare worker training was gradually yielding results in the form of improved uptake of long-acting reversible contraception, and in Alfred Nzo District, the facilities met the five minimum standards for adolescent and youthfriendly services (AYFS). Similarly, in uThukela District, it was reported that the formal comprehensive SRHR training targets, including in-house and facility-level training, were achieved by 2022.

Client exit interviews at baseline and end-line phases: Overall, during baseline assessments 70% (n=200) of clients welcomed receiving integrated SRHR and HIV services in one facility. However, clients expressed concerns about long waiting times, staff workload, and healthcare worker skills deficits. During the end-line assessment, it was observed that there was an increase in the uptake of services. On average, one additional SRHR service was received, and a greater variety of services (two services versus five) were offered to clients, this contributed to improved client satisfaction. For example, in uThukela District, the client satisfaction rate increased to over 80% at the end-line assessment (with some changes observed due to the emergence of COVID-19 between 2020 and 2021).

Challenges

The impact and challenges of the COVID-19 pandemic were reported in 2020-2021. During certain lockdown levels clients were unable to travel inter-provincially to access services at health facilities where they normally receive care. Service provision, mentoring, and supervisory visits were also adversely affected. Other ongoing challenges included some health facilities experiencing stock-outs of commodities – specifically contraceptives – and sometimes inefficient referral systems to other health facilities. Healthcare workers did not always have an enabling environment to accommodate SRHR service integration. This was due to limited or antiquated health facility infrastructure and high staff turnover. This in turn negatively impacted the client flow within some facilities. Education materials such as flyers and posters containing SRHR information for clients were not always available in local languages.

The annual approach to contracting between the donor and the implementers often reduced the time available for implementation and created a vacuum between the baseline assessment, pilot, and scaling-up phases. These findings and challenges shaped the lessons learnt throughout the implementation process.

Lessons learnt

Implementation using the three-phased approach (baseline, pilot, inception, and scale-up) contributed to the reported successes. The approaches needed to be agile and adaptable, as was observed when COVID-19 needed rapid containment. The utility of the phased intervention approach was demonstrated through facility baseline assessments followed by a pilot phase before the implementation. This phase should include a healthcare workers skills audit and identification of skills and competency deficits. It should further incorporate a mapping and scoping exercise to understand the policy level and the facility level landscape, which includes seeking to understand how health facilities function, whilst engaging stakeholders at facilities and district levels, as well as provincial and district health management teams. The insights gained through such a phased approach were critical for supporting linkages and referrals of clients at the facility level, as well as the provision of sustained mentorship and supportive supervision beyond the intervention process.

Results from the documentation exercise can be described as emerging promising practices⁴ because they highlight innovations that can inform further rigorous research and practice. Three broad emerging promising practices were identified, namely: (1) strengthening the health system to achieve person-centred and coordinated care; (2) improving the interface among health workers, clients, and other stakeholders; and (3) strengthening access to education and information, data collation tools and monitoring processes.

Conclusion and recommendations

Overall, the SRHR integration models showed success and they should continue to be scaled up in the selected provinces and beyond. The lessons learnt and emerging promising practices should be used for adaptation of the intervention in the scale-up to other health facilities. Key recommendations pertained to a need for standardised monitoring templates and guidelines, and data collection and reporting templates. This will mitigate the risk of missing data at the facility level and ensure SRHR components are comprehensively reflected in the implementers annual progress reports. There is a need for consensus on a basic model of SRHR integration, which includes the minimum SRHR indicators that should be monitored and reported by each facility. In terms of planning and continuity, the annual approach to contracting between UNFPA South Africa and the implementers should be revisited. There is also a need to mitigate facility-level human resources and infrastructure challenges, including investment in technology to enable ease of communication, and access to training materials and trainers using virtual platforms. Implementers and funders should ensure the sustainability of the intervention and provide ongoing supervision, technical support, and monitoring of the health facilities that are transitioning off the intervention. Finally, we recommend the adoption of a research approach as part of systematic documentation and scaling up of SRHR integrated interventions.

⁴ Emerging promising practices are defined as interventions that are new, innovative, and hold promise based on some evidence of effectiveness or observed change during the intervention (Canadian Homelessness Research Network, 2013 & WHO, 2017).

Background and introduction

In 2021, the United Nations Population Fund (UNFPA) commissioned the Human Sciences Research Council (HSRC) to conduct a desktop review and synthesise data from sexual reproductive health (SRH) intervention projects implemented in three districts in South Africa. These districts were Alfred Nzo and OR Tambo in the Eastern Cape (intervention conducted by the Umthombo weMpilo Institute), and uThukela District in KwaZulu-Natal (intervention conducted by Optidel Global). The scope of work was undertaken by the HSRC from November 2021 to December 2021, and from April 2022 to July 2022. In total, the HSRC reviewed and synthesised 20 project reports compiled by the two service providers. The focus of the review was to document innovation and best practices in the implementation of the integrated sexual and reproductive health and rights (SRHR), HIV, tuberculosis (TB), and sexual and gender-based violence (SGBV) in the selected health facilities.

The UNFPA¹ was founded in 1969 with a mission to ensure that every pregnancy is desired, every delivery is safe, and every young person's potential is realised. UNFPA provides reproductive health services to people in more than 150 countries, which translates to approximately 80% of the world's population. It also supports over one million pregnant women at risk of life-threatening conditions per month. UNFPA partners with governments to strengthen their health systems, promote access to integrated SRHR services, and train healthcare workers. UNFPA² country support is also aimed at ensuring that countries can achieve the Sustainable Development Goals (SDGs) “including regional and global targets aimed at fast-tracking the ending of AIDS as a public health threat and providing universal access to SRHR by 2030”.

The UNFPA South Africa, in collaboration with the South African National Department of Health (NDoH), the Eastern Cape and KwaZulu-Natal Provincial Departments of Health, set out to incorporate and implement the integration of SRHR, HIV, TB and SGBV services in three districts. The intervention included training, mentoring of healthcare workers, and monitoring and integration of these services into national and sub-national human resource plans for healthcare workers to ensure the provision of quality client-centred integrated SRHR, HIV, TB and SGBV services.

The structure of this report follows the reporting outline presented in the Guidelines for Promising Practice provided by the UNFPA.

1.1 The sexual and reproductive health and rights context (SRHR)

In this section, we will describe the sexual and reproductive health and rights (SRHR) context in South Africa. The importance of linking SRHR and HIV services was identified in 1994 at the International Conference on Population and Development and is now well recognised. Hopkins and Collins (2017) assert that the three-tier link between SRHR, HIV, and SGBV is important at policy, health systems, and service delivery levels. In reviewing SRHR and HIV strategies in 60 countries – including South Africa – they observed that several countries acknowledged this link and therefore the importance of driving these three services from idea to policy and ultimately to action. Due to the high rates of

1 <https://www.unfpa.org/about-us>

2 <https://esaro.unfpa.org/en/topics/what-are-we-aiming-towards?page=184%2C5>

HIV infections among young people coupled with GBV in South Africa, the imperative to integrate SRHR, HIV, and SGBV is recognised (Walker, 2021: 79). In the next three sub-sections, we discuss the following topics: (1) SRHR, HIV, and SGBV in South Africa focusing on adolescents and young people; (2) the South African national health system; and (3) the main public health issues that motivated the need for integration of SRH and HIV.

1.1.1 A case for SRHR and HIV integration in South Africa

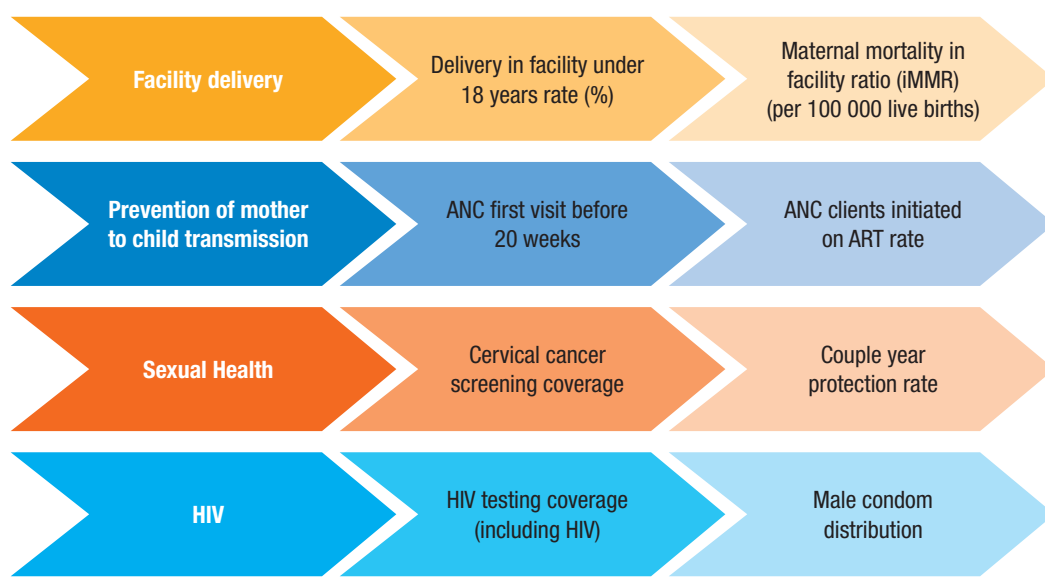
Since the first democratic elections held in 1994, the South African government has made major investments aimed at addressing gaps and inequalities in the health system. One of the key policies introduced in 2019 was the National Integrated SRHR Policy³. The policy ensures that SRHR is aligned with the SDGs, the South African Development Community (SADC) minimum package for SRHR services, and the SADC SRHR strategy (NDoH, 2019).

The South African integrated SRHR policy has five objectives.

- To equip all people to make informed decisions about their SRHR and ensure that their SRHR are respected, protected, and fulfilled.
- To increase the quality of and access to comprehensive and integrated SRHR care and treatment services across all life stages.
- To ensure access to respectful and non-judgmental SRHR services for priority groups.
- To strengthen the health system to deliver integrated SRHR services at the lowest feasible level in the healthcare system.
- To promote multisectoral engagement and shared accountability for a sustainable and rights-based service delivery.

The policy also identified four indicators that should be measured against national targets. These are: (1) delivery of babies in health facilities; (2) prevention of mother-to-child transmission (PMTCT) of HIV; (3) sexual health, HIV testing coverage; and (4) male condom distribution (see Figure 1).

Figure 1: Selected SRHR indicators against national targets



3 National Integrated Sexual and Reproductive Health and Rights policy. ED. 1. National Department of Health, 2019

Hopkins and Collins (2017: iv63) for example have argued that [the] elimination of MTCT “requires an integrated approach through HIV and SRHR platforms as it is focused on interventions affecting pregnancy, childbirth and breastfeeding, unintended pregnancies, STIs, and GBV, so *de facto* requires integrated SRHR and HIV services in order to deliver it”. The implementation of an integrated and comprehensive health system was, however, met with challenges that included the complex burden of diseases prevalent in South Africa, which affects maternal and child health (including, HIV and AIDS), TB, non-communicable diseases, SGBV, concerns about the quality of healthcare, ineffective, inefficient, and overburdened health system, and costs associated with healthcare – particularly in the private sector (Milford, *et. al.*, 2019: 6).

The National Integrated SRHR Policy lists the following client-related factors that influence their access to and uptake of SRHR services: socio-economic status and rural residence, educational attainment, gender norms, entrenched cultural practices, SGBV, partner, family, and community expectations around fertility, knowledge about conception, knowledge about contraceptive methods, stigma, and discrimination (NDoH, 2019).

In addition, the policy highlights the need to provide integrated services to youth. It draws from the 2016-2020 National Adolescent and Youth Health Policy aimed at addressing health challenges faced by youth, including the acquisition of HIV.

1.1.2 SRHR, HIV, and SGBV: A focus on adolescents and young people

In this section we will outline the SRHR context and describe SRHR, HIV, and SGBV challenges concerning adolescents and young people. In 2016, several countries committed to reducing HIV among adolescents and young girls⁴. Evidence shows that the number of children and adolescents newly infected with HIV has been slowly declining. However, mortality rates among adolescents living with HIV (ALHIV) are still higher when compared to other age groups (UNAIDS, 2021a). While we have observed declining HIV incidence rates among adolescent girls and young women, reducing HIV infection by 100 000 has not been achieved (UNAIDS, 2019, 2021a). Other key indicators that were not achieved include having 90% of young people who know about HIV transmission and prevention, and providing access to SRH services and combination HIV prevention to 90% of young people. In 2021, UNAIDS reported that a total of 37.7 million (30.2–45.1 million) people were living with HIV globally and of these 19.3 million (15.5–23.1 million) were females aged ≥ 15 years (UNAIDS, 8: 2021). In 2020, women and girls still accounted for 50% of all new infections (UNAIDS, 2021b). In sub-Saharan Africa, adolescent girls and young women (AGYW) comprised 25% of new infections (UNAIDS, 5: 2021c). Therefore “ending AIDS by 2030 requires that we address girls’ and women’s diverse roles by putting them at the centre of the response” (UNAIDS, 2019, 2021b).

Similar to other African countries, South African data shows that young people aged 15–24 years are more likely to be infected with HIV compared to other age groups (Simbayi *et al.*, 2019; UNAIDS, 2019). As of 2021, an estimated 1.7 million [1.2 million–2.2 million] children aged 0–14 years were HIV positive (UNICEF, 2019). The trends in risky sexual behaviours associated with HIV transmission are also of concern (Simbayi *et al.*, 2019; UNICEF, 2019). The South African Demographic Health Survey found that 16% of AGYW were either pregnant or had a child at the time of the survey (NDoH, Stats SA, SAMRC

⁴ https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/june/20160608_PS_HLM_PoliticalDeclaration

and ICF, 2019: 4). Of those attending school, 70% of girls and 56% of boys reported that they heard about family planning at school.

The HIV drivers outlined above occur in the context of gender discrimination and GBV, which fuel the HIV epidemic (Simbayi *et al.*, 2019). AGYW are prime victims of GBV. However, this risk of experiencing GBV is also pronounced among other categories of vulnerable women, including women who inject drugs and those excluded from mainstream social, economic, educational, and/or cultural life (Sevelius, 2009: 2020). Violence or the fear of violence can prevent women and girls from negotiating safer sex, accessing HIV and SRH services, and disclosing their HIV status to partners, family members, and health providers (UNAIDS, 2019: 7). Furthermore, young people's lives are affected by a "heightened risk of poverty, homelessness, dropping out of school, discrimination, loss of opportunities, prolonged illness, and death, and more recently COVID-19" (UNAIDS, 2021b). It is therefore dependent on the country's health system to remedy this by putting in place implementable policies along with trained human resources who will create youth-friendly health access points. In 2021, the UNFPA identified barriers to accessing SRHR services that were faced mainly by South African youth. The data were compiled from different research sources from 2016 to 2021 (UNFPA, 2021). The following barriers were identified: (1) lack of confidentiality and privacy; (2) inconvenient facility operating hours; (3) judgment and attitude of healthcare workers towards youth who seek SRH services, which result in fear and avoidance among adolescents and youth; and (4) misalignment of societal norms and young people's rights to SRHR (UNFPA, 2021). The above findings suggested the need for SRH services to specifically address the needs of young people and adolescents in South Africa. Hence, the investment and the piloting of and implementation of integrated services models by the UNFPA and the Provincial Departments of Health in the three districts presented in this report.

The National Integrated SRHR policy ensures that the South African government "has strengthened rights-based youth SRH legislation and policies" (NDoH, 2019: 6). It also guides the introduction of programmes directed at improving and prolonging the lives of young women. This includes interventions such as the provision of the Human Papilloma Virus (HPV) vaccine, which significantly reduces the incidence of cervical cancer among women. These services are provided within the macro health system, which is described in the next section of the report.

1.1.3 The National health system in South Africa

Section 27 of the Bill of Rights of the South African Constitution guarantees every citizen access to health services. According to the World Bank, South Africa spent 9.11% in 2019 of the country's gross domestic product on its healthcare system (World Bank, 2022).

South Africa had an estimated population of 60,14 million people (Stats SA, 2021), the majority of whom access health services through government-run public health facilities. The health system in South Africa is two-tiered and comprises the public and private sectors. Public health services are divided into primary, secondary, and tertiary levels that are delivered through health facilities that are located in and managed by the provincial Departments of Health. The provincial departments are the direct employers of the health workforce, while the NDoH is responsible for policy development and coordination.

The public health sector is funded through government funding and is estimated to serve 71% of the population (Rensburg, 2021). Everyone can access both public and private health services, with access to private health services depending on an individual's ability to pay the provider – which makes it difficult for the poor to access this healthcare system. This burden is exacerbated by high rates of HIV, non-communicable diseases (NCDs), COVID-19 and the related long-COVID and the challenges of accessing SRH services within the public health sector.

1.1.4 The state of the Public Health system in South Africa

This section outlines the prevailing challenges in the public health sector that motivated the need for an intervention programme that integrates SRHR, HIV and SGBV services. The World Health Organisation (WHO) asserts that social factors determine the health status of a person. Access to healthcare in South Africa is shaped by a range of social inequalities. WHO describes health inequalities as “differences in health status or the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age” (WHO, 2018).

Access to healthcare in South Africa remains unequal. The state of the public healthcare system in the country consists of a poor and ageing infrastructure, inadequate human resources, unequal funding, and poor governance. Rensburg (2021) describes a health system where “the public sector is underfunded, while most South Africans cannot afford the exorbitant cost of private care”. With significant funding and the best specialists employed in the private sector, there is a major gap between public and private healthcare facilities across the country. Private health services are extremely costly and out of reach for the majority of people who cannot obtain medical insurance to pay for them (Rispel & Hunter, 2015). Research shows that the greatest access barriers are encountered by those who are “Black Africans, poor, uninsured, and living in rural areas” (Harries *et al.*, 2011). Thus, the current task of healthcare reform is to “achiev[e] equitable universal health coverage, which requires the provision of accessible, necessary services for the entire population without imposing an unaffordable burden on individuals or households” (Harries *et al.*, 2011).

Health inequities described above are unfair and can be reduced by the right mix of government policies (WHO, 2018). Almost three decades post-democracy, South Africa continues its quest to address inequalities through the introduction of universal health coverage through the National Health Insurance (NHI) system (Shisana *et al.*, 2006). The NHI Bill was introduced in Parliament in 2019. Its main objective is to create a single, publicly owned and administered fund to purchase health services on behalf of the total population from suitably accredited and contracted providers (Hongoro, 2014). Underlying this objective is eliminating income and financial barriers to health access, with emphasis on both access and quality (Hongoro, 2014). The NHI policy is expressly geared to healthcare reform and underpinned by the central principle of social solidarity, which aligns with other social justice principles of the constitutional right to healthcare and equity (Naidoo, 2012).

It is critical that data are collected to assess the status of health services provision and for comparison with future service provision under the NHI system (Morison & Lynch 2017: 3). Important indicators for these purposes include healthcare utilisation and perceptions of healthcare services, including those targeted at SRH (Shisana *et al.*, 2006). The NHI plan appears promising. However, further research and analyses of its viability are needed to show the reality of the financial specifics required to implement it. Overall, the challenges mentioned above regarding equality in accessing quality healthcare in South Africa highlight the need to successfully reform the two-tiered healthcare system and centre integration in the delivery of healthcare services at the primary healthcare level. Funding, planning, coordination, and implementation of SRHR, HIV, and SGBV services within healthcare systems often occur through vertical structures, and these need to be aligned. There is also a lack of understanding of how HIV with SRHR services are linked (Hopkins and Collins, 2017), hence the importance of shifting to action policies that recommend integration, coupled with the piloting and implementation of evidence-based SRHR integration models that can be used to facilitate access and uptake of a minimum package of SRHR services by clients.

1.2 SRHR Integrated Intervention: Background

In response to the above-mentioned challenges, UNFPA undertook to “make a difference in health service delivery by linking SRHR and HIV at the policy and system levels” in 10 African countries, including South Africa.⁵ In three of the 10 countries, the intervention included SGBV services. In South Africa, UNFPA partnered with the NDoH and implemented the 2gether 4 SRHR integration of SRH, HIV, TB and SGBV services in the districts of Alfred Nzo (Eastern Cape), OR Tambo (Eastern Cape), and uThukela (KwaZulu-Natal) respectively. This was motivated by a belief that providing these services at the same time, during one consultation session, will benefit both the client and the healthcare system, as well as healthcare workers. The overall goal of this work was to improve SRH outcomes and reduce new infections of HIV.

The 2gether 4 SRHR programme is aimed at strengthening the provision of integrated SRHR, HIV and SGBV services for all, particularly adolescent girls, young people, and key populations. The programme is “a comprehensive regional programme with applied learning in ten countries, funded by the Regional SRHR Team of Sweden.”⁵ It is a joint project bringing together the expertise of UNAIDS, UNFPA, UNICEF and WHO at regional and country levels. The programme aims to improve the SRHR of all people in Eastern and Southern Africa, particularly adolescent girls, young people, and key populations, by promoting an integrated approach to SRHR, HIV and SGBV.⁵

The main objectives of the 2gether 4 SRHR programme are:

1. Create an enabling legal and policy environment that empowers people to exercise their SRH rights and access quality integrated SRHR, HIV and SGBV services.
2. Scale up the provision of client-centred quality assured integrated and sustainable SRHR, HIV and SGBV services to meet peoples' needs.
3. Empower people to adopt protective and promotive behaviours, and access quality integrated services.
4. Amplify the lessons learnt from the implementation of the Joint UN Regional Programme.

⁵ <https://esaro.unfpa.org/en/topics/srhr-and-hiv-linkages-project>

The UNFPA South Africa Country Office coordinated the programme and focussed on supporting two provinces. These two provinces had shown minimal progress on key indicators of poverty, maternal mortality, HIV prevalence, and SGBV.

The programme was rolled out in phases (baseline, pilot and scale-up). The first phase consisted of baseline assessments that were conducted in 2017 in pilot health facilities by Optidel Global. The roll-out followed from 2018 to 2022. Scale-up was implemented using a phased approach, whereby healthcare facilities that successfully implemented the intervention were handed over to the relevant Eastern Cape district Department of Health and new health facilities were added. In the Eastern Cape districts' inception phase, six facilities in the Alfred Nzo District and four facilities in OR Tambo District formed part of the pilot study in 2018. Scale-up occurred in ten healthcare facilities in OR Tambo and ten healthcare facilities in Alfred Nzo from 2019 to 2021. In the KwaZulu-Natal inception phase, five clinics were supported in uThukela District. By 2021, twelve clinics were supported in uThukela District, which was scaled up to 53 health facilities and extended to three districts (see Appendix 4).

The 2gether 4 SRHR programme provided the following services:

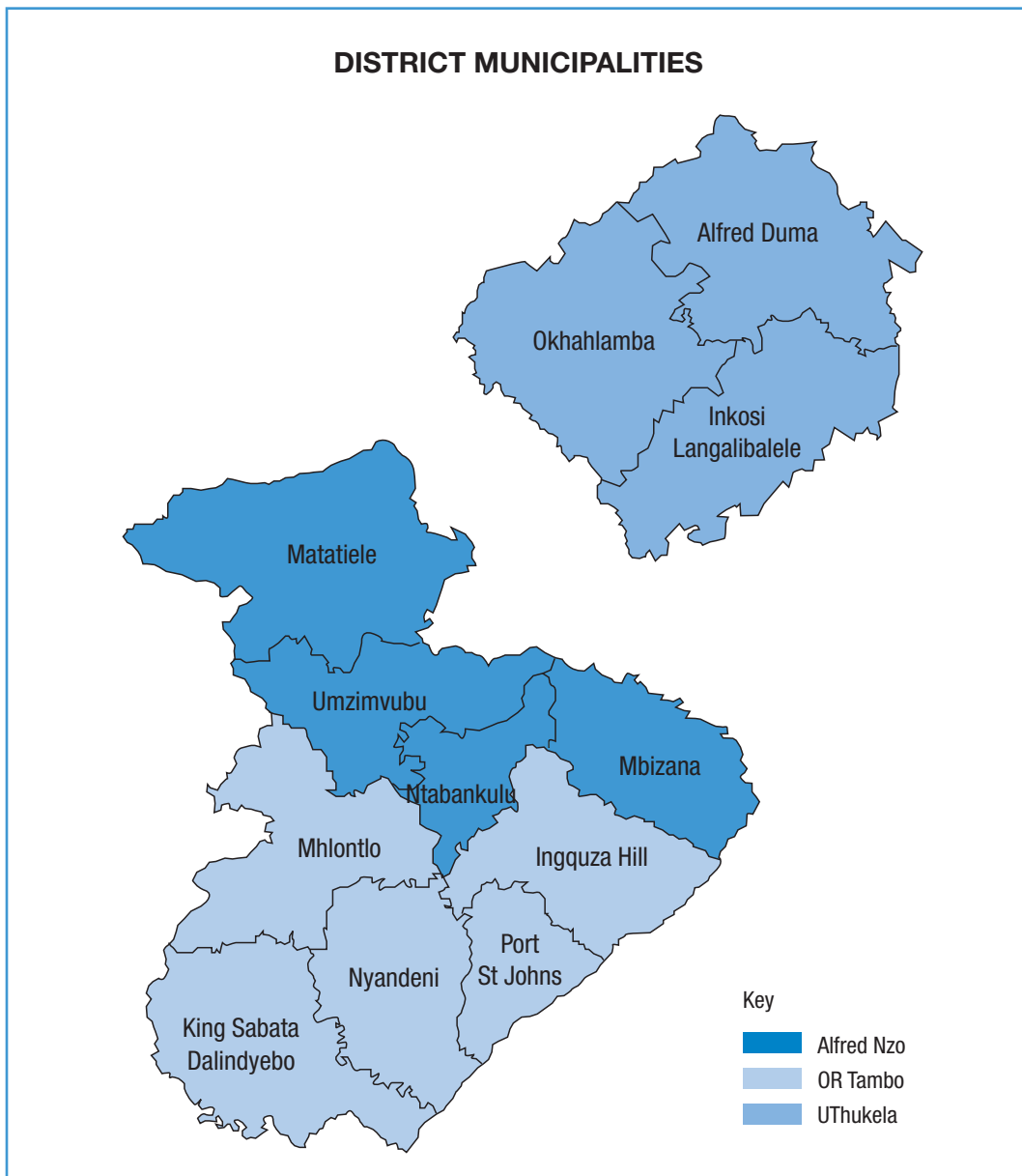
- integrated SRH and HIV services package to female sex workers through a sex worker,
- supported quality integrated services, focusing on providing technical support to Adolescent and Youth Friendly Services (AYFS),
- strengthening the five national minimum AYFS standards and linkages between health facilities and surrounding schools, and
- capacity building of healthcare workers in collecting and tracking data on the provision of integrated services.

1.3 Geographic context for the implementation of the SRHR integration models in South Africa

In this section we look at the geographical context of the SRHR integration intervention in South Africa. The details of the intervention implemented in South Africa will be discussed in Chapter 2.

As previously stated, the UNFPA collaborated with the NDoH and provincial health departments to facilitate the integration of non-discriminatory SRHR, HIV, and SGBV services at public health facilities in three selected districts in the UNFPA-supported provinces of KwaZulu-Natal (KZN) and Eastern Cape (EC) (see Figure 2) over the period 2017 to 2022. Both provinces are located in the southeastern part of South Africa, and were designated as homelands before 1994. Table 1 contextualises the districts and health facilities per district where the integration of services was implemented.

Figure 2: Three health districts where the interventions were conducted⁶



⁶ Sources: <http://www.uthukela.gov.za/about/about-uthukela-district-municipality>
<https://municipalities.co.za/map/101/alfred-nzo-district-municipality>
<https://municipalities.co.za/map/106/or-tambo-district-municipality>

Table 1: Description of the districts where interventions were implemented in the provinces of Eastern Cape and KwaZulu-Natal

Province and districts targeted for the interventions	KwaZulu-Natal, uThukela District Municipality ⁷	Eastern Cape, Alfred Nzo District ⁸	Eastern Cape, OR Tambo District ⁹
General description of the districts	UThukela district is one of 10 KZN districts. It consists of three local municipalities namely Alfred Duma, Inkosi Langalibalele and Okhahlamba.	Alfred Nzo district is one of six districts in the Eastern Cape. It is the smallest district in the province, which is subdivided into four local municipalities namely Matatiele, Umzimvubu, Mbizana and Ntabankulu. Historically it was part of the Transkei homelands.	OR Tambo district incorporates 80% of the former Transkei magisterial districts, which is divided into five local municipalities, namely King Sabata Dalindyebo, Nyandeni, Port St Johns, Ingquza Hill and Mhlontlo local municipalities.
Locality type	Mostly rural	Mostly rural	Mostly rural
Population size (2019)	724 248	878 635	1 514 306 (OR Tambo is the most highly populated district in the EC)
Estimated number of households/district (2016)	161 787 households consisting of 53% female-headed households and 2% child-headed households.	195 975 households consisting of 57% female-headed households and 2.5% child-headed households.	354 168 (in 2019) households consisting of 57% female-headed households and 4% child-headed households.
Human settlements by dwelling type	Of the dwelling types found in this district, 55% are formal dwellings, 28% are traditional dwellings, 7% live in a backyard, and 1.3% of households are informal dwellings.	Of the dwelling types found in this district, 34% are formal dwellings, 53% are traditional dwellings, and 2.3% of households are informal dwellings.	Of the dwelling types found in this district, 33% are formal dwellings, 54% are traditional dwellings, and 1.3% of households are informal dwellings.
Poverty levels/district	63% of people living in this district are living in poverty.	72% of people living in this district are living in poverty. This district is considered the poorest district in South Africa.	67% of people living in this district are living in poverty.

7 <https://www.cogta.gov.za/ddm/wp-content/uploads/2020/11/Uthukela-October-2020.pdf>

8 <https://www.cogta.gov.za/ddm/wp-content/uploads/2020/11/Alfred-Nzo-September-2020.pdf>

9 <https://www.cogta.gov.za/ddm/wp-content/uploads/2020/11/Uthukela-October-2020.pdf>

<p>Levels of access to water, sanitation, and electricity/district (2016)</p> <p>Predominantly all districts have poor and ageing water and sanitation infrastructure.</p>	<p>An estimated 77% of the population received water from a regional or local service provider, 50% used pit latrines, and 12% of the population had no access to electricity.</p>	<p>An estimated 6% of households had piped water inside the dwelling, 61.2% had no formal piped water, 16.4% had pit latrines, and 33.2% of households did not use electricity.</p>	<p>An estimated 12% of households had piped water inside the dwelling, 62% had no formal piped water, 16.4% had pit latrines, and 14% of households did not use electricity.</p>
Sex distribution/district	53% of the population is female, and 47% is male (2016)	54% of the population is female, and 46% is male (2016)	53% of the population is female, and 47% is male (2019)
Age distribution/district (2016)	Median age: 20 years, 23% are 10-19 years 19% are 20-29 years	Median age: 18 years, 27% are 10-19 years 19% are 20-29 years	Median age: 19 years 26% are 10-19 years 20% are 20-29 years
HIV prevalence Estimates/District	<p>HIV prevalence: 22.4% (95% CI 19.5-25.6) (Simbayi <i>et al.</i>, 2019)</p> <p>HIV prevalence among women attending antenatal care (ANC) was 41.5% (95% CI 38.0-45.1) in 2017 representing an increase since 2012 (Woldesenbet <i>et al.</i>, 2019).</p>	<p>HIV prevalence: 12% in 2018¹⁰.</p> <p>HIV prevalence among women attending ANC was 31.6% (95% CI 28.1-35.3) in 2017 representing an increase since 2012 (Woldesenbet <i>et al.</i>, 2019).</p>	<p>HIV prevalence: 17.3% (95% CI 14.4-20.7) (Simbayi <i>et al.</i>, 2019).</p> <p>HIV prevalence among women attending ANC was 35.2% (95% CI 31.8-38.7) in 2017 representing an increase since 2012 (Woldesenbet <i>et al.</i>, 2019).</p>
Health facilities/district	The district had 35 fixed primary healthcare clinics, 14 mobile clinics, and three COVID-19 quarantine facilities with 39 beds (as of May 2020).	The district had 72 clinics, 8 hospitals and 2 community health centres. Health facilities are reported to have challenges that include severe staff shortages, inadequate security measures, leaking roofs, inadequate ablution facilities, dilapidated infrastructure, poor filing systems, and inconsistent delivery of medication.	The district had 163 health facilities, 137 clinics, 10 community health centres, and 16 hospitals. Seven COVID-19 quarantine sites with 90 beds (as of June 2020) in Mthatha, King Sabata Dalindyebo local municipality.

10 <https://www.cogta.gov.za/ddm/wp-content/uploads/2020/11/Alfred-Nzo-September-2020.pdf>

Health Facilities where SRHR Integration intervention was implemented in each district ^{11, 12}	Bergville Clinic	Amantshangase Clinic	Bomvini Clinic
	Dukuza Clinic	Baleni Clinic	Buntingville Clinic
	Ekuvukeni Clinic	Dundee Clinic	Elujizweni Clinic
	Emmaus Gateway Clinic	Dungu Clinic	Flagstaff Clinic
	Ezakheni 2 Clinic	Greenville Gateway Clinic	Holycross Gateway CHC
	Injisuthi Clinic	Hlamandana Clinic	Libode Clinic
	KZ Steadville Clinic	Hlamandana Clinic	Mpeko Clinic
	Neibidwane Clinic	Isilindini Clinic	Mthatha Gateway Clinic
	Ntabamhlope Clinic	Lubaleko Clinic	Ngqeleni Clinic
	Oliviershoek Clinic	Mangqamzeni Clinic	Ngwenyana Clinic
	St Chads CHC	Mfundisweni Clinic	Nkonzo Clinic
	Walton Clinic	Mlotsheni Clinic	Nolita Clinic
	Watersmeet Clinic	Mnceba Clinic	Nolitha Clinic
	Wembezi Clinic	Mt Frere Gateway Clinic	Nontsikelelo Biko Clinic
	Xhamini Clinic	Mzongwana Clinic	Ntafufu Clinic
		Ndela Clinic	Ntaphane Clinic
		Ntshenthse Clinic	Nyandeni Clinic
		Rhode Clinic	Nzintlava Clinic
		St Patricks Gateway Clinic	Qumbu Clinic
		Tshungwana Clinic	Tombo Clinic
			Xurana Clinic

The next section of the report will describe the interventions undertaken in the three districts, outlines the particular model or approach used, and lists key activities that includes how beneficiaries were engaged.

11 Additional 28 health facilities from uGu and eThekweni Districts were added during the ongoing rollout. These are not included in the data analysed in this report.

12 Sources for facilities: Sanni Babatunde. Technical Assistance on SRH, HIV and GBV Integration Dissemination Meeting. Optidel Global presentation. 8 July 2022. Umthombo weMpilo. Integration of SRHR, HIV and SGBV Services. Umthombo weMpilo Institute presentation. 8 July 2022.

Implementation: SRHR, HIV and SGBV integration in selected health facilities

As previously stated, Optidel Global and Umthombo weMpilo Institute (UWI) were contracted by UNFPA to pilot and implement integrated service delivery models in selected health facilities in uThukela, Alfred Nzo and OR Tambo Districts. The Umthombo weMpilo Institute supported the implementation of the intervention in selected facilities in OR Tambo and Alfred Nzo Districts. Optidel Global supported the implementation in selected facilities in uThukela District (see Table 2). The two implementing partners started by conducting baseline assessments and then follow-up assessments. The intervention's SRHR integration models were implemented based on each district's needs. The process flow of each implementing partner is described briefly below, followed by a description of the interventions carried out.

Table 2: Summary of implementing partners, type of activities, and time periods

Partner	Activity	Location	Time Period	Phase
Optidel Global	Baseline assessment	Ten pilot facilities in uThukela, Alfred Nzo and OR Tambo Districts	2017	Implementation
Optidel Global	Implemented intervention	Five pilot facilities in uThukela District	September 2018 to January 2019	
Umthombo weMpilo Institute	Implemented intervention	Four facilities in Alfred Nzo District and one facility in OR Tambo District	2018	
Umthombo weMpilo Institute	Implemented intervention	Ten facilities in Alfred Nzo District and ten facilities in OR Tambo District	2019	
Umthombo weMpilo Institute	Scale-up from 2019 to 2021	Ten facilities in OR Tambo District and 10 facilities in Alfred Nzo District	2021	
Optidel Global	Documented the effectiveness of the model of integration implemented	Twelve facilities (1 district)	September 2021 to March 2022	
	Final intervention and review	Scale-up from five pilot facilities to 53 health facilities in uThukela, eThekweni, and Ugu Districts	September 2021 to March 2022	On-going scale-up

At the core of the intervention was the integration of SRHR, HIV, and SGBV services, which offer two or more healthcare services during one consultation session in a healthcare facility. Optidel Global (2021: 9) describes integrated services as “the organisation and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money”. The models adopted emerged from the policy guidelines of the Ideal Clinic Model (ICM). The ICM is defined as “a clinic with adequate infrastructure, staff, medicine and supplies, good administrative processes, and sufficient bulk supplies” (Optidel Global, 2021: 8).

The foundation of service integration at primary healthcare facilities is contained in the ICM. It uses applicable clinical policies, protocols and guidelines, and harnesses partner and stakeholder support. It collaborates with other government departments, the private sector, and non-governmental organisations to address the social determinants of health. Clients should receive consultation for all illnesses from the same healthcare professional once in a consulting room, rather than having to pass from one service provider to another if additional services are required. Integrated Clinical Services Management (ICSM) is a central pillar of health service delivery within the ICM. The purpose of ICSM is to reduce the burden of chronic diseases in South Africa by reorganising service delivery into four streams, which are acute illness, chronic disease, maternal and child health, and health support services. Thus, ICSM aims to reduce the need for clients to have multiple consultations and improve the quality of their care and outcomes. The intervention models described below are based on the ICM and therefore look to implement change according to each facility’s needs within each district. The models implemented by the partners were within the scope of the ICM. The models implemented by each partner are discussed below.

2.1 Intervention model implemented by Optidel Global

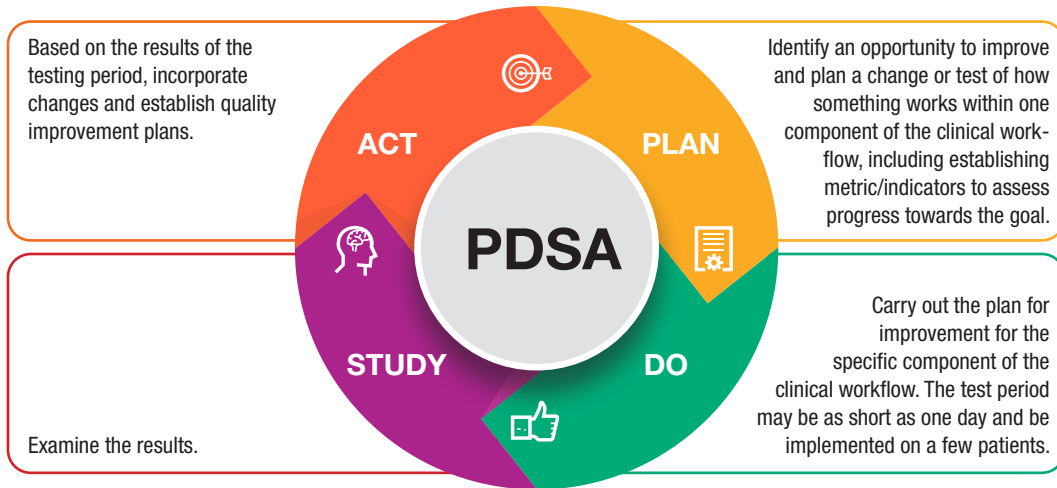
Optidel Global was the first partner to be contracted to conduct the initial assessment and intervention in 2017. The quality improvement methodology used was based on the Plan, Do, Study, Act (PDSA) cycle model. This model is also referred to as the 2gether 4 SRHR model, which is applied in ten countries. It aims to improve SRHR specifically in youth and key populations, by promoting an integrated approach to SRHR, HIV and SGBV.¹³

The PDSA cycle model (see Figure 3) was continuously implemented to target specific gaps that were identified throughout the implementation period. The principles guiding the use of this model (as listed by Optidel Global in their 2022 report) include:

- Ensuring that the health systems’ processes and procedures within the facilities do not duplicate services.
- Tailoring services as per the needs and capabilities of the facility.
- Designing training to ensure healthcare workers are not removed from their service points, therefore keeping clients waiting.
- Creating accountability by using tools such as the dashboard to track deliverables.
- Engendered ownership by district and facility staff (Optidel Global, 2022: 8).

¹³ <https://esaro.unfpa.org/en/2gether-4-srhr>

Figure 3: PDSA Model of integration



Source: Optidel Global, 2022

The PDSA model assisted in structuring the flow of services in the facilities and was adapted to each facility's needs and resources. Paired with the model, was a minimum Package of Care (PoC) for SRH and HIV. The PoC was developed to harmonise the provision of integrated SRH and HIV services “with the view to facilitate effective delivery of quality and comprehensive health services for all people” (Optidel Global, 2021: 14). The package also aligns with the NDOH Primary Care 101 Policy¹⁴.

As part of the PDSA implementation, workshops and training sessions were convened at district and facility levels. The activities and deliverables were aimed at strengthening integration and improving the quality of healthcare. The typical team involved in this process comprised district managers, primary healthcare (PHC) supervisors, operational managers, and other stakeholders. This team would then present the intervention project to the district health management team (DHMT) whose acceptance was critical in achieving the desired outcomes. District SRH and HIV teams were formed to coordinate the implementation at the facility level.

Optidel Global conducted baseline and rapid assessments on the intervention implementation status during the rollout and then scale-up of the interventions. Best practices were documented focusing on the importance of training and mentorship of healthcare workers, engagement with clients, and maintaining the clients' perspective in data collection and monitoring tools. The first phase of the 2gether 4 SRHR programme rollout was from 2018 to 2021.

¹⁴ Primary Care 101 is a symptom-based integrated clinical management guideline using an algorithmic approach for the management of common symptoms and chronic conditions in adults. The guidelines are intended for use by all healthcare practitioners working at primary care level in South Africa. <https://www.hst.org.za/publications/NonHST%20Publications/PC-101-Guideline-v2-2013-14-2.pdf>

Baseline assessments were conducted in ten pilot facilities from August to November 2017. Scale up of the integration model and documentation of its effectiveness in twelve facilities in uThukela District occurred from September 2019 to March 2020. This was further scaled up to 53 facilities from September 2021 to March 2022 (uThukela, eThekweni and Ugu Districts¹⁵).

The baseline assessments aimed to:

- Establish the national status of SRHR, and HIV linkages at the policy and system levels.
- Collect baseline data through the health management information systems (HMIS) on defined SRHR and HIV integration indicators.
- Conduct a rapid assessment of the status of SRHR and HIV integration.
- Conduct an assessment of health facility readiness to integrate SRHR and HIV services.
- Assess uptake and possible barriers to family planning services at the selected health facilities.

The baseline assessments involved a desktop review of policies, strategies and documents, analysis of routine data collected at the facilities, site visits, and stakeholder interviews. The baseline assessment also found that facility systems were misaligned. Fewer partners supported the integration of SRH with HIV programmes. In addition, at the community level, SRH programmes were promoted less intensively than the HIV programmes. This was mainly due to the HIV programmes having the support of external donors whose scope was limited to HIV. At the facility level, the baseline assessment found that clients welcomed receiving SRH and HIV services in one facility. However, clients expressed concerns about long waiting times, staff workload and staff training around what and how to integrate (Optidel Global, 2017: 68).

It was noted that the two provinces selected for the implementation of the intervention ran each component of implementation, supervision, and budgeting separately. The main challenge observed was that implementation and budgeting were not aligned. It was observed that the districts were familiar with the need to align service delivery with the rights entrenched in the Constitution and the National Strategic Plan for HIV, TB and STIs 2017-2022. The state of policies, systems, and SRH versus HIV programmes were identified as areas that could benefit from the intervention. These challenges were addressed in the intervention.

¹⁵ This report does not include uGu and eThekweni districts.

2.1.1 Piloting the intervention at uThukela District health facilities

From September 2018 to January 2019, Optidel Global implemented the intervention in five pilot facilities in uThukela District (Optidel Global, 2019). The initial activities were aimed at preparing facilities to implement the SRHR integration model, map client flow to minimise multiple visits, train healthcare workers on integration, conduct ongoing mentoring and support for both facilities and the district teams, and establish a district technical working group (TWG). Within the selected facilities they also established baseline and data collection systems, and analysed client services uptake data to identify gaps. At the community level, they facilitated community engagements, mapped the location of ward-based outreach teams (WBOTs), and community-based organisations within the catchment areas of the facilities to enable referrals. To promote the sustainability of the intervention, facilities and the district teams were supported through activities such as convening regular meetings.

The intervention during this period followed the UNFPA-Optidel Global process mapping. This mapping process has four steps (Optidel Global, 2021: 7), namely;

- Understanding the context of the health system, including national policies on PHC and scoping the implementation environment by selecting study facilities for rapid assessment.
- Engaging all known stakeholders, including facility staff, and the district team.
- Ensuring that the DHMT was given the role of coordinating the SRHR, HIV, SGBV, and TB integration implementation.
- In learning how the facility works, it was important to implement the PDSA cycle plan and monitor progress.

There were engagements among the selected facilities. The UNFPA and Optidel Global provided support, assessed progress, and noted the challenges experienced during implementation.

2.1.2 Intervention scale-up in KwaZulu-Natal province

During the period from September 2021 to March 2022, Optidel Global implemented the final intervention and review in 53 health facilities in uThukela, eThekweni, and Ugu Districts. The intervention was scaled up from the initial five facilities piloted at the initiation of the programme in 2017. Focal areas included assessing the working styles of the facilities in the three districts. This was followed by the training of healthcare workers. The district teams were supported to align the provision of SRHR, HIV, and SGBV services to meet the ICM's minimum standards. During this intervention, Optidel Global (2022: 8) addressed the following:

- Facilitated sustainability and institutionalisation of the integration.
- Trained and mentored healthcare workers in SRH, HIV, SGBV, and TB integration services. This process involved training healthcare workers on cervical cancer screening and testing, disseminating the condom communication plan, and familiarising healthcare workers with the revised SRH policy and guidelines.
- Related shared human-interest stories as evidence of positive uptake of the integration.
- Facilitated the correct use of data collected to enable analyses and identify gaps, successes, and dissemination and ultimately use these to inform the integration, and documentation exercise.

2.1.3 Engagement of beneficiaries in KwaZulu-Natal province

Optidel Global engaged clients in their interventions in the three districts, beginning with clients who attended the five facilities in the 2019 review period. Baseline and end-line surveys were conducted with clients to determine their perceptions of services received at healthcare facilities (Optidel Global 2019: 13). In 2017, Optidel Global conducted exit interviews with 200 clients from ten health facilities in the three districts. In the Alfred Nzo and OR Tambo Districts they conducted these exit interviews in Ndela, Amadiba, Libode, Ntaphane and Tombo Clinics. In uThukela, exit interviews were held in Injisuthi, Ntabamhlophe, Wembezi, AE Havilland, and Ncibidwane Clinics.

Between September 2018 to January 2019 clients from five facilities (Injisuthi Clinic, Ntabamhlophe Clinic, Wembezi Clinic, AE Havilland Clinic, and Ncibidwane Clinic) in uThukela District were interviewed for both baseline and end-line exit interviews. The baseline survey aimed to investigate the following tracer indicators:

- Clients visiting HIV service points receive more than one service.
- The percentage of clients who had more than one service mentioned to them in a consultation room.
- The proportion of eligible females who were offered cervical and breast cancer services (Optidel Global, 2019: 13).

All three indicators were reviewed during end-line interviews, where improved service delivery and uptake were observed. The details of the results are discussed in the results section below.

In 2020, Optidel Global interviewed 183 clients in twelve facilities to assess the number of services they received in one visit. Again in 2021, they assessed more than 240 clients in 20 facilities at both baseline and end-line surveys of the year's intervention. In both these interventions, the client satisfaction rate increased to over 80% from baseline to end-line. From 2021 to 2022, Optidel Global conducted client satisfaction interviews in the three KwaZulu-Natal districts where they again found that the number of services provided had increased at the end-line assessment when compared to baseline.

2.2 Intervention model implemented by Umthombo weMpilo Institute (UWI)

There are a few models for delivering SRH and HIV integrated services at health facilities, such as the “one-stop-shop/kiosk” model or the “supermarket” model (UNFPA ESARO, 2016) which form part of the comprehensive healthcare package in South Africa. Comprehensive healthcare encompasses a range of services offered to the community. The Umthombo weMpilo Institute was contracted to implement the SRHR integration Model in two districts in the Eastern Cape province in 2018. They used a one-stop-shop model and supermarket approach (UWI, 2018: 2), which are both based on the ICM models described above.

The one-stop-shop approach is where the health facility is structured to offer comprehensive health services during the same visit by one provider in the same consultation room (UNFPA ESARO, 2016). It is a process of combining “multiple health and human service providers in a single location to deliver services” (RHIH, 2018). This approach improves clients’ access to different healthcare services and facilitates referrals where needed. It can also reduce transport-related costs by minimising the need to access multiple services on different days at different locations. To further improve access to care, program planners can also establish one-stop-shop in easily accessible locations, such as in a mobile clinic or near a grocery store. The supermarket approach offers all services during the same visit under the same roof (UNFPA ESARO, 2016). Hence while the one-stop-shop model and supermarket approach have the ICM foundation, they differ in that the one-stop-shop model is implemented at one facility, whereas with the supermarket model facilities refer patients to either other facilities or community-based organisations. The supermarket model is mostly used by healthcare workers when there is a need for a facilitated referral to other services within the district.

2.2.1 Piloting the intervention in Alfred Nzo and OR Tambo Districts health facilities

The two models were implemented to achieve comprehensive care, especially for young people. In 2018, UWI first implemented the intervention in four facilities in the Alfred Nzo District and one facility in OR Tambo Districts. The following activities were undertaken:

- Scaling up integrated SRHR, HIV, and SGBV services in selected facilities.
- Supporting policy implementation through strengthening provincial capacity to implement the revised family planning and choice on termination of pregnancy (CTOP) guidelines.
- Providing sexual education to adolescents and out-of-school youth.
- Strengthening provincial health systems’ capacity to deliver quality integrated youth-friendly services.
- Introducing targeted HIV combination prevention programme for adolescents and youth.

2.2.2 Intervention scale-up in Alfred Nzo and OR Tambo Districts

Supported facilities were reviewed during each project year. Facilities that were performing well were removed and new facilities were added each year. This was done so that SRH integration was augmented to more facilities across the districts. In 2019, UWI supported five additional facilities, thus totalling ten facilities supported: six facilities in the Alfred Nzo District and four in OR Tambo District (UWI, 2019: 2). The following five activities were implemented:

- A three-day workshop was organised to review the 2018 integration results and planning for 2019. During this meeting, five additional facilities were identified to implement the scale-up of the intervention. The termination of pregnancy (TOP) service was identified for inclusion in the scale-up phase. This was followed up by TOP training that targeted health workers at the health facility (i.e., hospitals) level and by staff based at community health centres.

- Supported policy implementation through strengthening provincial capacity to implement the revised family planning and Choice on Termination of Pregnancy (CTOP) guidelines. Ipas¹⁶ was contracted to train healthcare workers on the family planning and TOP guidelines.
- Rolled out comprehensive sexuality education and Social and Behaviour Change Communication¹⁷ (SBCC) for out-of-school adolescents and youth. This included dialogues with out-of-school youth conducted in collaboration with community-based organisations. The following topics were presented: teenage pregnancy, alcohol and substance abuse, and early marriage among adolescent girls.
- Within the provincial health system, capacity was strengthened to achieve all five minimum standards for AYFS (see Appendix 3 for AYFS standards). This was done through monthly visits by the district teams (also known as mentors). The eight assessment criteria outlined in the ICM were used to assess the integration. The mentor worked with operation managers in the facilities to implement interventions to improve AYFS service delivery (UWI 2019: 16).
- Provided targeted HIV combination prevention programmes for adolescents and youth by introducing SBCC and Integrated School Health Programme.

This was scaled up to 20 facilities, (ten in Alfred Nzo District and ten in OR Tambo District). The scale-up included the following activities:

- Provided technical and financial support to the SRH and HIV integration district technical working groups to conduct quarterly supervisory visits to five priority healthcare facilities in the Eastern Cape province.
- Conducted capacity building for staff in healthcare facilities in Alfred Nzo and OR Tambo Districts to provide integrated SRHR and HIV services.
- Capacitated WBOTS, health promoters, and community-based organisations (CBOs) to enable SRHR and HIV integration community linkages to the appropriate care streams.
- Replicated the Nzululwazi Model¹⁸ in schools linked to the 20 UNFPA-supported healthcare facilities in the Alfred Nzo and OR Tambo Districts.
- Conducted inter-generational dialogues and outreach interventions on SRHR, HIV and GBV.
- Mentored 20 health facilities in the Eastern Cape to improve the AYFS and collect age-disaggregated data on access to services.

A total of ten health facilities for the Alfred Nzo District and ten health facilities for OR Tambo District were retained over the implementation years of 2019–2021 (see Appendix 5). However, over the years, facilities that excelled during the intervention were handed over to the Eastern Cape District office for further support and monitoring to sustain the intervention's successes. Through this process, new healthcare facilities were added to the intervention list of health facilities in the Eastern Cape to benefit from the promising practices achieved in the health facilities deemed to have successfully implemented the interventions.

16 Ipas “works in five continents with a comprehensive approach that centres on the needs of those who seek abortion care. We aim to build sustainable abortion ecosystems that address all factors impacting a person’s ability to access abortion—from individual health knowledge, to social and community support, to a trained health workforce, to political leadership and supportive laws”: <https://www.ipas.org/about-us/>

17 An SBCC strategy provides a “road map” for changing behaviours and social norms. An SBCC strategy provides the guiding design for SBCC campaigns and interventions. <https://healthcommcapacity.org/i-kits/sbcc-strategy/>

18 The Nzululwazi model is an intervention by UNFPA in collaboration with Student Partnership Worldwide (SPW) South Africa Trust, Eastern Cape Departments of Social Development and Health. This intervention was requested by the EC Department of Education in response to high rates of pregnant young girls aged 10 to 24 years. The model intended to improve sexual and reproductive education for this age group with the main

Although school-based activities are not included in this analysis, as part of the UWI mandate, the focus on adolescents and youth continued in 2020. They also delivered interventions that focused on youth empowerment and the strengthening of integrated SRHR services for youth. Youth-focused interventions were aimed at empowering adolescents and young people with knowledge and skills to make informed decisions and maintain healthy sexual behaviour. The second focal area was to strengthen institutional capacity to deliver youth-friendly and integrated SRHR, HIV and GBV services at all levels (UWI, 2020: 2). This was achieved through strengthening provincial health systems' capacity to deliver quality-integrated youth-friendly services and scaled-up integrated SRHR, HIV, and SGBV services. During the intervention, facilities were supported in data management, strengthening the delivery of quality AYFS. The interventions implemented by Optidel Global and UWI were aligned with the integration of the health services delivery approach as outlined in the ICM.

2.2.3 Engagement of beneficiaries

In 2018, UWI worked with local community-based organisations to conduct intergenerational dialogues with 1 107 school learners in quarter three and 1 174 in quarter four. They also reached 134 out-of-school youth and 222 female learners who were attending the Girl Learner Camp¹⁹. In addition, this intervention was shared on the local community radio station and reached approximately 136 000 out-of-school youth²⁰.

Peer educators were identified during the same year. These were learners aged 10 to 19 years old. They were given skills-based health education and taught about SRH services and communication skills. In addition, they were taught to be comfortable sharing any challenges with other peers. To ensure continuity, project mentors gave emotional and informational support to the peer educators every month.

In 2019, additional dialogues with out-of-school youth in OR Tambo District were conducted by UWI. Before each dialogue session, participants' knowledge of SRH was assessed. Then the dialogues would focus on the gaps identified during the assessment. Communities were asked to participate in the intervention by drawing up plans to assist the youth in their struggles with drugs, unplanned pregnancies, and SGBV.

In 2020, UWI reported that they reached 1 129 youth through dialogues. Two CBOs were mentored to conduct comprehensive sexual education. These CBOs had existing rapport with the districts and government partners in the communities where the integration of SRHR, HIV, and GBV services programme was implemented by UWI. Because of COVID-19 restrictions such as the maximum number of people allowed for social gatherings and school closures, in-school dialogues were disrupted and thus the number of youths reached through the dialogues was lower than the targeted goal.

19 The camp was held at Phondolwendlovu Senior Secondary School, in an area called Ngqeleni on the 23rd of November [2018]. The focus of the dialogue was the prevention of teenage pregnancy, prevention of HIV/STIs, family planning, dual protection, emergency contraception, and the effects of age-disparate relationships (also known as bladders).

20 Umthombo weMpilo Institute, 2018.

In response to SRHR, HIV, and GBV services utilisation barriers among young people, in 2021, UWI facilitated further dialogues with youth in OR Tambo District. (Umthombo weMpilo Institute Q2 2021: 21). The two main objectives for this initiative were to:

- Provide truthful information about SRH to girls and boys to enable them to make healthy decisions.
- Foster positive morals and attitudes towards sexual and reproductive issues and challenge the commonly accepted beliefs of male dominance, female subordination, and GBV (Umthombo weMpilo Institute Q2 2021: 21).

The next section summarises overarching activities carried out by the implementers.

Key activities

Inception: The key activities started with inception meetings to introduce the SRH and HIV integration approach. The meetings were held at the district offices and some facilities. Individual facility baseline assessments were conducted, and results were shared with facilities as part of the process of developing an implementation plan. Contextualised findings, areas of focus, and integration champions were identified. Results were shared with TWGs, and individual facility plans were developed. Drawing from the baseline assessment findings, the TWG identified marker indicators for dashboard monitoring.

Capacity building: The majority of training sessions were conducted in-house to minimise removing healthcare workers from the health facilities. The training schedule allowed flexibility around client loads at each health facility. Optidel Global kept a register to track the number of trained and competent healthcare workers against the baseline. Professional nurses were mentored on the use of UNFPA SRHR, HIV, SGBV, and TB integration job aid and the minimum package of SRH and HIV integration service stream. There was direct supervision within facilities by the PHC supervisors. The district SRH and HIV working groups were responsible for coordination and oversight.

Communication: To facilitate information exchange, meetings were held at the health facilities to assess progress, study the implementation process and activities on site, and identify barriers, enablers, and opportunities. Progress was evaluated through the monitoring of routine District Health Information System (DHIS) data. The progress of healthcare worker training and competence was assessed to ultimately improve facility performance. Root cause analysis was used to identify challenges. Finally, the facilities drew up remedial action plans on gaps found in the pilot study stage, which will lead to an updated healthcare worker skills matrix and move to the planning stage for continuous improvement.

Collaboration and referrals: To improve the interface of services for clients, in-facility service linkages were established at supported facilities to ensure that clients referred from one service delivery point to the other were not lost to care by exiting the facility without receiving comprehensive services. Client and referral pathways were implemented to facilitate clients' service uptake. Lay counsellors also assisted clients to be linked to internal referral sites before exiting the facility. For example, referral systems were used in Alfred Nzo District, while client pathways were used in uThukela District health facilities.

As part of the national and provincial prevention and response to GBV, UWI (2021) implemented referral systems at ten facilities in Alfred Nzo District, which included the follow-up of GBV victims. Referral pathways were displayed in all Alfred Nzo District health facilities. Community health workers assisted in tracing clients that were lost to follow-up. The contact numbers of the clients were also recorded and used for following up when necessary.

Client Pathways in uThukela District health facilities: To facilitate client uptake of services in uThukela District, client pathways were developed as a tool to facilitate the integration of SRHR and HIV services. The use of client referral pathways was emphasised to assist healthcare workers in facilitating effective linkages and a continuum of care, and to contextualise the integration model being implemented (Optidel Global, 2022: 16). In some facilities, infrastructure challenges e.g., shortage of space, posed challenges in implementing the integration of SRHR services, which compromised client's confidentiality and privacy and prevented adequate service linkage guide to clients – especially when service points were in different buildings. Referrals were done using the standardised forms of the ICM. Once the client pathways were implemented, clients visiting the facilities for services followed different pathways based on their individual needs and the services on offer at that health facility (e.g., some facilities did not have AYFS or central chronic medicines dispensing and distribution (CCMDD) services) on site.

The ideal situation was to offer client-centred services at specific service points (e.g., chronic care) without referring clients to any other entry points. In some facilities, clients received their consultation, prescription, and medication dispensed in the same consulting room. Hence the client would not need to go to the pharmacy once their consultation was completed, e.g., some facilities could offer the client their choice of family planning method at the vital signs point. However, in some cases, clients needed to be linked to other services within that facility for care, or referred to different service points for specialised services (e.g., termination of pregnancy, rape/crisis centres, or dental services).

An example of one such client pathway is to channel clients through the following pathways:

- chronic care clients could go straight to the central CCMDD service point,
- depending on the needs assessment by the healthcare worker, clients could access additional services such as AYFS for a specific youth-friendly service, and
- the pathway then directs all clients to the vital sign service point, where they could enter one of the three service streams of the ICM (mother, child and newborn, acute/minor ailments, or chronic streams).

Key results

This chapter reviews the outcomes of the implemented intervention in the three selected districts. The main objective was to integrate SRHR, HIV/TB, and SGBV services in selected healthcare facilities within the selected districts. An important expected outcome was to assess sustainability and the possibility of scaling up the SRHR integration models. The HSRC reviewed 20 source documents provided by UNFPA. We then synthesised the available indicator data by district for the different implementation phases to collate and identify emerging promising and best practices from the case studies reviewed. The list of reports that were reviewed is provided in Appendix 1.

The results are presented in the baseline results per district, results in terms of process (proportion of healthcare workers trained and client exit interviews), and positive changes and impact of the intervention. The focus of interventions in the three districts was targeted and focused on responding to each facility's needs. The models and the periods of implementation differed per district. Therefore, the results are shown for each district and where data were available, common themes were collated from the different case studies to facilitate comparisons.

The implementers used selected indicators that were extracted from the list of 81 key indicators on SRHR, HIV and SGBV. These indicators were identified by the regional monitoring and evaluation team through a regional desk review and mapping of standardised indicators from programme documents, population-based surveys, and policy sources (UNFPA, 2020). These indicators serve as the foundation for generating and analysing data as well as dissemination of results. Table 3 lists key indicators that were synthesised from the implementing partner reports. The indicators selected for monitoring during the inception phase were informed by the facility baseline assessments. Therefore, there was no standard set of indicators to monitor the progress of SRH and HIV integration at the facility level over time. However, the indicators that were used for reporting can be used to assist in identifying facilities that have gaps in their implementation.

Table 3: List of indicators reported for uThukela, Alfred Nzo and OR Tambo Districts

Indicator	Description	UThukela	Alfred Nzo	OR Tambo
2	Percentage of clients receiving services at HIV service delivery points who received modern family planning services	✓	✓	
3	Percentage of clients receiving services at HIV service delivery points who were screened for sexually transmitted infections (STIs)	✓	✓	✓
4	Percentage of clients accessing services at family planning service delivery points who were tested for HIV	✓	✓	✓
5	Percentage of clients accessing services at family planning service delivery points who were screened for STIs	✓	✓	
6	Percentage of clients accessing services at family planning service delivery points who were screened for cervical cancer	✓	✓	✓
7	Percentage of clients attending antenatal clinics who were tested for HIV	✓	✓	✓
8	Percentage of clients attending antenatal clinics who were screened for STIs	✓	✓	
9	Percentage of pregnant women living with HIV who received antiretroviral (ARVs) to reduce the risk of mother-to-child transmission of HIV	✓	✓	
17	Percentage of clients who received two or more services	✓	✓	✓

The following are the key indicators²¹ that were reported in OR Tambo district health facilities for assessing SRHR, HIV and TB services integration: Maternal, child and women's health (MCWH) indicators; HIV indicators; ANC HIV positive; total number of HIV tests done; ANC HIV positive screened STI, HIV tests positive; HIV positive screened for TB; ART Naïve start ART; CD4 done on newly diagnosed HIV+ and condom distribution.

The following are the key indicators that were reported in facilities in all three districts for assessing SRH, HIV and TB services integration: Incidence of TB (all types), 2015 (Cases per 100 000 population); delivery in a facility under 18 years rate, 2015/16 (%); cervical cancer screening coverage²², 2015/16 (Percentage of women 30+ /10); male condom distribution coverage by district, 2015/16 HIV testing coverage (including ANC)²³; 2015/16 (%); couple year protection rate²⁴, 2015/16 (Optidel Global, 2017: 16).

21 We used the indicators from Optidel baseline Data 3. A similar list of indicators was not provided for OR Tambo.

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

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

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

The next section summarises the results of the 2gether 4 SRHR programme and presents data per district by available indicator/s at baseline. The 2gether 4 SRHR data collection tool was administered in quarter one of the 2018/2019 financial year. Data in Figures 15 to 22, Tables 4 and 5 were collated from the Data 7 Report of 2gether 4 SRHR Baseline Data Quarter one – 2018/19 FY: Addendum to Final Project Report. The data collected were grouped into the following broad areas: (a) Obstetrics and gynaecology, (b) Family planning, (c) HIV, (d) Ante-Natal Care (ANC), (e) PMTCT, and (f) SGBV.

4.1 Baseline: OR Tambo District

The 2019 Umthombo weMpilo Institute report contained data for three months of assessment and the majority of the 2gether 4 SRHR indicators were not reported routinely at the selected facilities (UWI, 2019: 6). The implementers found that the district health information system monthly reporting form had only the following denominators:

- Total number of clients receiving services at HIV service delivery points.
- Total number of clients accessing services at family planning delivery points.
- The total number of clients attending ANC.

Data were collected for the following seven indicators in four health facilities in the OR Tambo District.

Indicator 3

Indicator three is the percentage of clients receiving services at HIV service delivery points who were screened for STIs. The data showed that in 2018, 87% ($n=302/347$) of clients at the Libodo clinic who were provided with HIV testing services (HTS) services, were also screened for STIs. During this assessment period, $n=163$ male clients who presented for STI treatment were also offered male condoms. Of these male clients, 58% ($n=95/163$) consented to HTS. At the Dundee clinic, 127 clients who were offered HTS were also screened for STIs and offered condoms. The Lubaleko clinic offered HTS and STI screening and information on contraceptive use to $n=97$ clients. At the Mtwana clinic, nine of $n=162$ clients were screened for STIs and offered condoms.

Indicator 4

Indicator four is the percentage of clients accessing services at family planning service delivery points who were tested for HIV. The data showed that in quarter 3 of 2019, $n=1\ 051$ HIV tests were conducted in the four facilities in OR Tambo. The majority of HIV tests were conducted at the Ntapane clinic (44.2%) and the Libode clinic (33.3%). Approximately 86% of females aged between 15-24 years old who accessed family planning services were also offered HIV counselling and testing. The most common family planning method provided to young females was injectables.

Indicator 5

Indicator five is the percentage of clients accessing services at family planning service delivery points who were screened for STIs. The data showed that during August and September 2018, the Libodo clinic conducted $n=139$ pregnancy tests for clients aged between 25-49 years of age. Of this number, 79% were screened for STIs, counselled and offered contraceptives.

Indicator 6

Indicator six is the percentage of clients accessing services at family planning service delivery points who were screened for cervical cancer. In 2018 it was reported that cervical cancer screening was well integrated into the SRHR services in OR Tambo, although no specific client numbers were reported.

Indicator 7

Indicator seven is the percentage of clients attending antenatal clinics who were tested for HIV. The data showed that in quarter three of 2019, $n=89$ women who attended the antenatal clinic were tested for HIV. The highest HIV-positive proportion (55%) was reported at the Ntapane clinic, while the Nolitha clinic reported the lowest HIV-positive proportion at 3.4%.

Indicator 8

Indicator eight is the percentage of clients attending antenatal clinics who were screened for STIs, showed that $n=89$ women attending ANC were screened for STIs in quarter three of 2019. As with indicator seven above, the Ntapane clinic had the highest percentage of STI cases at 55%, while the Nolitha clinic had the lowest proportion of recorded STIs at 3.4%.

Indicator 17

Indicator seventeen is the percentage of clients who received two or more services, showed that the provision of services for GBV, prevention of unsafe abortions and the management of post-abortion care was low. The facilities assessed in 2019 did not offer these services, instead, they referred clients to outside providers. In addition, termination of pregnancies services were not delivered in these facilities.

4.2 Baseline Results: Alfred Nzo District

Alfred Nzo District reported on all nine indicators (see Table 2). In this section, we summarise available data for nine indicators at baseline. The data are presented as proportions for each indicator in the five health facilities, and were categorised into the following age categories (10-14, 15-19, 20-24, 25-49 and 50+ years).

Indicator 2

Indicator two is the percentage of clients receiving services at the HIV services delivery point who received modern family planning services. The results show that overall, only 34% of the clients accessing HIV services also received family planning services. Among all age groups, less than 50% of clients received integrated HIV and family planning, with the highest among 20-24 years (47%) and lowest among 10-14 years (2%) and 50+ years (6%).

Indicator 3

Indicator three is the percentage of clients receiving services at HIV service points who were screened for STIs. For this indicator, only Rode Clinic provided this service at baseline, and in the Mangqamzeni healthcare facility, data were reported only for the 20-24-year-old age group. Hence an average of 18% of clients were reported to have been screened for STIs across all five health facilities. Compared to the other clinics assessed, this clinic had well-documented records of services provided to clients.

Indicator 4

Indicator four is the percentage of clients accessing services at family planning service delivery points who tested for HIV. All five facilities except for the Amantshangase clinic reported data for this indicator. Overall, an estimated average of 36% of clients were tested for HIV in the four clinics at family planning service delivery points. An estimated 39% of clients aged 25-49 years tested for HIV in four facilities, while only 3% of 10-14-year-old clients and 11% of 50 years and above had tested. Rode clinic had the best coverage, where over 80% of clients aged 15-49 years accessed this service.

Indicator 5

Indicator five is the percentage of clients accessing services at family planning service delivery points who were screened for STIs. During the period under assessment, only two facilities had integrated family planning services with STI screening, namely, the Ndela and Rode clinics (average of 18%). At the Ndela clinic, approximately 1% of clients aged 15-19 years, 2% of clients aged 20-24 years, and 1% of clients aged 25-49 years old accessing family planning services were screened for STIs. Rode clinic, on the other hand, had high rates of STI screening with 71% of clients aged 15-19 years, 64% aged 20-24 years, and 15% of clients aged 25-49 years old (Optidel Global: Data 3_uThukela and Alfred Nzo baseline data).

Indicator 6

Indicator six is the percentage of clients accessing services at family planning service delivery points who were screened for cervical cancer. An average of 4% of clients accessing cervical cancer services were screened, 1% aged between 20-25 years, 9% for 25-49 years, and 14% for 50 years and above. The report cautions though that data collection did not consider the eligibility criteria for this service and the lack of recording related modalities of 2gether 4 SRHR Baseline Data (Quarter one – 2018/19 FY: Addendum to Final Project Report).

Indicator 7

Indicator seven is the percentage of clients attending antenatal clinics who tested for HIV. The data showed that over 90% of clients accessing ANC services were tested for HIV. Alfred Nzo is the only district that reported HIV testing data for clients aged 10-14 years in the Mangqamzeni healthcare facility.

Indicator 8

Indicator eight is the percentage of clients attending antenatal clinics who were screened for STIs. The data showed that all clients attending antenatal clinics were also screened for STIs. This result is attributed to the routine screening for syphilis.

Indicator 9

Indicator nine is the percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of transmission of HIV from mother to child. The finding presented in the baseline report showed that all pregnant women aged 20 years and older who tested positive for HIV, were on antiretroviral treatment in the five facilities. However, data for young females aged 10-14 years were limited.

Indicator 17

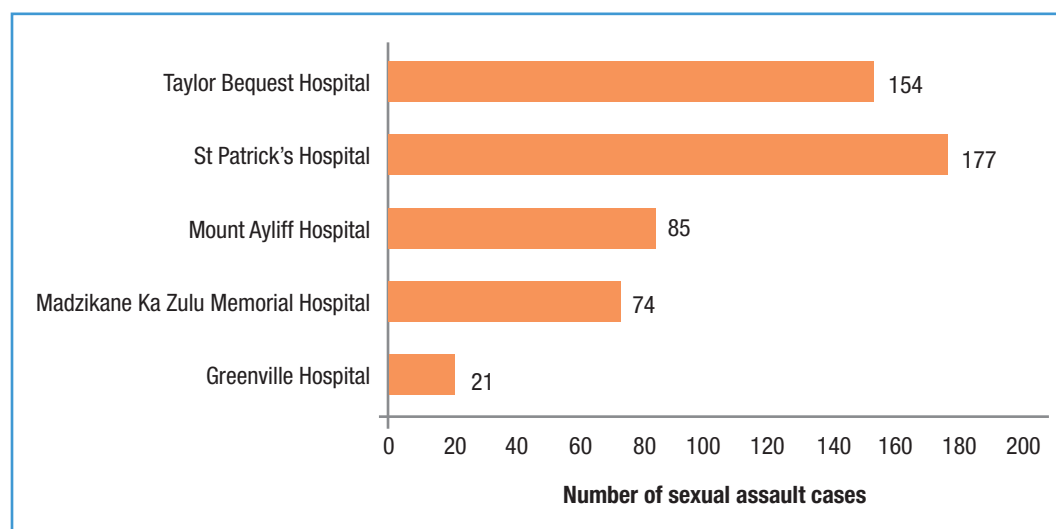
Indicator 17 is the percentage of clients who received two or more SRHR, HIV and SGBV services. The data showed that the Mangqamzeni and Rode clinics were the only facilities that reported providing services to the 10-14-year-old age group. In all five health facilities, these services were mostly accessed by 20-24-year-old young people.

In addition to the nine indicators reported, the Alfred Nzo District also reported on SGBV indicators i.e., new sexual assault cases and care services offered to sexually assaulted clients. These services are not provided at the five Alfred Nzo health facilities and are usually performed by specialised hospital facilities.

Other relevant indicators**Indicator 11**

Indicator 11 is the total number of clients accessing SGBV services. The health facilities were also required to collect data on GBV indicators. Of the five hospitals reviewed in the 2018-2019 financial year in Alfred Nzo, St Patrick's ($n=177$) and Taylor Bequest Hospitals ($n=154$) reported the most clients who were sexually assaulted.

Figure 4: New Sexual Assault Cases in Alfred Nzo – 2018-2019



Source: Report of 2gether 4 SRHR Baseline Data (Quarter one – 2018/19 FY): Addendum to Final Project Report.

Indicator 11 also included the percentage of clients accessing SGBV services at health facilities who have been provided with the full package of post-exposure prophylaxis (PEP) within 72 hours of an incident, both males and females²⁵.

Care Services offered to Sexual Assault Clients: PEP, 2020-2021 in the Alfred Nzo District

Among sexually assaulted clients who presented at the hospitals, on average prophylaxis treatment was given to 62%. However, the results for this indicator must be interpreted with caution as the proportion of clients eligible for PEP is unknown and is dependent on the number of HIV-negative clients who presented at the facility for this service. The facility with the lowest proportion of clients who were offered PEP was Mount Ayliff (55%) followed by Madzikane KaZulu Memorial Hospital (68%) and St Patrick (69%). Sipepetu (94%) and Greenville Hospitals (100%) had the highest proportion of clients who were offered PEP.

4.3 Baseline: uThukela District

UThukela District reported on nine additional services provided at baseline for the facilities listed in Table 3. The data are presented as proportions for each indicator in the 12 health facilities and categorised into the following age categories (10-14, 15-19, 20-24, 25-49 and 50+ years). Our review of the data (Optidel 2018/2019) showed no data reported for the 10-14 and 50+ age groups. Reasons for this were not provided in the report that was reviewed.

Indicator 2

Indicator two is the percentage of clients receiving services at HIV service delivery points that received modern family planning services. The data showed that in the 2018/2019 financial year there was no record of services provided to clients younger than 15 years and clients older than 50 years.

Overall, for the district, an average of 32% of clients were reported to receive family planning services at the HIV service delivery point. Across all 12 facilities, for clients accessing family planning services, approximately 20% were aged 15-19 years, whilst 43% were 20-24 years, and 48% were aged 25-49 years (together 4 SRHR baseline data). The report indicates that data were available but noted challenges in that the data had to be synthesised from different sources, and that data were inconsistent and not routinely collected at the facility level in the required format.

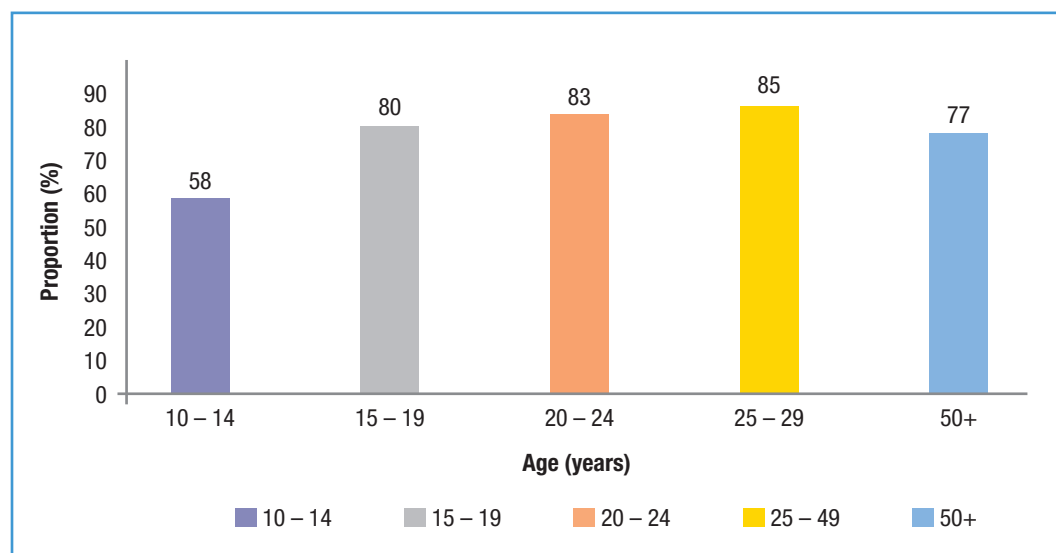
Indicator 3

Indicator three is the percentage of clients receiving services at HIV service delivery points that were screened for STIs. An average of 70% of clients were tested for both HIV and STIs. This indicator is theoretically meant to achieve a 100% deliverable because all clients who are tested for HIV should also be tested for other STIs per the STI screening and testing guidelines (NDoH, 2018).

²⁵ Indicator 11 on SGBV Services includes total number of clients accessing SGBV services at health facilities as well as the number of clients accessing SGBV services at health facilities provided with the full package of post-exposure prophylaxis (PEP), hence both indicators are referred to as Indicator 11. (Source: Report of Together 4 SRHR Baseline Data - addendum to Final Project Report)

It was noted that STI screening is part of routine screening among HIV-positive people presenting at health facilities. Figure 5 shows the proportion of clients who received services at HIV service delivery points and were screened for STIs by age group in the 12 health facilities in uThukela District. Between 58%-85% of clients (on average) were screened for STIs. Screening for STIs was lowest among the youngest age group of 10-14 years (Figure 5).

Figure 5: 2gether 4 SRHR – Average percentage of clients receiving HIV services who were screened for STIs, 2018/2019, 12 health facilities in uThukela



Source: Report of 2gether 4 SRHR Baseline Data: Quarter one- 2018/19 FY: Addendum to Final Project Report. Data 3_uThukela and Alfred Nzo Baseline data (percentages are reported)

Indicator 4

Indicator four is the percentage of clients accessing services at family planning service delivery points that tested for HIV. The data showed that the majority of family planning clients of all ages were tested for HIV (average of 88%) across all 12 health facilities (Figure 5). Data for the youngest (10-14 years) and oldest age groups (50+ years) were not reported. Optidel Global also provided a cautionary note that the reported data were not reliable (Optidel Global, 2019).

Indicator 5

Indicator five is the percentage of clients accessing services at family planning delivery points who were screened for STIs. The data found that an average of 98% of clients received this service in the district, with data reported for 15–49-year-old clients.

Indicator 6

Indicator six is the percentage of clients accessing services at family planning service points who were screened for cervical cancer. The data showed that the proportion of clients screened was low and data were reported for age groups 25-49-year-old for all 12 health facilities while only the Injisuthi healthcare facility reported this indicator for 20-24-year-old young women.

Indicator 7

Indicator seven is the percentage of clients attending ANC that tested for HIV. The data showed that 100% was achieved in all 12 health facilities in this district for ages 15-49 years; with 0% reported for ages 10-14 years and 50+ years.

Indicator 8

Indicator eight is the percentage of clients attending ANC that were screened for STIs. The data showed that all (100%) clients were screened for STIs in the 12 health facilities in this district for ages 15-49 years with 0% reported for ages 10-14 years and 50+ years.

Indicator 9

Indicator nine is the percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission (MTCT) of HIV. The results showed that all (100%) clients received ART for PMTCT in the 12 health facilities in this district for ages 20-49 years, with 0% reported for ages 10-14 years, 15-19 years and 50+ years.

4.4 Results in terms of process

The previous section presented baseline results for key SRHR and SGBV indicators in the three districts. As mentioned previously, the baseline results were used to establish the status of SRHR and HIV integration at the facility level. The rapid assessments conducted at facilities informed the focus of the integrated SRHR and HIV services in each district. Each intervention was adapted to the needs of each facility and hence the indicators reported and monitored varied. In terms of process, once the baseline assessments were completed, inception activities commenced as part of the roll out of the intervention, and this entailed strengthening areas where specific needs were identified. In this section, we present results from the health system strengthening activities regarding healthcare workers, training and clients' uptake of services.

To close the gaps identified during the facilities skills audit conducted as part of the baseline assessment, strengthening human resources was identified as a critical focal area needing appropriate intervention. As part of the SRHR integration intervention, a selected number of healthcare workers were trained on the importance and practical steps of integrating the SRHR, HIV, and SGBV services. The recommendation from the baseline assessment for training was that capacity building of healthcare workers could be achieved using different approaches including in-service training, mentorship and supportive supervision in the district. The next section will present results from the healthcare workers training programme for OR Tambo and Alfred Nzo Districts. Some of the results will be presented per district, while others will be combined as per the sources from which the data were extracted.

4.4.1 Healthcare worker training: OR Tambo and Alfred Nzo Districts

The data sources for this section were annual reports provided by Optidel Global in 2017 and by UWI for 2018, 2019 and 2020, and the quarter four report for 2021. The facilities skills audit for the five health facilities in Alfred Nzo and OR Tambo Districts found a low proportion of staff trained (< 30%) in all the service areas analysed. Furthermore, Libode clinic in OR Tambo District consistently showed a higher proportion of staff trained.

4.4.1.1 *Healthcare worker training: OR Tambo District*

Training of healthcare workers was rolled out in five healthcare facilities in OR Tambo district in 2018. The training covered different aspects of SRHR integration and the improvement of services. Capacity building needs of healthcare workers varied, and the training offered was specifically adapted for each facility. In OR Tambo District, all healthcare workers from the supported facilities received some SRHR, HIV, and SGBV integrated training over the project period from 2018 to 2021. Continuous on-site training was provided during mentoring support visits during the implementation years. Training areas included family planning, prevention, treatment of reproductive cancers, and comprehensive sexuality education including AYFS. For family planning, OR Tambo District trained 59% of healthcare workers on the intra-uterine contraceptive device (IUCD) and 100% on sub-dermal implants. For the prevention and treatment of reproductive cancers, all (100%) healthcare workers were trained in cervical cancer screening. The implementers are currently mentoring 20 clinics in the Eastern Cape as part of the scale-up to improve the quality of AYFS. Below we present the key findings for each year of the implementation.

In 2017, across all five health facilities, there was no specific training data and only baseline data were presented in the annual report. In 2018, Libode clinic in OR Tambo District trained only one professional nurse on IUCD insertion, and the two resident nurses had not received training on taking cervical smears. In addition, the resident (two or three) Libode clinic nurses were trained in family planning counselling which included IUCD, and in liquid-based cytology.

In total, healthcare workers at 20 clinics in the Eastern Cape were mentored to improve the quality of AYFS and collect age-disaggregated data on access to SRH services. All 20 facilities were providing AYFS. However, in about half of the facilities, healthcare workers who were knowledgeable about AYFS had moved to other facilities. Therefore, new nurses had to receive on-site training on AYFS standards, together with training on the collection of age and sex-disaggregated data and the rationale for the collection of these.

The number of healthcare workers trained on data aspects was reported cumulatively for both OR Tambo and Alfred Nzo Districts. All ($n=23$) healthcare workers from the five facilities were trained on-site on data analysis and presentation of graphical outputs such as graphs, use of data for action, and development of quality improvement plans to track the facility's performance for HIV and family planning indicators. All facilities had quality improvement plans that could be updated monthly and graphs that could be used to track programme performance. Five facilities in both OR Tambo and Alfred Nzo Districts were assisted to develop client flow maps to ensure clients entering each ICM stream were offered related SRH/HIV services.

In total, 27 professional nurses from the five healthcare facilities in both OR Tambo and Alfred Nzo Districts were mentored on programmes to integrate each stream of the ICM. During each mentoring visit, on-site training on the delivery of SRH, HIV, TB and STIs and CTOP integration was done. At the acute and chronic streams, mentoring covered screening, counselling and provision of family planning, HIV testing and counselling, and cervical cancer screening. At the MCWH stream, mentoring covered TB screening, ARV initiation, and adherence counselling/screening.

In 2019, the scale-up of SRH integration focussed on healthcare worker training about TOP. The targeted facilities were those that were not providing the services and gradually

included the community health centres, monthly mentoring of the facilities to strengthen the SRHR and HIV services integration in four OR Tambo District healthcare facilities commenced in quarter three of 2019. In both OR Tambo and Alfred Nzo Districts, comprehensive abortion care (CAC) training covering 17 modules was provided to $n=33$ registered midwives and nurses from eight Eastern Cape Health Districts. Thus the training was provided well beyond the two intervention districts. A pre-test was administered at the start of the training, tests were written after each module, and a final examination was written at the end to measure the healthcare workers' knowledge, awareness, and attitudes following the training intervention. At the end of the training, participants improved their knowledge regarding abortion services, rights, and contraception (family planning). Based on the written assessments of the training areas, the training of professional nurses was found to be successful with the average mark achieved being 86%. It was reported that the training offered was well coordinated, and the facilitators were well prepared and supported by the Eastern Cape Provincial Department of Health senior personnel from the Maternal Child and Women's Health Department.

In both OR Tambo and Alfred Nzo Districts, mentors continued to monitor progress and interventions during their support visits and focused on re-training of healthcare workers on data collection to minimise errors, data analyses, and use of data to improve the AYFS services, development of AYFS service plans, assistance in monitoring and tracking referrals between the facilities and the communities (i.e., schools, WBOTs).

In March 2020, the emergence of COVID-19 in South Africa led to lockdown risk-adjusted strategies that restricted movements and mass gatherings, although people could seek out healthcare services. Therefore, face-to-face training of healthcare workers was delayed in 2020 and 2021. Attempts were made to use virtual platforms to conduct virtual training, however, this was not feasible because of the technological challenges of healthcare workers not having smart devices, data and experiencing connectivity issues. In 2020, there was a rollout of on-site training in each of the health facilities in both OR Tambo and Alfred Nzo Districts, covering the NDoH and NICD COVID-19 guidelines. In lockdown level three healthcare service delivery was intermittently disrupted in five facilities for a short period. This was mainly due to healthcare worker infections. During lockdown level four, health facility attendance of clients was not greatly affected, and all facilities remained open. However, there were several reported challenges that included the non-availability of personal protective equipment for staff.

The focus on youth services continued with mainly on-site training with two professional nurses per facility in both OR Tambo and Alfred Nzo Districts (i.e., a total of $n=42$). Monthly refresher training covered the 10 AYFS standards, AYFS indicators, data collection, analysis, reporting, and use of data to improve AYFS services (which was covered in the first quarter). Training needs were also identified by reviewing a sample of client cards ($n=3$ client cards per facility) to inspect evidence of integration of services. On-site training was then provided to close gaps identified during this exercise.

In 2021, there was a transition to strengthening and supporting the SRHR interventions adopted in the implementing health facilities and the districts to facilitate sustainability. All the supported facilities were sustaining the integration of HIV and SRHR services (e.g., HIV testing and counselling, ARV treatment, condom provision, family planning, STI screening and treatment, ANC and PMTCT). With regard to strengthening the delivery of quality AYFS, 10 facilities were mentored on the delivery of quality AYFS and collection of age and sex-disaggregated data, and were found to be reporting these (UWI Quarter

four report, 2021). Seven facilities in OR Tambo District were fulfilling the five minimum standards for AYFS and were considered implementing sites. Nyandeni in OR Tambo District did not meet the minimum standards for AYFS, and it was reported that there was no training plan in place to meet the standards.

With regards to SGBV screening, Optidel Global facilitated the use of the SGBV client data collection tool in 2019, which was introduced by uThukela District Department of Health and distributed to the facilities. The tool assists in referrals and linkages to support SGBV clients. Furthermore, on-site training of healthcare workers on SGBV guidelines continued during mentorship visits. In 2020 it was reported that there was a gap in SGBV services training of healthcare workers, particularly on the new NDoH guidelines. In 2021, data on the integration of SGBV services was reported for the first time. It was reported that there were improvements at primary healthcare clinics in the SGBV service uptake. Healthcare workers' skills to screen for SGBV also improved as they provided a safe and confidential environment for facilitating disclosure of violence and offered an empathic response using the LIVES approach. Furthermore, SGBV clients were offered emergency prophylactic treatments and coordinated referrals to other resources and services (UWI Quarter Four Report, 2021). The next section summarises additional healthcare worker training that was rolled-out in the Alfred Nzo District.

4.4.1.2 Healthcare worker training: Alfred Nzo District

The results for healthcare workers' training were synthesised from UWI reports dated 2018, 2020 and 2021. In 2017, it was reported that two nurses who were trained on AYFS had left the facility in Dundee. By 2018, there was an increase in the number of professional nurses that were trained. Four professional nurses were trained on AYFS standards in Dundee. In Lubaleko, one professional nurse was not trained in Implanon insertion. In Lubaleko, on-site demonstrations were conducted on Implanon insertion. In Amadiba, in-service training was conducted for one professional nurse in the acute care stream on the guidelines for cervical and breast cancer screening. During the 2019-2020 reporting period, training of healthcare workers in the Alfred Nzo District healthcare facilities continued as shown in Table 6. The training areas covered integrated services on SRHR, HIV and SGBV, comprehensive sexuality education including AYFS, ANC and postnatal care, family planning, safe and post-abortion care, HIV and STI treatment and care, prevention, treatment of reproductive cancers, and SGBV prevention, mitigation and response.

In 2020, mentorship visits were conducted focusing on the insertion and removal of implants. This was aimed at improving the competency of healthcare workers in this area. Alfred Nzo District delivered formal training on long-acting reversible contraception (LARC) to 55 professional nurses. Therefore, each facility in Alfred Nzo District had at least one professional nurse who was trained on LARC. As mentioned for OR Tambo District, training of healthcare workers was disrupted due to COVID-19, however, all healthcare workers from the supported facilities received SRHR, HIV, and SGBV integrated training in the form of continuing on-site training during mentoring support visits. In addition, UNFPA donated personal protective equipment to the Alfred Nzo District healthcare facilities in September 2020. Strengthening the delivery of services continued in 2020-2021 in Alfred Nzo District and 48% of professional nurses were trained on IUCD insertion, 78% on cervical cancer screening, and 93% on insertion of sub-dermal implants. In 2021, SRHR training conducted in Alfred Nzo District was gradually yielding results, as reflected in the provision or uptake of LARC.

In 2021, Alfred Nzo District transitioned from the implementation phase and moved toward strengthening and supporting the existing SRHR interventions in the implementing healthcare facilities, and this included mentoring at the facilities. Training covering AYFS was provided to $n=40$ professional nurses. On-going support was provided to the trained nurses in the following areas: integrating syndromic management of STIs; HIV counselling and testing; ARV treatment; condom provision, family planning, ANC and PMTCT; management and referral of GBV; and mental health as essential components of SRH services for adolescents. With regard to strengthening the delivery of quality AYFS, 10 facilities in the Alfred Nzo District were mentored on the delivery of quality AYFS and collection of age and sex-disaggregated data, and were found to be reporting these (UWI Quarter four report, 2021). The training was supported by the Eastern Cape Province Department of Health. Nine facilities in Alfred Nzo District were fulfilling the five minimum standards for AYFS and were considered as implementing sites. Furthermore, the partners conducted and supported the training of healthcare workers within the implementing districts as well as other districts in the Eastern Cape. Therefore, the training benefits were accrued across the healthcare facilities within the Eastern Cape Province.

Table 4: Training results in the Alfred Nzo District 2019-2020

Training area	Intervention year: 2019-2020	Intervention year: 2020
Integrated services on SRH/HIV/SGBV	10 nurses out of a total of 15 nurses were trained in two clinics namely the Rode and Mangqamzeni clinics	Three nurses out of a total of ten were trained in the Rode clinic
Comprehensive sexuality education including AYFS	Two nurses out of a total of nine nurses were trained in the Ndela and Mangqamzeni clinics	
Antenatal and postnatal care	Six out of a total of nine nurses were trained in the Ndela and Mangqamzeni clinics	
Family planning	13 out of 19 nurses were trained in the Rode, Ndela and Mangqamzeni clinics	Three nurses out of a total of ten were trained in the Rode clinic
Safe and post-abortion care	All nurses in Ndela ($n=4$) and Mangqamzeni ($n=5$) clinics were trained	
HIV and STI treatment and care	12 out of a total of 15 nurses were trained in the Rode, Ndela and Mangqamzeni clinics	
Prevention and treatment of reproductive cancers	10 out of a total of 19 nurses were trained in the Rode, Ndela and Mangqamzeni clinics	
SGBV prevention, mitigation and response	Five of 25 nurses were trained in the Mangqamzeni clinic	

In the next section, we describe the training provided by Optidel Global for healthcare workers in uThukela District health facilities.

4.4.2 Healthcare worker training: uThukela District

The results for healthcare worker training were synthesised from the following Optidel Global reports: 2017, 2018, 2019, 2020, 2021 and 2022. Over this period, baseline and end-line training assessments were carried out from the inception phase, to rollout and scale-up in the selected uThukela District healthcare facilities, and these results are summarised in this section.

A training needs assessment questionnaire was used in the five healthcare facilities during the initial baseline assessment. This facilitated identifying specific training gap areas. After the baseline assessment was concluded, it was reported that more staff were trained in family planning services than any other SRH services in the five healthcare facilities in uThukela District (i.e., Injisuthi, Ntabamhlophe, Wembezi, AE Havilland and Ncibidwane Clinics), and some gaps were found e.g., for IUCD insertion, Implanon insertion and cervical cancer screening. Furthermore, less than 40% of staff were trained in the other SRHR services that were assessed. Therefore, as was observed in the Eastern Cape Districts, the recommendation was that capacity building of healthcare workers could be provided using different approaches including in-service training, mentorship, and supportive supervision.

Training of healthcare workers was rolled out in September 2018. At the end of December 2018, only three healthcare workers from the five supported healthcare facilities attended a five-day family planning training session. The main reason for healthcare workers not being able to attend the training session was staff shortages at their workplaces. Hence the recommendation was to implement on-site training at the health facilities. At the end-line assessment in 2019, there were some reported improvements in training, but some gaps remained for IUCD insertion, Implanon insertion and cervical cancer screening (see Table 6).

In 2020, a survey of $n=128$ professional nurses from the 12 facilities in uThukela District showed some gaps in implementing SRH and HIV services. The targeted approach to training focused on integrated services (SRH, HIV, TB, and SGBV); comprehensive sexuality education (including AYFS), postnatal care, IUCD insertion, Implanon insertion; safe and post-abortion care, HIV and STI treatment and care; prevention and treatment of reproductive cancers (cervical cancer screening), SGBV prevention, mitigation and response; and TB management.

As from December 2020, Optidel Global together with district training units worked with healthcare workers at the 12 supported facilities to implement facility-specific interventions. Peer learning, training and competency mentorship continued, whilst monitoring other SRH/HIV indicators to ensure integration of services occurred. Competency levels were also assessed in 2020-2021. Overall, lower proportions of the trained healthcare workers were reported to be competent in most of the training areas at the initial assessment in 2020 (see Table 6). In 2020, training of healthcare workers in abortion-related services and SGBV services was low. Only 3% ($n=4/128$) of healthcare workers were trained in abortion-related services, while 2% of those healthcare workers were found to be competent. Similarly, only 9% ($n=10/128$) of healthcare workers were trained in SGBV services, while 8% of those healthcare workers trained were found to be competent. In 2020, between 30-55% of healthcare workers were trained in IUCD and Implanon insertion, and the proportion of competent healthcare workers in these indicators was reported to be lower than the proportion trained.

Overall, by 2021, the training skills audit showed an increase over time in the number of trained professional nurses closing the training gaps identified at baseline in the 12 uThukela District health facilities (see Table 6). In addition, competency improved compared to baseline assessments, specifically in the following key capacity-building SRHR/HIV focal areas: IUCD and Implanon insertion, as well as SGBV services. In 2021, more healthcare workers were trained in abortion-related services and SGBV services than in previous years. Approximately 63% ($n=97/153$) of healthcare workers were trained in abortion-related services, while 38% of those healthcare workers trained were found to be competent. During 2021, more healthcare workers were trained in SGBV services (81%, $n=124/153$) and 75% of those healthcare workers trained were found to be competent.

With regard to the other indicator areas, training healthcare workers for cervical screening was over 80% ($n=51$) in 2018-2019 and this improved to over 90% in 2020-2021 (see Table 7). The training of healthcare workers in cervical cancer screening was sustained from 2020-2021. Competency in cervical screening remained over 90% among healthcare workers trained in 2020-2021 (see Table 6). Similarly, in 2020, over 87% ($n=128$) healthcare workers trained in ANC and postnatal care, comprehensive sexuality education, HIV and STI treatment and care, and SRHR/HIV/TB/SGBV integration, and competency levels were over 90%.

During the seven-month implementation period from September 2021 to March 2022, the project was scaled up to 53 healthcare facilities in three districts in KwaZulu-Natal, namely uThukela, Ugu and eThekweni. During the on-site training, there were COVID-19 restrictions, which limited the number of healthcare workers that could be trained at one venue. However, it was reported that all three KwaZulu-Natal districts received training. A training needs assessment or skills audit was first conducted, and areas with the most training gaps identified were: safer conception, Nurse Initiated Management of Antiretroviral Treatment (NIMART), IUCD insertion removal and standard operating procedures for condoms (as less than 50% of healthcare workers were trained) (Optidel Global, 2022). On-site training and refresher training were provided as part of mentorship activities using tools, job aids and guidelines (see Appendix 2 for a list of data collection tools). Practical demonstrations were also provided to improve competency. A total of $n=26$ healthcare workers from uThukela out of $n=79$ healthcare workers from the three KwaZulu-Natal districts were trained on cervical cancer screening, SGBV and contraceptive services during a three-day comprehensive off-site training schedule.

Training results for uThukela District showed that a total of $n=26/178$ healthcare workers were trained as part of comprehensive off-site SGBV services training. A further $n=45/178$ healthcare workers were trained as part of on-site SGBV services training. In addition to the formal training on SGBV services at the district level, $n=71/178$ healthcare workers were trained in the LIVES methodology. Furthermore, $n=231$ healthcare workers were mentored on the use of LARC, $n=241$ were mentored on cervical cancer screening and $n=230$ healthcare workers were mentored on the use of job aids and the dashboard for supervision. A total of $n=21$ campaigns were held to deliver practical demonstrations of Implanon and IUCD insertions. By the end of the 2022 intervention period, it was reported that the formal comprehensive SRH training targets – including in-house and facility level training – were achieved. The training of healthcare workers was a critical part of the intervention to improve the integration of SRHR and HIV services.

Table 5: Training of healthcare workers in uThukela District, 2018-2021²⁶

Year	2018 (September baseline) ²⁷	2019 (February end-line)	2020 ²⁸ (January to March and October to December)	2020 (October to December baseline) ²⁹	2021 (January to March end- line) ⁴⁴
Specific Training needs	Number and Proportion of Nurses trained in five facilities		Number and Proportion of Nurses trained and found to be competent in 12 facilities		
IUCD insertion	24% (12/51)	45% (23/51)	37% (47/128) Competent 20% (20/128)	34% (44/129) Competent 19% (24/129)	63% (97/153) Competent 38% (58/153)
Implanon insertion	61% (31/51)	63% (32/51)	54% (69/128) Competent 43% (55/128)	55% (71/129) Competent 44% (57/129)	81% (124/153) Competent 75% (114/153)
Cervical screening	82% (42/51)	84% (43/51)	93% (119/128) Competent 93% (119/128)	92% (119/129) Competent 92% (119/129)	97% (149/153) Competent 96% (147/153)
Abortion related services			3% (4/128) Competent 2% (3/128)		
SGBV			9% (12/128) Competent 8% (10/128)	9% (12/128) Competent 8% (10/128)	75% (115/153) Competent 75% (115/153)
ANC and postnatal care			92% (118/128) Competent 90% (115/128)		
TB management			87% (111/128) Competent 93% (119/128)		
Comprehensive sexuality education			95% (122/128) Competent 95%		
HIV and STI treatment and care			96% (123/128) Competent 95% (122/128)		
SRH/HIV/TB/SGBV integration			96% (123/128) Competent 96% (123/128)		

26 We used percentages and numbers from the Optidel report rather than the spreadsheet from Data 1.

27 Report 3_Optidel UNFPA uThukela SRH/HIV Integration-Project Report, 2019.

28 We calculated the number of nurses trained using the total number of nurses in all 12 health facilities ($n=128$) and proportions provided in Figure 3 for each training area from the UNFPA-Optidel Mid Project Report 2020.

29 Optidel Model of SRH/SGBV/TB integration report April 2021.

In addition to improving healthcare workers' skills through training, mentoring and supervision, Optidel Global also interviewed healthcare workers in 10 health facilities in 2017 to gain insights into their perceptions of and perspectives on SRHR integration (Optidel Global, 2017). At that time, most healthcare workers indicated that SRHR integration would increase their workload, time spent per client, and need for equipment as barriers. Hence it was important to assess the uptake of services at baseline in 2017 to identify gaps and improve the efficacy of the provision of integrated services. However, it is important to note that these negative perceptions changed over time at the scale-up phase, and healthcare workers held a view that efficiency in service provision would be improved with integration. They also believed that the integration of SRHR and HIV services provide an opportunity to facilitate and enhance the offering to clients at these facilities.

The next section summarises the clients' uptake of services. Clients' uptake of services was measured at different service points namely, at baseline and end-line. The focus of the measurement of services was on the integration with HIV, family planning and ANC end-line. The data sources for this section were the Optidel Global in 2017 and the annual reports provided by UWI for 2018, 2019 and 2020, and the quarter four report for 2021.

4.5 Client services uptake in OR Tambo and Alfred Nzo Districts

To quantify the uptake of SRHR and HIV services amongst youth in the Eastern Cape district health facilities, data were collected monthly. In 2019, it was reported that clients seeking family planning and STI services were receiving a wider range of HIV services as part of the services provided by healthcare workers (UWI, 2019). It was also reported that due to COVID-19, fewer healthcare workers were available for service provision which included TOP (UWI, 2020). During implementation, where HIV services were offered within SRH services, those services were implemented by the same healthcare worker at the same site and on the same day. Therefore, this suggests that the implementation of SRHR and HIV services was successfully integrated. Overall, 20–24-year-old females had the highest uptake of integrated services when compared to males.

4.5.1 Client Services Uptake: OR Tambo District

When the districts were compared, we observed that OR Tambo District had focused on adolescents and young adults. As of 2021, a total of $n=5\ 835$ adolescents and young adults aged 10–24 years accessed Integrated SRHR, HIV and GBV services in OR Tambo District healthcare facilities. Therefore, OR Tambo district health facilities showed an improvement in the integration of GBV services with SRHR services. This is aligned with indicator 17, which is the percentage of clients who received two or more SRHR, HIV and GBV services. In total $n=3\ 564$ young females were provided with family planning methods that included oral contraceptives, injectables, and implants. During this period, injectables were the most common (88%) family planning method reported ($n=3\ 146/3\ 564$). Oral contraceptives were taken up by 11% of young women. However, none of the adolescent and young women presenting at the health facilities had received IUCDs (see Table 7) (UWI, 2021). It was reported that the high proportions of teenage pregnancies suggested a need for community-based interventions to increase the demand for SRHR services (UWI, 2021).

In total $n=793$ young girls and women aged 10-24 years were reported to have accessed ANC services. A further $n=3\ 134$ family planning clients aged 15-24 years were offered HIV counseling and testing (HCT) (aligned with indicator four which is the percentage of clients accessing services at family planning service delivery points who were tested for HIV). Therefore, the majority of 15-24-year-old females who accessed family planning services were offered HCT (UWI, 2021: 2). A total of $n=3\ 134$ female family planning clients aged 15-24 years in OR Tambo District were screened and treated for STIs. This is aligned with indicator five which is the percentage of clients accessing services at family planning service delivery points who were screened for STIs.

Termination of Pregnancy (TOP) Services

Umthombo weMpilo Institute, DoH and UNFPA collaborated in 2019 to scale up the TOP Services in six additional facilities in Alfred Nzo (Amadiba, Imizizi, Lubaleko, Dundee, Mntwana and Rhode), and four in OR Tambo (Libode, Ntaphane, Nontsikelelo Biko and Nolitha).

Umthombo weMpilo Institute contracted Ipas14 to conduct CAC, and values clarification and attitude transformation (VCAT) training for managers and pharmacists in the Alfred Nzo and OR Tambo Districts. Providers and managers reported having significant challenges regarding providing quality TOP services and meeting the demand for services.

Recommendations to address these challenges included training providers to increase the pool of existing TOP providers and sustain delivery of safe TOP services; conducting community awareness; and expanding TOP facilities and provision of both medical and surgical abortion. The following indicators showed improvements:

- provider-initiated counselling and testing as standard protocol in family planning services,
- capturing in tick registers,
- comprehensive ART, care, and support programs,
- post-natal care.

Sexual and gender based violence and abortion services

According to UWI (2019), SGBV, prevention of unsafe abortion, and management of post-abortion care service provision/uptake were low at baseline assessment. Another unintended consequence of the COVID-19 pandemic was an increased number of SGBV victims, especially young schoolgirls (as described in the excerpt below):

“...consequences of enforced self-quarantine or compulsory quarantine policy to contain the outbreak yielded negative results. The obligation for most people to be confined at home during the lockdown and the tension and pressure associated with that created a breeding ground for SGBV against women and children”
(UWI, 2020: 22).

4.5.2 Client services uptake: Alfred Nzo District

In 2021, a total of $n=10\ 113$ young people aged 10-24 years accessed integrated SRHR/HIV/GBV services in Alfred Nzo district health facilities. This service is aligned with indicator 17, which is the percentage of clients who received two or more SRHR/HIV/SGBV services. In total $n=6\ 493$ young females were provided with family planning methods including oral contraceptives, injectables and implants. During this period, injectables were the most common (73%) family planning method ($n=4\ 742/6\ 493$) (see Table 8). Oral contraceptives were accessed by 25% of young women. However, very few of the adolescent young women had received IUCD ($n=8/6\ 493$) or implants ($n=134/6\ 493$) (UWI, 2021). In total $n=1\ 400$ young girls and women aged 10-24 years had accessed ANC services. A further $n=5\ 768$ family planning clients aged 15-24 years were offered HCT, which is aligned with indicator four (percentage of clients accessing services at family planning service delivery points who were tested for HIV). It was reported that the majority of 15-24-year-old females who accessed family planning services were offered HCT (UWI, 2021: 2). A total of $n=5\ 768$ female family planning clients aged 15-24 years in OR Tambo District were screened and treated for STIs. This is aligned with indicator five (percentage of clients accessing services at family planning service delivery points who were screened for STIs). The screening of STIs was consistently done at Lubaleko Clinic over time. Mangqamzeni Clinic and Ndela Clinics did not screen clients for STIs at the HIV service points in the first and second quarters of 2020. This could be attributed to the COVID-19 epidemic, which overwhelmed healthcare facilities and redirected resources and focuses across the country to the epidemic response.

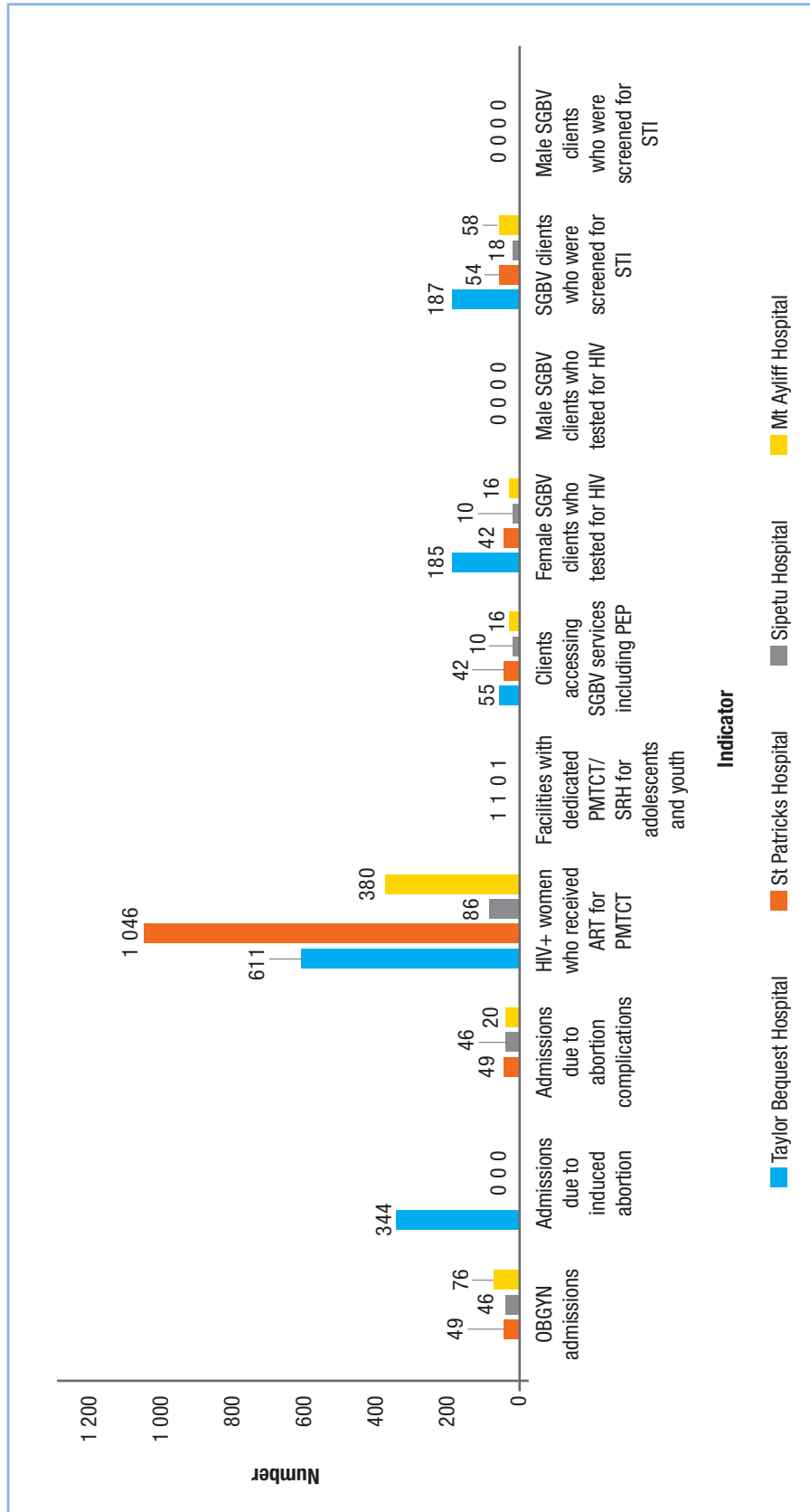
Sexual and gender based violence and abortion services

In 2017 it was reported that the least available services to clients were SGBV, prevention of unsafe abortion, and management of post-abortion care (Optidel Global 2017: 62). In October 2020 SGBV services uptake for four hospitals in Alfred Nzo were reported. The total number of clients who visited the facility during this period was not reported.

Taylor Bequest hospital was the only facility that recorded the number of women who were admitted due to induced abortion (aligned with indicator OCI three, which is the percentage of obstetric and gynaecological admissions due to abortion in selected districts)³⁰. This hospital admitted $n=344$ women because of induced abortions. The other three facilities recorded between $n=20$ and $n=49$ clients who were admitted due to abortion complications. It was not recorded whether the complications were caused by the hospital or by out-of-hospital induced abortions. The four hospitals reported the number of SGBV clients who were tested for HIV (aligned with indicator OCI 14, which is the percentage of clients accessing SGBV services who tested for HIV)²⁷ and screened for STIs (aligned with indicator 15 which is the percentage of clients accessing SGBV services that were screened for STIs). These data, however, showed that there were no male clients in this category (see Figure 6). The report does not include context as to why males were not listed.

30 Data 4 SGBV, Abortion and other SRHR Indicators

Figure 6: Number of clients who accessed GBV or abortion services in Alfred Nzo hospitals, 2020



Source: Data 4 SGBV, Abortion and other SRHR Indicators

Table 6: Number of clients who accessed integrated SRHR and HIV services in OR Tambo and Alfred Nzo Districts, 2021

Services utilised by clients	2021 (20 health facilities) in Eastern Cape	
	Alfred Nzo District	OR Tambo District
Indicator 17		
Number accessed integrated SRHR/HIV/GBV services		
10-14	1915	1246
15-19	3332	1393
20-24	4866	3196
Total (10-24)	10113	5835
Number of young girls provided with family planning methods		
Oral contraceptives	1609	401
Injectables	4742	3146
IUCD	8	0
Implant	134	17
Total	6493	3564
Indicator 4	5768	3134
Number of family planning clients aged 15-24 years offered HCT		
Number of HIV tests done on young people aged 15-24 years	4637	1490
Number tested positive	106	24
Number initiated on ART	106	24
Indicator 5	5768	3134
Number of family planning clients (females aged 15-24 years) screened and treated for STIs		
Number of young girls aged 10-24 years who accessed ANC services	1400	793

The next section reports on clients' uptake in uThukela District health facilities.

4.5.3 Clients' services uptake: uThukela District

Progress on clients' uptake of services was collated from routinely collected data for the service streams and the dashboard. The reported services were IUCD insertion, sub-dermal implants, and cervical cancer screening. This was part of the assessment for SRHR and HIV implementation (e.g., improved number of IUCD insertions over time). Performance levels were compared with the number of available healthcare workers per facility, and this was triangulated with the facility's client headcount. There was a decline in the facility head counts due to COVID-19, however, it was reported that project sites did show some improvements in clients' services uptake over time. Table 8 shows that IUCD insertion for clients was reported as being low, particularly in 2020, which also correlated with the low proportion of healthcare workers trained. Thereafter, the number of clients receiving IUCD insertions increased from 2020 to 2022 as part of the intervention. All HIV-positive women 20 years and older were eligible for cervical cancer screening. However, the numbers for cervical cancer screening among HIV-positive women 20-years and older, were less than that reported in 2020.

Sexual gender-based violence and termination of pregnancy services

During 2019-2020, none of uThukela health facilities reported data on the number or percentage of clients accessing SGBV services who were provided with the full package of PEP within 72 hours of a sexual assault incident (indicator *OCI 13*) (Optidel, 2019-2020). Similarly, there were no data on the number or percentage of obstetric and gynaecological admissions due to abortion or treatment of abortion complications (indicator *OCI 3*). In 2022, it was reported that $n=402$ new sexual assault cases were seen at uThukela District health facilities, and of those who were HIV negative, $n=169$ were issued with PEP, while $n=54$ testing positive were issued with PEP (Optidel, 2022). There were $n=130$ sexual assault cases reported for children aged 12 years and younger (Optidel, 2022).

Table 7: Number of clients who accessed family planning and cervical cancer screening services in uThukela District health facilities, 2019-2022

Year	April 2019 to March 2020 ³¹	April to June 2020	July to September 2020	September 2021 ³²	February 2022
Indicator	Number of clients receiving SRHR services at uThukela District (12–15 health facilities)				
IUCD insertion	409	68	58	83	119
Sub-dermal implant (Implanon insertion)	875	652	670	260	765
Cervical cancer screening for HIV-positive (20 years and older)	1 566	197	250	660	564
Cervical cancer screening for HIV-negative (30 years and older)	Not reported	199	224	220	250

³¹ Optidel, uThukela UNFPA SRHR/HIV integration mid-project report, 2020

³² Optidel, End of project report SRH/HIV/GBV/TB integration report. March 2022

4.6 Baseline assessment: Client exit interviews

To monitor the effectiveness of SRHR, HIV and SGBV services implementation, clients who were end-users of these services were also engaged in client exit interviews through convenience sampling at the healthcare facilities. The client exit interviews were semi-structured and performed at baseline and end-line to document selected clients' perceptions of the variety of services received at the selected facilities. Clients were also interviewed about their satisfaction levels with the services received. Results were reported as the percentage of clients who reported that they had received all of the services they wanted during their healthcare facility visit. The clients could rate their satisfaction levels with the service(s) received using a Likert scale: very dissatisfied, somewhat dissatisfied, mostly satisfied, very satisfied, don't know or does not wish to answer. In addition, the reason for their visits was documented. The baseline assessment results are presented first followed by end-line results where available.

A baseline assessment was undertaken where clients were interviewed to establish whether or not they had received all the services they sought in 10 health facilities, as well as their satisfaction levels with the services received. With regards to the demographics of the participants in the client exit interviews, generally, there were more female compared to male clients. The clients were predominately in the age range of 15-40 years ($n=151/189$ client interviews) (Optidel Global, 2017). Overall, for 2017 it was reported that an estimated 70% ($n=200$) of clients from all 10 health facilities in OR Tambo, Alfred Nzo and uThukela District preferred receiving SRH and HIV services from the same facility (Optidel Global, 2017). This finding suggests there was a demand and need for integrated SRHR and HIV services. The main reasons mentioned by clients for not receiving the services they sought were as follows: healthcare worker staffing (too busy, no social worker on site), shortage of equipment, lack of infrastructure (insufficient room for nurses), and unavailability of services (lack of particular service on weekends, not being able to take blood due to striking, lack of electricity), healthcare worker attitudes of being unfriendly, stock-outs, long waiting time, and clients cited as not knowing the reason or not being given an explanation as to the lack of service when they visited the facility (Optidel Global, 2017). Clients exit interview findings for each health district are described below.

4.6.1 Baseline client exit interviews: OR Tambo and Alfred Nzo district health facilities

In both OR Tambo and Alfred Nzo District healthcare facilities, 20 client exit interviews per health facility were conducted at baseline in 2017. The most common reasons for clients visiting the clinics were the need for HIV monitoring and/or treatment, minor ailments, integrated management of childhood illness (IMCI), maternal and newborn services, and family planning. Fewer clients visited the health facilities for SGBV, HIV prevention services, and STI management (Optidel Global, 2017).

In 2017, in OR Tambo District healthcare facilities, 60 client interviews were conducted (i.e. $n=20$ clients interviewed from three health facilities). A comparison of client services uptake among the three OR Tambo District health facilities found that the majority of clients had received the services they visited Libode clinic for (95%, $n=19/20$). This was followed by Ntaphane Clinic where 80% ($n=19/20$) of clients reported having received the services they came for. However, lower proportions of clients in Tombo clinic (70%, $n=14/20$) indicated they had received the services they sought. In 2017, in the Alfred Nzo District healthcare facilities, a total of 40 client interviews were conducted (i.e., 20 clients interviewed from two health facilities). A comparison between the two health facilities in Alfred Nzo district found more clients had received the services they sought at the Amadiba Clinic (75%, $n=15/20$) compared to the Ndela Clinic (65%, $n=13/20$). In terms of client satisfaction with the services received, overall, most clients expressed being satisfied across all OR Tambo and Alfred Nzo District healthcare facilities.

4.6.2 Baseline client exit interviews: uThukela District healthcare facilities

In uThukela District healthcare facilities, 20 client exit interviews in each of the five health facilities were conducted at baseline in 2017 (Optidel Global, 2017). The most common reasons for the decreasing order of services sought for clients visiting the clinics were, the need for HIV monitoring and/or treatment, family planning, ART treatment preparedness, minor ailments and IMCI. Fewer clients visited the health facilities for SGBV, psychosocial and HIV prevention services (including PEP and HIV education) (Optidel Global, 2017). Most clients (95%, $n=19/20$) indicated they had received the services they sought in both the Ntabamhlophe and Wembezi healthcare facilities in uThukela District. However, among all five uThukela healthcare facilities, fewer clients had received all the services they needed. In the Ncibidwane Clinic 70% ($n=14/20$) of clients visiting the clinic reported receiving the services. Furthermore, client satisfaction was reported across all uThukela District healthcare facilities, with the exception being clients at Ntabamhlophe Clinic, who reported the highest dissatisfaction. The majority of clients suggested that the main two priority areas for the facility to deliver SRHR services were adequate training of staff ($n=41/200$), and reduction of waiting times ($n=47/200$). The two main reasons for clients' preference for receiving SRHR services at the same facility were to minimise their travel costs and time is taken to access the health facility ($n=97/173$), and reduce waiting times ($n=52/173$). The results of the client exit interviews conducted at end-line are described next.

4.7 Positive changes and impact

4.7.1 Client exit interviews after intervention: OR Tambo and Alfred Nzo District healthcare facilities

As indicated above, Optidel Global conducted pre- and post-interviews to assess client satisfaction with the services rendered at the intervention sites. In 2021, it was reported that across all 10 facilities in the Eastern Cape, clients seeking family planning and STI services had received a wider range of HIV services at each stream of the ICM. When HIV services were offered within SRHR services, these were implemented by the same healthcare worker, at the same site, and on the same day (UWI, 2021).

4.7.2 Client exit interviews after intervention: uThukela District healthcare facilities

From September 2018, the following three indicators were chosen as tracer indicators for the baseline assessment of clients' services uptake of integrated SRHR and HIV services in the five health facilities: (1) HIV clients that received other services apart from the HIV services they came for; (2) proportion of eligible female clients offered cervical/breast cancer services (Information/screening/procedure); and (3) proportion of clients that had any other services mentioned to them during consultation. The above three indicators were followed up at the end-line of the project after five months, and changes in clients' uptake of the services during the intervention, were reported (Optidel Global, 2019). The client exit interviews were conducted across the three streams of service provision, namely, chronic, acute, and maternal and child health streams.

For the first indicator (HIV clients that received other services apart from the HIV services they came for), there was an overall improvement reported in the proportion of clients accessing HIV services who also received other services from baseline to end-line (Optidel Global, 2019). At baseline, 22% ($n=18/83$) of HIV clients had received other additional services, compared to 75% who had received additional services at the end-line assessment ($n=135/180$). For the second indicator (proportion of eligible females offered cervical/breast cancer services), there was an overall improvement in the proportion of eligible females offered cervical cancer or breast cancer services. At baseline, approximately 17% of females ($n=14/81$) were offered cervical or breast cancer screening services, which increased to 56% ($n=98/174$) at the end-line assessment. There was also an increase in the variety of services mentioned to clients during the consultation, i.e., an average of two services were mentioned to clients at baseline compared to five services mentioned at end-line across all five facilities in uThukela District.

Between September 2021 and February 2022, another baseline and end-line assessment was conducted to determine if clients received more than just the services they sought at the health facility. This was part of the SRHR and HIV service integration across all the ideal clinic streams at 12 uThukela healthcare facilities (Optidel, 2021). Over 240 clients were interviewed in total with about 20 clients per facility at both baseline and end-line assessments. It was reported that across all 12 healthcare facilities at baseline, clients received on average one additional SRHR service. At the end-line of the project in 2021, clients reported receiving (on average) three additional SRHR services (Optidel Global, 2021). This was sustained in 2022 (Optidel Global, 2022). Clients reported having high satisfaction levels with the services received. It was also reported that high proportions of clients preferred to receive the SRH and HIV services in one facility at the same time to save costs and waiting times.

4.8 Summary of uptake of services and clients' perspective

Since the emergence of COVID-19 in early 2020, the epidemic response overwhelmed healthcare facilities and caused disruptions, whilst resources had to be redirected to other health priorities. There was a subsequent decline in the facility head counts. However, it was reported that overall, the health districts in the projects showed improvements in clients' SRHR and HIV integrated services uptake.

In 2021, in OR Tambo and Alfred Nzo Districts, injectables were the most common family planning method utilised. The majority of 15–24-year-old females who accessed family planning services were offered HTS. Relatively fewer adolescent young women had received IUCD, or implants. Family planning clients aged 15-24 years in OR Tambo District were also screened and treated for STIs. The screening of STIs was consistently done at Lubaleko Clinic over time, however, some clinics did not screen for STIs. As of 2019, prevention of unsafe abortion and management of post-abortion care service provision/uptake was low. In uThukela District health facilities, IUCD insertion uptake was also low, particularly in 2020. Thereafter, in 2022 there was a reported increase in the number of clients receiving IUCD insertion because of the SRHR and HIV service integration intervention. However, the reports showed that during 2020-2022, cervical cancer screening among HIV-positive women aged 20 years and older, was low.

With regards to client perspectives in OR Tambo and Alfred Nzo Districts, clients expressed the need for integrated SRHR and HIV services, and preferred to receive the SRHR services at the same facility to save on their travel costs and minimise long waiting times at the facilities. Across all facilities in the Eastern Cape, clients seeking family planning and STI services had received a wider range of HIV services at each stream of the ICM. Similar promising results were reported for uThukela District healthcare facilities from the client's perspective. In uThukela District health facilities, at the end-line of the project in 2021, clients reported receiving on average three additional SRHR services, and this service provision was sustained in 2022. In summary, it was reported that there were observed improvements in the uptake of SRHR and HIV-integrated services during the project implementation.

Lessons learnt

In this section, we summarise lessons learnt in each of the intervention districts. Key lessons that emerged from the full SRHR integration intervention period are consolidated below.

- 1.** Overall, it was found that the phased approach adopted by Optidel Global and Umthombo weMpilo Institute was key to the success of the intervention. This agile and targeted approach to implementing the integrated SRHR intervention programme (pilot/baseline, inception, scale up) assisted in delivering positive changes over time. It also allowed implementers to use emerging lessons thoroughly to adapt and improve service delivery at intervention sites.
- 2.** Conducting facility baseline assessments before implementation was another key element that was important for gathering facility-specific information to inform and focus the implementation to address the specific needs of each facility, particularly in resource poor settings. This approach also ensured that the perspective of healthcare providers and their clients was factored into the intervention. Using the findings of the baseline assessments, the intervention was adapted to each facility's needs and situation, and upscaled to other facilities in the district and beyond. For scaling up the intervention, future implementers and the facilities they support need to adopt this agile and adaptable approach.
- 3.** Conducting skills audits and identifying skill gaps in selected intervention facilities was another critical component in the implementation of the integrated SRHR intervention. Tailored and continuous on-site training (incorporating face-to-face and practical lessons) during mentoring support visits contributed to improvements and sustained delivery of quality integrated services. Capacity building and training assisted in strengthening healthcare workers' knowledge, skills, and improved attitudes toward SRHR integration positively. It also ensured that healthcare facilities were at the forefront of service delivery by ensuring that clients could access the newer forms of LARCs.
- 4.** The importance of undertaking a scoping and mapping exercise before implementation also emerged as a critical step for linking and embedding the SRHR integration intervention within the existing services and resources in and outside the facilities. The mapping process followed four steps which included: (1) Understanding the context of the healthcare system, including National policies on PHC, and scoping the implementation environment by selecting study facilities for rapid assessment and pilot studies. (2) Engaging all known stakeholders, including facility staff and the district team. (3) Ensuring that the DHMT is assigned the role of coordinating the SRHR, HIV, SGBV, and TB integration implementation. (4) Learning how the facility works, in order to implement the plan and monitor progress to ensure that the intervention is effective (Optidel Global, 2021).

Enhancing linkages and referrals at the facility level was shown to have a positive impact on the delivery of integrated SRHR services in that it could also be used to support and assist clients at service points. For example, clients accessing SGBV services could be linked to the relevant support such as the Thuthuzela Care Centres (TCC) where available. Where the TCC were not available, healthcare workers could link clients to previously mapped services, which included relevant NGOs, the South African Police Services, and the Department of Justice and Constitutional Development.

5. The provision of mentorship and supportive supervision of facility-based healthcare workers was another key element in the success of the SRHR integration intervention scale-up. A few key lessons were highlighted through this intervention: (1) To strengthen oversight and supervision at the facility level it was important to partner with the Provincial and District Departments of Health. (2) To enhance functional and effective implementation, it is important to strengthen the quality of supervision that is delivered by all role players through regular visits by the implementor and the Department of Health district officials. These visits should be aimed at providing oversight, highlighting areas of improvement, identifying gaps, challenges and troubleshoot where necessary. (3) The intervention also illustrated the importance of including the perspectives of clients as part of supervision and monitoring of the intervention at health facilities. Where client interviews were conducted, this information was useful to provide feedback during supervision visits, and thus facilitated positive change. Reports of client satisfaction served to motivate the healthcare workers, while areas of dissatisfaction provided an opportunity to discuss challenges and identify what needed adjustment to achieve the required change within the facility.
6. The SRHR integration intervention also demonstrated the importance of enhancing documentation and handling of data within healthcare facilities. Part of the process to monitor and scale up the integration is to refine and enhance data collation tools and monitoring processes. To achieve this, healthcare facilities have to keep verifiable registers for all indicators for reporting and monitoring. These records should include, abortion-related admissions, SGBV clients, and males who tested for HIV. Dashboards and data collection tools were some of the innovative measures that were developed and implemented to monitor the progress and uptake of SRHR integrated services within the clinics. The intervention also illustrated that if dashboards are implemented well, they can be used as both tracking and motivation tools for the healthcare facility.
7. The importance of implementing an agile and adaptive SRHR intervention model was underscored by the advent of COVID-19 in 2020. For example, when COVID-19-related disruptions occurred, implementers had to rapidly pivot their focus, while still being able to sustain the intervention in the selected health facilities. The use of virtual technology (even though there were limitations) to continue providing off-site support to healthcare workers, was critical for the sustainability of the intervention during the lockdown, suggesting a need to invest in access to technology, Wifi routers, mobile data, and virtual platforms to facilitate communication and support for staff during periods where face-to-face meetings and visits are prohibited.
8. The sustainability of the integration of the SRHR, HIV, and SGBV services has to be facilitated from the beginning of the intervention by anchoring the intervention within the priorities and the policies of the National Department of Health. It is also important to ensure ownership of the intervention by the National, Provincial, and the District Departments of Health, together with the healthcare facilities. Within each facility, sustainability can be secured by appointing facility-based SRHR champions who will act as buddies or peer mentors for their colleagues. This is another form of additional support and mentoring that can be used to address the training and skills deficits within the facility.

9. For increasing coverage, achieving sustainability and showing success over time, the practice implemented by Umthombo weMpilo Institute of off-loading and adding new facilities annually is recommended. This practice involved assessing the performance of each facility and off-loading the best performing ones, then handing them over to be supported and monitored by the district Department of Health. Facilities that were deemed to be under-performing on the key indicators were retained and new facilities were added to replace those handed to the district Department of Health for continued support. Annually, 10 healthcare facilities in Alfred Nzo and 10 health facilities in OR Tambo were retained over the implementation. Through this process, new facilities were added to the intervention list of healthcare facilities. This practice is important for illustrating success of the intervention and also for testing mechanisms for ensuring technical support and sustainability of the intervention over time.

5.1 Challenges

Along with the positive changes already outlined, challenges were experienced during the implementation of the SRHR, HIV and SGBV services integration intervention. This section will summarise some of these challenges that made the implementation of SRHR integration difficult. These challenges were collated through the documentation exercise. The summary of challenges will focus on common themes across the three districts under review.

1. Although not common, some facilities experienced stock-outs of commodities – specifically, contraceptive methods. As such, female clients were the most affected by stock-outs. It was also noted that some of these challenges were a consequence of healthcare facilities not capturing some of the required indicators on their internal reporting systems.
2. As mentioned previously, referral systems were found to be important for facilitating a one-stop-shop or a supermarket model. Where services could not be accessed in the facility, adequate linkage to care was required. It was observed that referral systems did not always work efficiently when services that are not housed within primary healthcare facilities were required (e.g., clients seeking certain family planning methods such as contraceptive implants and termination of pregnancy).
3. There were also challenges in providing an enabling environment for healthcare workers to accommodate SRHR services integration. Some of the challenges cited included facilities having limited or ageing infrastructure, which negatively impacted client/client flow within some facilities. The high turn-over of nurses (loss of skills and numbers) also affected service delivery and increased pressure on the remaining healthcare workers.
4. The SRHR programme is facilitated by education and empowerment, not only of healthcare workers, but also clients accessing the services. Information, education, and communication materials have to be shared during consultation sessions with clients, however, the flyers and posters that are needed were not always available in local languages to facilitate accessibility to the information.

5. The annual approach to contracting between UNFPA and the implementers was also cited as a challenge for planning and continuity of the SRHR integration intervention. The reviewed reports showed that in some cases the implementing partners were given short-term contracts of between three to seven months. The relatively short timeframes created a vacuum between the baseline, training, pilot, and upscaling of the intervention.
6. With the emergence of COVID-19, several challenges were noted in all districts. Clients were unable to travel inter-provincially to access services where they usually access them because of the lockdown restrictions (e.g., Kokstad clients went to Alfred Nzo). This caused a decline in headcounts at some healthcare facilities. Lockdown also negatively impacted service delivery and stock availability as supply chain and logistics management systems were disrupted. There were also changing patterns in the historical demands for family planning at facilities. For example, during the COVID-19 lockdown uThukela District healthcare facilities, noted that short-acting contraceptive uptake declined, while long-acting reversible contraceptive uptake increased. Possible explanations are that during this time nurses either promoted or clients preferred LARC because the short-acting contraceptive requires frequent attendance at facilities. It is also possible that there were stock-outs of their preferred contraceptive method, which forced women to consider other alternatives. The implementers expressed a need to evaluate the drivers for this shift in contraceptive preference. This is an area where client exit interviews or human-interest stories can add value in the form of qualitative data.

Services at health facilities were also disrupted because of healthcare workers related factors. These included, healthcare worker infections, staff shortages at healthcare facilities, fear, and burnout due to colliding epidemics (COVID, HIV, TB, SGBV) adversely affecting the psycho-social well-being of nurses.

Mentoring and supervision visits were negatively affected. Face-to-face training of healthcare workers had to be postponed in some instances, and virtual training was not possible due to healthcare workers' lack of access to the necessary digital technology. The workloads of healthcare workers increased with added tasks such as COVID-testing and vaccine rollout.

The next section highlights promising and best practices that emanated from the intervention.

5.2 Emerging promising practices

This section presents emerging promising practices that were introduced to the healthcare facilities in the three districts to enable sustainable integration and scale-up of SRHR, HIV, and SGBV services. These practices led to positive outcomes for the intervention. After reviewing the client's reports and the data contained in them, we propose that the successes reported should be regarded as emerging promising practices. Emerging promising practices³³ are defined as interventions that are new, innovative, and hold promise based on some evidence of effectiveness or observed change during the intervention. Although these are not research-based to be deemed a 'promising' or 'best' practice³⁴, the practices led to positive change and contributed to knowledge generation for SRHR, HIV and SGBV integration in South Africa (Canadian Homelessness Research Network, 2013). Results from this current documentation exercise can be viewed as emerging promising practices because it highlights innovation that can inform further rigorous research and practice. These emerging promising practices are summarised below and are presented under three domains.

5.2.1 Strengthening of the health system to achieve a person-centred and coordinated care

To achieve the goal of delivering integrated SRHR services that are person-centred and coordinated, a set of emerging promising actions were implemented to inform the intervention during roll-out at each healthcare facility. The first set of actions focused on gathering information as part of a baseline assessment. This included a desktop review of the state of SRHR policies, a skills audit, a training needs assessments, mapping of services, assessment of facilities, and interviews with healthcare workers and their clients. This step provided the implementers with insights that were used to tailor the intervention and strengthen the delivery of SRHR services in the selected healthcare district and facilities.

Once the gaps were identified, each facility received a targeted package of interventions. This included a non-generic, facility-specific and targeted on-site training and mentorship approach catering to each facility's needs. At the health facility level, champions were identified to promote SRHR integration and to serve as peer support for other healthcare workers. This was an important part of the activities to sustain the intervention model. Champions also acted as mentors and trained healthcare workers during organised facility-specific campaigns. To strengthen the implementation and sustainability of the intervention in each district, UNFPA partnered with the Department of Health at all levels (i.e., National, Provincial and District) to provide technical support through continuous supervision and providing oversight.

33 The determination of best and promising practices is a question of evidence and may involve conducting research or reviews of the literature, including meta-syntheses and meta-analyses. It may also involve "case studies"; that is, detailed investigations of specific examples. In either case, the goal of conducting such research is to decide about effectiveness, and to assist in the dissemination and adaptation of practices that work (Canadian Homelessness Research Network, 2013).

34 The WHO defines "Best practices" as public health practices that have achieved excellent results, which need to be expanded and scaled up to reach more people (WHO, 2017). It also provides very specific criteria that must be met to label a practice as such. This includes applying judgement, which requires prior analysis using the following set of criteria: effectiveness, efficiency, relevance, ethical soundness, sustainability and the possibility of duplication, the involvement of partners and the community, and political commitment (WHO, 2017). WHO also suggests that a best practice should meet at least the *effectiveness*, *efficiency*, *relevance*, and *ethical soundness* criteria, in addition to one or more of the other criteria.

To promote linkages and strengthen communication and referral pathways, a facility-based care and support “Nerve Centre”, which consisted of decision-makers, was established. The role of the centre was to facilitate the management of information, monitor progress in achieving the integrated services, discussing challenges promptly and troubleshooting solutions to these. This led to the establishment of a Technical Working Group (TWG) with clear terms of reference to provide support and encourage interaction and sharing of experiences through facilitated meetings. These meetings were critical for sharing and encouraging the use of facility data to assess progress in integrating services, identifying gaps and using quality improvement methodology to plan interventions.

5.2.2 Improving the interface between the health worker, clients, and other stakeholders

Amplifying multiple voices to inform and monitor the intervention was another emerging promising action implemented in the healthcare facilities. This was done through factoring in the client’s perspective, and enhancing facility-service linkages to existing community resources and services. Client interviews were conducted at baseline and the data collected was used to inform the intervention, measure change over time, and improve the delivery of integrated SRHR services at each facility. The client’s experiences were also included during the monitoring of the intervention through exit interviews. These were conducted at regular time points to monitor and assess service integration and quality. Human interest stories were also added at the end-line assessment in uThukela District. The insights from these stories provided another opportunity to engage with clients and understand their needs.

The design and the delivery approach of intervention is another emerging promising practice in that it demonstrated an ability to be agile and respond to the needs and changing circumstances (SGBV and COVID-19) on the ground. This included the increased focus on sexual and gender-based violence screening and provision of care at facilities. The emphasis on creating adolescent and youth-friendly clinics is also commended – this was more prominent in the Eastern Cape intervention. The importance of delivering services to youth and reaching out-of-school youth is critical for SRHR integration and prevention of STIs. It also provides platform for demand creation in communities e.g., engaged NGOs, and can be used to facilitate intergenerational dialogues in communities that are serviced by the healthcare facilities.

5.2.3 Strengthening access to education and information, data collation tools and monitoring processes

SRHR integration includes a component of capacity building and education, not only for the healthcare worker but the clients too. UNFPA worked closely with the implementers and the Department of Health to develop standardised tools and aids, for example the UNFPA SRH, HIV Integration job aid was used to strengthen implementation of the ICM per service stream and for the PDSA cycle. This included mentoring trained healthcare workers on the use of logbooks and registers. With the increasing rates of GBV in the country, the training of healthcare workers also extended to the screening of GBV and covered the LIVES approach for first-line support for GBV victims, GBV screening, and data collection tools.

Clients also needed to be factored in, however, the education tools such as brochures and posters that needed to educate clients were often not available in the local languages spoken by clients. This created a communication barrier for the health worker. Another promising practice was to translate and use information, education, and communication materials in local languages to promote integrated service uptake at the facility level.

Enhanced data collation tools and monitoring processes were one of the critical areas identified for improvement. A critical part of the process to monitoring and scaling up the integration entails refining and enhancing data collation tools and monitoring processes. One of the emerging promising practices was the development and use of Dashboards to monitor (1) indicators and track progress in achieving integration targets in real-time; and (2) to monitor stock at facilities. These dashboards were used for multiple purposes, namely, to track SRHR integration progress, identify areas that need action, and motivate facility-based teams by sharing achievements.

There was also an improvement in the data collected. This seemed to have been a function of using improved data collection forms that included the collection of compulsory key demographic variables that allow for stratification by sex and by age to support (1) targeted interventions for these groups in communities, and (2) reporting standardisation across facilities and districts.

Recommendations

In this section, we will outline the recommendations for consideration by the Department of Health, Optidel Global, Umthombo weMpilo Institute and the UNFPA South Africa – 2gether 4 SRHR programme. The overall recommendation is that the current SRHR integration models should continue to be scaled up in the selected provinces and beyond. The lessons learnt and emerging promising practices should be used in the adaptation of the intervention for scaling up to other healthcare facilities. The challenges reported should be addressed (where possible) in the scale-up.

We recommend the following actions for the sustainability of the intervention:

- 1. Standardise monitoring templates and guidelines:** Gathering baseline data before implementation at each healthcare facility is an important step to gaining insight for choosing the integration model to be implemented and designing the intervention. The 2gether 4 SRHR programme and the implementers should engage with healthcare workers and other stakeholders to standardise the processes of choosing the integration model for the district, documenting the intervention, methods, and reporting templates for monitoring the progress of integration in each healthcare facility.
- 2. Ensure that all components of the SRHR integration are reflected in the implementer's annual progress reports:** Although the initial focus of the SRHR integration was on HIV; TB, STIs and SGBV were also included. However, the reports that were reviewed carry very limited data on TB and STIs, and later reports include data on SGBV. TB and STIs should be amplified as there is an intersection of risk between HIV, TB and STIs.
- 3. Standardise data collection and reporting templates and address data missingness at the facility level:** A documenting exercise similar to the one conducted by the HSRC requires data that is comparable and is complete across all districts and facilities. To facilitate data pooling and synthesising across the intervention districts, there should be an agreement on the minimum set of indicators that all intervention districts should collect and report on.

Health facilities and implementers should also seek to address missingness in the data collated from the facility data collection tools – especially for males and abortion-related admissions. The missing SRHR and HIV indicator data observed in some implementer's reports, together with the data reporting challenges, demonstrates the importance of gathering data from different sources in a consolidated manner without overburdening healthcare facilities.
- 4. Address human resources and infrastructure challenges:** SRHR integration requires an enabling environment. To address the HR and infrastructure challenges highlighted by both Optidel Global and Umthombo weMpilo Institute, it is recommended that the provincial Departments of Health address challenges related to staff turnover and poor or ageing infrastructure in some healthcare facilities. Having adequate nursing staff at facilities, and ongoing capacity development of nurses using adaptable training offerings, are critical aspects that need to be addressed.

5. **Facilitate sustainability of the intervention and provide supervision, technical support and monitoring of the healthcare facilities that are transitioning off the intervention:** The collaboration between UNFPA, the Department of Health at all levels, Optidel Global, and the Umthombo weMpilo Institute is commendable. Immediate positive outcomes include a greater ownership of the intervention and provision of technical support by the Department of Health. At some facilities, transitioning from the intervention and scale-up phase has begun, and the facilities have been handed over to the district for continued support and monitoring. Therefore, mechanisms to provide ongoing technical assistance to the district should be institutionalised by the collaborators. This can include basic guidelines on support, mentoring, and a monitoring package that health facilities should continue to receive post the intervention. This should also include a collection of basic statistics that can be used to show the successes and impact of the intervention over time in each facility, district, and province.
6. **Review the annual approach for contracting between the UNFPA South Africa and the implementers:** UNFPA should consider a multi-year funding approach. The current approach where contracts are negotiated every year was found to leave a relatively short timeframe for the implementation of the intervention during some years. We recommend a multi-year approach for the implementers to go through the inception, pilot, and implementation phases in one cycle of funding. This will address the short duration of time available for implementation.
7. **Attain consensus on a basic model of SRHR integration to be recommended, including the minimum SRHR indicators that should be monitored and reported by each facility:** UNFPA and the Department of Health should consult with all stakeholders to agree on what a basic model of SRHR, HIV and SGBV integration should include, and what minimum set of indicators should be collected to demonstrate success or impact at the facility level. The same indicators can also be used for monitoring and evaluation of SRHR, HIV and SGBV integration for each district.
8. **Fund a research component as part of a systematic documentation and up-scaling of SRHR intervention:** The next phase should consider adopting an implementation science approach at selected sites and districts to provide rigorous evidence-based results. This approach will assist to answer critical research questions about the intervention, such as what the conditions that facilitate or cause barriers to success are; which model best facilitated service integration; what facilitated the service integration; what could be utilised to fast-track integration of services; what indicators are needed for programme sustainability; and what are the best practices that should be scaled up based on evidence generated systematically.

At a minimum, implementers should be encouraged to design and imbed studies to monitor and evaluate the intervention in different healthcare facilities. This component should be structured to measure impact using mixed and participatory study design methods. We also recommend developing a standard reporting template to document the intervention, coupled with an adoption of guidelines for identifying and documenting best practices like the WHO, which includes a checklist that can be used to document practices for potential scale-up during the implementation (WHO, 2017).

9. **Invest in technology to facilitate communication using virtual platforms:** One of the lessons learnt from the emergence of COVID-19 is that interventions need to be agile and adaptable, and technology is one way to bridge the gap and distance during times of crisis. It is recommended that the Department of Health and UNFPA should provide support for acquiring basic digital technology to facilitate supervision, mentorship, training, and communication with the implementers. This is an important part of strengthening the infrastructure to support healthcare workers at healthcare facilities.

Conclusion

The programme aimed to integrate SRHR, HIV, and SGBV services within healthcare facilities in uThukela, Alfred Nzo, and OR Tambo Districts. The integrated intervention was based on ICSM within the ICM, which delivers services through four streams namely acute illness, chronic disease, maternal and child health, and health support services. This comprehensive service integration would mitigate clients having multiple consultations through vertical streams, and improve the quality of care and outcomes. At baseline it was found that the lack of awareness about the benefits of integrated services by both clients and healthcare workers led to the delivery of services in silos.

Using the results of the baseline assessments as a guide, the intervention focused on educating and upskilling healthcare providers in the provision of specific SRHR services. This led to an increase in staff competence and uptake of integrated services by clients. Continuous supervision and mentorship by the implementers and the district and provincial Departments of Health, were also introduced. The collaboration and partnership with the Department of Health at all levels also increased a sense of ownership and contributed to the sustainability of the SRHR integration intervention. At the facility level, SRHR champions were identified to reinforce practical training, support, and mentoring.

The results showed that the integration of SRHR and HIV services at healthcare facilities in the selected districts was achieved. Overall, services provided at three of the four service delivery points increased. Clients receiving services at HIV service delivery points were provided with additional services. The percentage of clients accessing services at family planning service delivery points who were tested for HIV, screened for STIs, and screened for cervical cancer, also increased. In addition, clients attending antenatal clinics were also tested for HIV and screened for STIs. Generally, clients reported being satisfied with the increased number of services received during one consultation at each stream of the ICM.

The intervention also showed improvements from the client's perspective. Clients reported receiving an increased number of integrated SRHR and HIV services at a single service delivery point. Benefits reported included saving travel costs and minimising long waiting times at the facilities. In summary, it was reported that there were observed improvements in the uptake of SRHR and HIV integrated services during the project implementation

In this report, we presented several successes that highlighted the achievements of the integration. Among these was a phased approach that was adopted by the implementors Optidel Global and Umthombo weMpilo Institute. The approach was shown to be agile and facility-specific, which enabled positive changes in service delivery. Baseline assessments at the beginning of the intervention phase were important for directing the implementation and resources to where they were needed most. Conducting a skills audit assisted in identifying areas for strengthening the healthcare system for the planned integration intervention. This was coupled with insights and linkages that were identified during the mapping exercise, ensuring that the SRHR integration intervention was linked to existing services and resources within and outside the healthcare facilities.

The lessons learnt and achievements present a solid foundation for scaling up the intervention. The knowledge and experience gained during the intervention adds to the existing body of knowledge on SRHR integration in South Africa. The success observed demonstrates that the intervention had a positive impact and assisted in strengthening the health system in the three study districts.

We recommend that the intervention should be scaled up across the selected provinces. In the scale-up there should be a focus on embedding research methodologies and monitoring and evaluation; the standardisation of data collection and monitoring templates and guidelines; addressing human resource challenges and the maintenance and replacement of infrastructure; institutionalisation of mechanisms to provide ongoing technical assistance to the district Departments of Health; and all key role players in the field of SRHR, HIV, health monitoring and evaluation (including academia), UNFPA, and government departments at all levels, should reach a consensus on the basic integration model and minimum indicators that should be monitored for the SRHR integration programme.

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Appendix 1: List of reviewed source documents

Report label and date	Report title	Number of facilities in the report	Date of the data referred to in the report; specify model/approach used; specify theory of change	Districts discussed in the report	Short description of report/presentation/ data sheet contents	Data collection tools ³⁵
REPORT 1 _ Final Draft SRH and HIV integration 76 pages Date of report: 23 October 2017	Facility assessments of the status of Sexual and Reproductive Health (SRH)/Human immunodeficiency (HIV)/Tuberculosis (TB) and Sexual and Gender-based violence (SGBV) integration and implementation in 10 health facilities in Alfred Nzo, OR Tambo and uThukela Districts, South Africa	10	August 2017-October 2017 Model not specified No theory of change	Alfred Nzo, OR Tambo and uThukela	Assessment followed a cross-sectional, descriptive, multi-site design	Data collection tools were adapted from Rapid Assessment Tool for SRH and HIV Linkages. Semi-structured surveys were done for policy level, systems, service delivery and client exit interviews. Observation based on a checklist was done for client waiting times.
						Desktop review DHIS data were extracted.

³⁵ see Appendix 2 for a list of data collection tools

Report label and date	Report title	Number of facilities in the report	Date of the data referred to in the report; specify model/approach used; specify theory of change	Districts discussed in the report	Short description of report/presentation/ data sheet contents	Data collection tools ^{3,5}
REPORT 2_Final Project Report and Model of Implementation 40 pages	Model of SRH/HIV/SGBV/TB Integration Report April 2021	12 health facilities in uThukela	Quarter four 2020/2021 Oct-March 2019/2020; Oct-Dec 2019; Jan-March 2020; Oct-Dec 2020, Jan-March 2021 Oct-March 2020/2021 April-June 2020 July-Sept 2020	Alfred Nzo, OR Tambo and uThukela	Report documented the model of SRHR/HIV/SGBV/TB integration, described the process that built up to the development of the model, describes the model itself, and the results of the implementation of the model.	Documentation exercise
Date of report: April 2021			Optidel Global Plan, Do, Study and Act (PDSA) SRHR/HIV/SGBV Integration model implemented at uThukela One-stop-shop model implemented at Alfred Nzo			
			Model of integration: aligned with Ideal Clinic Model and strengthened implementation of the integrated clinical services management.			
			Model of change at Alfred Nzo aligned with Ideal Clinic Model, One-stop-shop Model and super-market approach			

Report label and date	Report title	Number of facilities in the report	Date of the data referred to in the report; specify model/approach used; specify theory of change	Districts discussed in the report	Short description of report/presentation/data sheet contents	Data collection tools ³⁵
REPORT 3 _ uThukela SRH-HIV Final Project Report-Optidel Global 2018	UNFPA uThukela SRH/HIV Integration-Project Report	5	Project inception in September 2018. Data for November 2018-February 2019	UThukela	Mid-project report: assessment of HCW training needs, client exit interviews, client in flow mapping, community engagement mapping	Discussion with clinic supervisors, Client exit interview (survey) on three streams namely chronic, acute, maternal and child health, self-administered questionnaire on training needs of healthcare workers in five health facilities. This was done at baseline and end-line
40 pages			Quality improvement methodology adapting the PLAN, DO, STUDY and ACT (PDSA) approach			
Date of report: 21 March 2019						

Report label and date	Report title	Number of facilities in the report	Date of the data referred to in the report; specify model/approach used; specify theory of change	Districts discussed in the report	Short description of report/presentation/ data sheet contents	Data collection tools ³⁵
REPORT 4_ 2021 Q2 GPS_WPR Umthombo	Workplan progress report	10	12 March 2021- 31 March 2021 Ideal Clinic Model	Alfred Nzo	Workplan progress report taken from section 2.2 scaling up integrated SRHR/HIV/SGBV services: Enhance HCW capacity to implement evidence-based models on provision of quality integrated SRHR/ HIV/GBV services including SGBV screening in Eastern Cape targeted districts Documentation of good practice pertaining to district-level SRHR/HIV/GBV service provision to enable provincial and national scale up	A performance improvement approach was implemented. This involved discussions with health workers, clinic supervisors, and programme managers from the 10 Alfred Nzo district health facilities. Community dialogues for SGBV were done with community leaders and school-going young people as well as out-of-school young people. On-site training targeting HCWs was done to strengthen health service delivery and capacity to respond to GBV.

Report label and date	Report title	Number of facilities in the report	Date of the data referred to in the report; specify model/approach used; specify theory of change	Districts discussed in the report	Short description of report/presentation/ data sheet contents	Data collection tools ³⁵
REPORT 5 _ UNFPA Optidel Global Baseline Assessment-Progress Meeting (Power Point presentation) 7 slides Date of report: December 2020	Implementation of Sexual and Reproductive Health (SRH)/HIV Service Integration in 12 Health Facilities uThukela District in KZN Facility Dashboard December 2020	12	November-December 2020	UThukela	This is a PowerPoint presentation that presents data on IUCD and Implanon insertions, and cervical cancer screening	Tool to facilitate performance monitoring and intervention planning for the 12 supported facilities, feedback on these indicators is provided to facilities weekly and to the district office monthly.
REPORT 6 _ UNFPA-Optidel Global Mid Project Report – December 2020 Date of report: December 2020	UThukela UNFPA SRH/ HIV INTEGRATION Mid-Project Report	12	April 2019-March 2020 Ideal Clinic Model	Alfred Nzo and uThukela	This is a mid-project report	A performance monitoring approach was implemented. Used both routine and non-routine survey (Baseline and End-line) data for performance monitoring.
DATA 1 _ Data uThukela – UNFPA Optidel Global Data tool	Not applicable	12	April 2019 – March 2020; Q1 & Q2 of 2020	UThukela	Excel spreadsheet with data for health facilities (clinics) and indicators	Not applicable
DATA 2 _ Data-Alfred Nzo Facilities	Not applicable	4	April 2019 – March 2020; Q1 & Q2 of 2020	Alfred Nzo	Excel spreadsheet with data for health facilities (clinics) and indicators	Not applicable

Report label and date	Report title	Number of facilities in the report	Date of the data referred to in the report; specify model/approach used; specify theory of change	Districts discussed in the report	Short description of report/presentation/ data sheet contents	Data collection tools ³⁵
DATA 3 _ UThukela and Alfred Nzo Baseline Data – All facilities	Not applicable	17	Not provided in spreadsheet	Alfred Nzo and uThukela	Excel spreadsheet with baseline data for both districts stratified by age (10-14, 15-19, 20-24, 25-49 and 50+ years)	Not applicable
DATA 4 _ SGBV-Abortion Indicators Alfred Nzo	Not applicable	4	January 2020-September 2020	Alfred Nzo	Word document with SGBV, abortion and other SRH indicators	Not applicable
Date of report: 20 October 2020 Contained as Annex 5 in report 6						
DATA 5_ Facility Dashboard – December 2020 (Power point presentation)	Not applicable	12		UThukela		Not applicable
Date of report: December 2020						
DATA 6 _ Facility Score Board – November 2020 (Power point presentation)	Implementation of Sexual and Reproductive Health (SRH)/HIV Service Integration in 12 Health Facilities uThukela District in KZN	12	November 2020	UThukela	This is a PowerPoint presentation that presents data on IUCD and Implanon insertions, and cervical cancer screening	Not applicable
Date of report: November 2020	Facility Dashboard November 2020					

Report label and date	Report title	Number of facilities in the report	Date of the data referred to in the report; specify model/approach used; specify theory of change	Districts discussed in the report	Short description of report/presentation/ data sheet contents	Data collection tools ^{3,5}
DATA 7_Addendum to Final Report – Baseline Analysis – Alfred Nzo and uThukela Date of report: Quarter 1 2018/2019 Also refer to data 3 spreadsheets	Report of 2gether 4 SRHR Baseline Data (Quarter 1 – 2018/19 FY): Addendum to Final Project Report	12	Quarter 1 (April-June) 2018	Alfred Nzo and uThukela	Baseline assessment of the following service delivery points: obstetric and gynaecological, family planning, HIV, ANC, PMTCT, sexual and gender-based violence, safe abortion care or post-abortion care	2gether 4 SRHR baseline data collection tool-facility.
Annual report Umthombo_2018 Date of report: 2018	Annual Progress Report Format	5	June mentoring, Aug and Sep AYFS data collection, October and November monthly mentoring visits, Nov dialogues by ECDOE One-stop-shop model and supermarket approach	Alfred Nzo & OR Tambo District	Provide technical support to the SRH/HIV integration district, training of staff and WBOTs	Monthly meetings, workshops, training needs assessments, AYFS monthly data collection tool to track integration of SRH & HIV.

6 pages

Report label and date	Report title	Number of facilities in the report	Date of the data referred to in the report; specify model/approach used; specify theory of change	Districts discussed in the report	Short description of report/presentation/ data sheet contents	Data collection tools ³⁵
Annual report Umthombo_2019 Date of report: 2019	Annual Progress Report Format	10	June 2019 Jan – Mar 2018 Dec 2019 Scale up integrated SRHR/HIV/SGBV services Support policy implementation Enhance policy implementation Targeted HIV combination prevention programme for adolescents and youth	Alfred Nzo and OR Tambo	Scale up integrated SRHR/HIV/SGBV services including termination of pregnancy, support policy implementation	Workshop to review SRHR/HIV integration results, mentoring visits. Facility source documents were: DHIS monthly input form, HIV Testing service registers and PHC Comprehensive tick register. This tick register was used to record all services provided in health facilities. However it was reported to be unsuitable for the integration of SRHR and HIV services because it was not age and sex-disaggregated, and did not capture integrated services indicators (UWI 2020: 3).
Annual report Umthombo_2020 Date of report: 2020	Annual Progress Report Format	20	01 Jan 2020 – 31 Dec 2020 one-stop-shop model (pp 17)	Alfred Nzo and OR Tambo	Contains outputs and planned results, addition of COVID support	Training of HCWs at health facilities, on-site training of CBOs. Scale up integrated SRHR and HIV services.

Report label and date	Report title	Number of facilities in the report	Date of the data referred to in the report; specify model/approach used; specify theory of change	Districts discussed in the report	Short description of report/presentation/data sheet contents	Data collection tools ³⁵
Umthombo weMpilo quarter 4 report 2021 Date of report: 2021 9 pages	Quarter 4 Report 2021	10	Quarter 4 2021 Adding integration of SRHR/HIV/SGBV to the Ideal Clinic Model	Alfred Nzo and OR Tambo	Contains updates on SRHR/HIV/SGBV integration	Data reported by district, sex, age group (10-14, 15-19, 20-24 years).
End of project report SRH/HIV/GBV/TB Integration Report Date of report: March 2022 34 pages		53	September 2021 to March 2022 The PDSA Cycle	UThukela, eThekweni and Ugu	Final report on 7 months' implementation	Baseline and end-line assessments, healthcare worker's training needs skills audit and competency assessments, client exit interviews, human stories (project album).

Appendix 2: Data collection tools used for all three districts

	Use	Bearing on information capturing	Monitoring and analysis	Indicate different tools used to address policy, system, service delivery
Job aid chart	Identifies minimum package of SRH/HIV integration services that should be integrated per service stream	Indicates which services to integrate into the three streams	Assists in improving integration as well as helping the nurses to become competent	
Logbooks		Helps in improving integration as well as helping the nurses to become competent		
Client flow maps	Client flow is generally determined by many factors at the facility level, these include infrastructural set-up, space availability, availability of staff, etc.	Ensure clients entering each stream are being offered related SRH/HIV services		
Routine data tracking tables	Tracking tables help in the development of the dashboard as an early warning indicator and for supportive supervision	Monitoring progress of selected indicators		
Monthly dashboards	Monthly dashboard facilitated the identification of facilities for targeted supportive supervision and mentorship		The colour coding reflects the performance at a glance. The green has achieved the target, orange is making progress or borderline performance, and red is not achieved	

	Use	Bearing on information capturing	Monitoring and analysis	Indicate different tools used to address policy, system, service delivery
Positive reinforcement	The selection of the three best-performing facilities per district was conducted by Optidel Global Technical Advisors in their respective districts	For the identification of the best-performing facilities for recognition	The selection criteria were based on the general performance and quality of improvement as guided by the monthly dashboards. Optidel Global Technical Advisors shared and discussed monthly dashboards with facilities to monitor progress, identified gaps, and made recommendations for the development of facility-focused quality improvement plans. In most indicators, the best-performing facilities met these criteria and were recognised for their performances.	
AYFS tool	The PHC Comprehensive tick register is used by healthcare workers to enter the different services that are provided			

Sources: Umtombo weMpilo Institute 2018, 2019, 2020, and 2022

Appendix 3: Adolescent and Youth Friendly Services monthly data collection tool

The Adolescent and Youth Friendly Services (AYFS) tool was developed by the National Department of Health and LoveLife. “These standards were developed by Wits RHI as part of National Adolescent Friendly Clinic Initiative I, following a lengthy process of consultations with professionals and youth, and informed the development of the World Health Organisation (WHO) recommended standards for the field” (James *et al.*, 2018). A total of ten standards are listed below:

Standard 1	Management systems are in place to support the effective provision of health services for young people. Management systems include AYFS teams, quality improvement plans, youth exit interviews or focus group discussions, youth records and follow-ups.
Standard 2	The clinic has policies and processes that support the rights of adolescents. The Adolescent and Youth Health policy is an important element for the 2nd standard. In addition, clinic staff should have adequate SRHR knowledge.
Standard 3	The appropriate adolescent health services are available and accessible. A clinic meeting the third standard should have a comprehensive list of 13 services, including convenient service times, pregnancy-related services, TOP referrals and mental health and abuse counselling.
Standard 4	The clinic has a physical environment conducive to AYFS provision. Conducive infrastructure for AYFS includes cleanliness, infection control, lighting and adequate seating.
Standard 5	The clinic has drugs, supplies, and equipment necessary to provide the essential services package for AYF healthcare. Equipment and supplies needed to provide services to youth include pregnancy test kits, drugs, and contraceptives for both females and males.
Standard 6	Information, education, and communication promoting behaviour change are consistent with the AYFS essential package provided. Youth targeted IEC in local languages is essential in order to promote behavioural change.
Standard 7	Systems are in place to train staff to provide effective adolescent-friendly health services. Healthcare workers who are providing services to youth have to be trained on all AYFS principles.
Standard 8	Adolescents receive adequate psychosocial and physical assessments Youth visiting healthcare facilities are to receive a holistic assessment that includes counselling and comprehensive history.
Standard 9	Adolescents receive individualised care based on standard case management guidelines and protocols. The standard case management guidelines encourage staff to be skilled in communicating with youth.

Source: Eastern Cape Department of Health: <http://www.echealth.gov.za/index.php/document-library/newsroom/publications?task=download.send&id=465&catid=28&m=0>

Appendix 4: List of health facilities in KwaZulu-Natal: uThukela, eThekwini and Ugu Districts

No.	eThekwini District	Ugu District	UThukela District
1	Cato Mano CHC	Assisi Clinic	Xhamini Clinic
2	Chatsworth Township	Baphumile Clinic	Bergville Clinic
3	Hlengisizwe CHC	Dududu Clinic	Dukuza Clinic
4	Inanda C CHC	Gcilima Clinic	Ekuvukeni Clinic
5	Isipingo Clinic	Harding Clinic	Emmaus Gateway Clinic
6	KwaDabeka CHC	KwaJali Clinic	Ezakheni 2 Clinic
7	KwaMakhutha Clinic	KwaMbunde Clinic	Injisuthi Clinic
8	KwaMashu Poly CHC	Madlala Clinic	Ncibidwane Clinic
9	Lancers Road Clinic	Marburg Clinic	Ntabamhlope Clinic
10	Lindelani Clinic	Margate Clinic	Oliviershoek Clinic
11	Mpumalanga Clinic	Mgangeni Clinic	St Chads CHC
12	Ntuzuma Clinic	Ntabeni Clinic	KZ Steadville Clinic
13	Peaceville Clinic	Port Edward Clinic	Walton Clinic
14	Pheonix CHC	Port Shepstone Clinic	Watersmeet Clinic
15	Pinetown Clinic	Southport Clinic	Wembezi Clinic
16	Tongaat CHC	Umzinto Clinic	
17	Umlazi D Clinic	Weza Clinic	
18	Umlazi U21 Clinic	Xhamini Clinic	
19	Verulam Clinic		
20	Umlazi H (Umzomuhle)		

Data source for 53 health facilities: End of Project Report SRH/HIV/GBV/TB Integration Report March, 2022

Appendix 5: List of health facilities in Eastern Cape: the Alfred Nzo and OR Tambo Districts

No.	Alfred Nzo District	OR Tambo District
1	Amadiba Clinic	Buntingville Clinic
2	Amantshangase Clinic	Bomvini Clinic
3	Baleni Clinic	Elujizweni Clinic
4	Dundee Clinic	Flagstaff CHC
5	Dungu Clinic	Holy Cross Gateway Clinic
6	Elubaleko Clinic	Libode Clinic
7	Greenville Clinic	Mgwenyana Clinic
8	Gateway Clinic	Mthatha Gateway
9	Imizizi Clinic	Mpeko Clinic
10	Mfundisweni Clinic	Mzintlava Clinic
11	Mhlotsheni Clinic	Ngqeleni Clinic
12	Mnceba Clinic	Nkonzo Clinic
13	Mntwana Clinic	Ntaphane Clinic
14	Mt Frere Gateway Clinic	Ntafufu Clinic
15	Mzongwana Clinic	Nolita Clinic
16	Rhode Clinic	Nontsikelelo Biko Clinic
17	Rode Clinic	Qumbu CHC
18		Tombo CHC
19		Xurana Clinic



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