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

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

Proceedings of the Integrated Sexual and Reproductive Health, and Sexual Gender-Based Violence Documentation Project Symposium, held on 8th July 2022, Durban, KwaZulu-Natal, South Africa

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Contents

List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AGYW	Adolescent Girls and Young Women
AYFS	Adolescent and Youth-Friendly Services
CHW	Community Healthcare Workers
CBM	Curriculum- Based Measurement
CDC	Centre for Disease Control
COVID-19	Coronavirus – 2019
DMPA	Depot-Medroxyprogesterone Acetate
DoH	Department of Health
GBV	Gender-Based Violence
HCW	Healthcare Workers
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
HTS	HIV Testing Services
ICM	Ideal Clinic Model
ICSM	Integrated Clinical Service Management
ICPD	International Conference on Population and Development
IUCD	Intrauterine Contraceptive Device
LARC	Long-Acting Reversible Contraception
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
LNG	Levonorgestrel implant
MatCH	Maternal, Adolescent and Child Health Institute
NACOSA	Networking HIV and AIDS Community of Southern Africa
NDoH	National Department of Health
PDSA	Plan, Do, Study, Act cycle
PeP	Post-exposure Prophylaxis
POWER	Prevention Options for Women Evaluation Research
PrEP	Pre-Exposure Prophylaxis
PRIYA	PrEP implementation in young women and adolescents
SGBV	Sexual and Gender-Based Violence
SRH	Sexual Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOP	Termination of Pregnancy
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Summary

Background

There has been a strong global focus on the integration of sexual and reproductive health (SRH) services over the past three decades. The 1994 International Conference on Population and Development (ICPD) called for global efforts to integrate SRH services, within primary healthcare[1]. The 2gether 4 SRHR programme is a Joint United Nations (UN) Regional Programme combining efforts from UNFPA, UNAIDS, UNICEF, and WHO, to improve SRHR in the Eastern and Southern African region[2]. It focuses on strengthening the provision of integrated (SRHR, human immunodeficiency virus (HIV), and sexual and gender-based violence) services, targeting adolescent girls and young people as well as key populations.

In South Africa, UNFPA collaborates with the South African National Department of Health (NDoH) and through this partnership contracted Optidel Global and Umthombo weMpilo Institute to incorporate and implement integrated service delivery models during the period 2017-2022. The two implementers were funded by UNFPA through a grant from the Swedish government to facilitate the integration of SRHR, HIV, and SGBV services in selected districts within two provinces namely Eastern Cape and KwaZulu-Natal. These provinces and districts were selected based on their high burden of HIV and Acquired Immune Deficiency Syndrome (AIDS), maternal mortality, SGBV as well as poverty. The implementation of integrated services was carried out in a phased approach.

In 2021, the UNFPA commissioned the Human Sciences Research Council (HSRC) to conduct a documentation exercise that included a desktop review, consolidation, and a synthesis of data contained in the two implementers' baseline, pilot, inception, and scale-up reports. This exercise aimed to document lessons learnt and to amplify emerging best practices from the implemented SRHR integration interventions.

As part of a broader dissemination strategy the UNFPA in collaboration with the HSRC, and the DOH at national and provincial levels, hosted a one-day hybrid symposium in KwaZulu-Natal on the 8th of July 2022.

Purpose of the symposium

The symposium was convened to share key findings, experiences, and lessons that could be amplified following the implementation of SRHR, HIV, tuberculosis (TB), and SGBV integrated services in selected facilities by the UNFPA and its partners.

This report provides a summary of the proceedings of the symposium and includes presentations delivered by various presenters and stakeholders that were key in the implementation of the SRHR integration in selected districts.

Programme, Participants and Discussion

The symposium was held at the Premier Hotel, Umhlanga, KwaZulu-Natal, and was attended by 35 in-person and 70 online participants. In attendance were delegates from government departments namely the NDOH, KwaZulu-Natal Provincial DOH, Department of Women, Youth, and Persons with Disabilities, Department of Basic Education, Metro District Health Services, uThukela, and Ugu Districts. The UN agencies were represented by delegates from the UNFPA, UNAIDS, and WHO. The academia was represented by universities, research councils and institutions namely, the University of KwaZulu-Natal and the University of Witwatersrand (Female Academic Leaders

1 United Nations. International Conference on Population and Development Programme of Action Twentieth Anniversary Edition. 2014. https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf .

2 https://esaro.unfpa.org/en/topics/srhr-and-hiv-linkages-project

Fellowship), the South African Medical Research Council, Health Systems Trust, HIV Research, and Maternal, Adolescent and Child Health Institute (MatCH) Research Unit and the HSRC. Civil society organisations in attendance included Networking HIV and AIDS Community of Southern Africa (NACOSA), Businesswoman's Association of South Africa, Save the Children, The Health Foundation, and Beyond Zero. For the full list of attendees, see Appendix 3. The symposium programme and presentations are attached as Appendices 1 and 2. Some changes were made to the programme on the day to accommodate speakers who could not join the symposium virtually due to connectivity challenges.

The symposium consisted of four sessions. Sessions two to four were followed by a question and answer session. Session one to three were moderated by Dr Thato Chidarikire, Director of prevention programmes at the National Department of Health. Sessions one and two provided a foundation by outlining the South African policy landscape and presenting an overview of the SRHR integration interventions and experiences of implementers on the ground. Presenters included Ms Thembi Zulu who presented on the SRH policy landscape. In Session two, the implementing partners Ms Nobanzi Dana and Dr Babatunde Sanni, presented models of integration and lessons learnt. Session three provided a glimpse into SRHR integration interventions projects that have been implemented by UNFPA partners, Prof Mags Beksinska, Mrs Thobekile Mpembe, Ms Linda Dlamini, and Ms Siziwe Jongizulu presented district experiences of SRHR integration.

Session four was moderated by Dr Tebogo Gumede, Research Specialist from the HSRC. During Session four Prof Mags Beksinska, Dr Thato Chidarikire, Ms Regina Maithufi, Ms Melanie Pleaner, Dr Elzette Rousseau presented on various topics related to SRH such as STIs and HIV, HIV Testing Services (HTS), contraceptives, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PeP). Dr Inbarani Naidoo was the last presenter and presented findings from the SRHR documentation exercise focusing on the lessons learnt and emerging best practices. Dr Nompumelelo Zungu concluded the symposium with a summary of the proceedings and closing remarks.

Welcome & Opening Remarks

Dr Nontsikelelo Manzini-Matebula, *Programme Specialist: SRHR, HIV, and AIDS Linkages, UNFPA*

Dr Manzini-Matebula thanked participants for attending, especially the National Departments, District teams, and the HSRC for coordinating the meeting. She acknowledged all the invited speakers, including colleagues from different institutions who conduct work in the SRHR field. She recognised the implementing partners, Optidel Global, and Umthombo weMpilo Institute. She also acknowledged the support from UNFPA teams both the provincial and National offices, the UN agencies, UNAIDS and WHO, and all non-governmental organisations.

Dr Manzini-Matebula provided an overview of the 2gether 4 SRHR joint programme which was funded by the Swedish government. She indicated that in other countries the programme is implemented by four agencies, i.e., WHO, UNFPA, UNAIDS and UNICEF. In South Africa, the 2gether 4 SRHR programme is implemented by UNFPA with the following objectives:

- Create an enabling environment to promote integrated services around SRHR, HIV and gender-based violence (GBV).
- Create an enabling legal and policy environment that empowers all people, particularly adolescent girls, young people, and key populations, to exercise their SRH rights and access quality integrated SRHR, HIV and SGBV services.
- Strengthen the delivery of quality integrated and sustainable SRHR, HIV and TB and SGBV services that meet all people's needs, particularly adolescent girls, young people, and key populations.
- Strengthen communication, ownership, empowerment, and participation of all people, but focus on adolescent girls, young people, and key populations to exercise their SRHR, adopt protective and promotive behaviour, and have access to quality integrated services on time.
- Amplify the lessons learnt from the programme implementation to strengthen integrated SRHR, HIV and SGBV services.

Dr Manzini-Matebula then outlined the aims of the symposium as follows a) highlight key components and models that work for the integration of SRHR, HIV and SGBV services. She noted that different models were used in different districts. She added that it was important to draw on lessons from work done by other organisations in the room. b) Learn from challenges. c) Provide best practices to scale up the interventions. d) Identify opportunities for future collaborations.

Dr Manzini-Matebula elaborated on the scaling up of the 2gether 4 SRHR programme and indicated that it included the following: supporting and mentoring healthcare workers, ensuring that the process of implementation and integration was well documented, communication was strengthened and that the Government took ownership of the programme for sustainability. She also mentioned that the approach included amplifying the lessons learnt from the programme implementation and identifying other opportunities to scale up and integrate with other programmes on the ground. In addition, the symposium aimed to provide a platform where partners can learn from other organisations doing similar work on integrated SRHR, HIV and SGBV services. Finally, the symposium was a platform to identify challenges experienced during implementation and to chart a collective sustainable programme using the best practices to upscale the integration of SRHR, HIV and SGBV services.

Sexual and Reproductive Health and Rights, Progress and Achievement

Ms Thembi Zulu, Deputy Director: SRHR National Department of Health

Ms Zulu gave background to the development of the SRHR policy. She indicated that the National Department of Health had developed the SRHR policy titled "The Integrated Sexual and Reproductive Health and Rights (SRHR) policy" that was finalised in 2019. The policy is an overarching document that includes all SRHR components. It was developed in consultation with different stakeholders and reference documents, including international guidelines. The goal of the policy is to promote, through informed choice, safer reproductive health practices among women, men, and youth including the use of quality and accessible reproductive health services.

The policy combines various clinical guidelines relating to SRHR namely (1) National guideline for the implementation of Termination of Pregnancy; (2) National Contraception Clinical Guideline, which was last updated in 2012; (3) National Guideline for Safe Conception and Infertility; (4) Breast and Cervical Cancer Guidelines and (5) National Guideline on Management of Post-exposure Prophylaxis (PeP) in occupational and non-occupational exposure. All these guidelines are available on the NDoH's website.

The SRHR policy document emphasises the following:

- Breaking the silos.
- Equity is important. Services should be provided to everyone.
- Linking both national and international policies.
- Accountability linked with rights.
- A rights-based approach.

The NDoH standardised training of nurses by developing a training curriculum launched through the Knowledge training hub and it is open to all healthcare workers, not only clinicians. The course has 14 modules consisting of several learning sessions, including some practical sessions. Participants can navigate the modules flexibly, however Module 1 is compulsory. Sessions must be completed within 72 hours and trainees need 80% to pass each module. Trainees receive a certificate of completion and can gain continuing professional development points through the University of Pretoria.

Session 2: Implementing Partners - Models of Integration and Lessons Learnt

The second session focused on the experiences of UNFPA South African implementing partners, Umthombo weMpilo Institute and Optidel Global in implementing the integrated SRHR, HIV, and SGBV services in selected health facilities.

Integration of SRHR, HIV, and SGBV services

Ms Nobanzi Dana
CEO Umthombo weMpilo Institute

Umthombo weMpilo Institute is the implementing partner in the Eastern Cape Province. They rolled out the 2gether 4 SRHR programme in the years 2018 to 2021. A baseline study was conducted in 2018 which informed the model of integration in the Eastern Cape. The inception phase was in 10 health facilities in two districts, Alfred Nzo and OR Tambo. The success enabled a scale-up to 12 facilities in 2019 and 20 facilities in 2020 and 2021. Facilities that sustained the integration were removed and substituted with new facilities, enabling the saturation of health facilities receiving the intervention in the province.

Facilities in this province were set up in a way that supported a one-stop-shop model where SRHR and HIV services were provided by one healthcare worker in the same room at the same time. The model was tailored to respond to the challenges and opportunities presenting at health facilities. A minimum package of services was agreed on and these comprised HIV Testing Services, TB, antiretroviral therapy, condom use education and promotion, family planning, and contraception, antenatal care, cervical cancer screening, STI services, SGBV, maternal and new-born care. The UNFPA's Job Aid was used to strengthen the delivery of these services. The strengthening of integrating service was done within the Ideal Clinic Model (ICM). This model was used to avoid parallel systems. The super-market approach was used to implement the integration of services, where specialised services were needed. This approach involves patients receiving all services from one healthcare worker, this ensured access, quality, and continuity of care. The service delivery points were set up in a way that promoted the one-stop-shop service delivery (one service provider offers services in the same room at the same time).

All healthcare workers from the supported facilities were trained on the integrated services. It was noted that healthcare workers' training continued even during 2020- 2021 when there were restrictions on mass gatherings due to the COVID-19 pandemic. In 2021 Alfred Nzo district trained 48% of professional nurses in Intrauterine Contraceptive Device (IUCD) insertion, 78% in cervical cancer screening, and 93% in sub-dermal implant insertion. OR Tambo district trained 59% of professional nurses in IUCD, 100% on sub-dermal implants and cervical cancer screening.

Healthcare worker training was conducted on-site. Training included practical and classroom training, followed by regular visits and monitoring to strengthen healthcare workers' knowledge, skills and attitudes. Ten champions were selected, based on their competencies to serve as buddies to support their colleagues. The champions were able to travel to sub-districts to offer peer support.

The following challenges were noted during the implementation of integrating services:

- Frequent contraceptives stock-out.
- Some key indicators were not collected by health facilities.
- Clients and communities were not informed about the benefits of integrated services.
- There were some gaps in the referral systems.
- Lack of a supportive environment for healthcare workers.

- Information, education, and communication material were not available in local languages.
- There were gaps in the periods between implementation activities which impacted on continuity of service provision.

As a result of these challenges, several recommendations were highlighted noting the need for:

- Functional forecasting of stock needs and supply, improvement of the ordering systems for these supplies and estimate stock order levels to be done in advance.
- Revision of data collection tools to address the gaps created by some indicators not being collected.
- Improvements in referral systems for continuity of care to accommodate service integration.
- Provision of a supportive and enabling environment for healthcare workers.
- Availability of Information, education, and communication material to clients in local languages.

In Ms Dana's concluding remarks, she stated that the COVID-19 pandemic presented challenges for the delivery of integrated services. Therefore, there was a need to support healthcare workers and address their well-being and mental health. Healthcare workers moved from their stations because of COVID-19 demands on their time. In addition, facilities were overwhelmed by patients from other provinces due to the ban on inter-provincial travel. The closure of the borders also meant that the delivery of essential medicine was delayed.

The second presentation in Session two was delivered by Dr Sanni, who presented on the integration model that was implemented in KwaZulu-Natal.

Technical Assistance on SRH, HIV and GBV integration Dissemination

Dr Babatunde Sanni
Executive Director & South Africa Country Lead, Optidel Global

Optidel Global was contracted to implement the SRHR integration intervention in KwaZulu-Natal mainly. They started the implementation of the SRHR integration programme with five facilities, in 2017. From the success of these facilities, there was a scale up to 12 facilities in uThukela district. Optidel Global worked in a total of 53 facilities across uThukela, eThekwini, and Ugu districts. The programme was based on Ideal Clinic Model (ICM)-integration at the primary healthcare level. The integrated clinical service management (ICSM) was used to strengthen the integration of SRH and HIV. The ICSM has four streams namely Acute, Chronic, Preventative, and Health support services. The links among HIV, STI and SGBV made it imperative to integrate these services.

At baseline, healthcare workers reported several constraints including a lack of training, staff shortages, and insufficient infrastructure. Healthcare workers' competence in delivering integrated services was very low. In 2017 UNFPA assisted in developing the minimum package of care for SRHR, HIV, and SGBV. On the client's side, the baseline interviews revealed that the facilities in the programme provided only one additional service apart from the service clients sought. In addition, female clients were not offered cervical or breast cancer services.

The scope of the project by Optidel Global was:

- Ensuring sustainability and institutionalisation.
- Training and mentorship.
- Data use, documentation of evidence, and dissemination (3Ds).

The model of integration used by Optidel Global was **Plan** – inception, training assessment, analysis, patient pathway flow review, **Do** – Inclusion, mentorship, action; **Study** – meeting to assess progress, and **Act** - action on activities identified (PDSA). The PDSA cycles in an overarching plan to guide the implementation of the SRH integration model.

The model was not a one size fits all approach in that each facility and district applied components as needed. Therefore, the approach was targeted to the health facility's needs. However, Dr Sanni also noted that the intervention was not just beneficial at the health facility level but also at the health system level.

The training was conducted in-house to avoid taking healthcare workers from their workstations. Tools used included the Training Alert, the dashboard, and Job Aid.

Dr Sanni shared the proof of efficiency using uThukela district as an example. Data on key indicators were collected at different times during the implementation of the intervention. Before March 2020 some progress was noted in the effectiveness of the model implementation. However, once ~~Covid~~ 19 emerged, there was a 20% decrease in headcount. Yet, an increase in the uptake of long-acting contraceptive services was observed during this period. There was a shift from the short-acting to the long-acting contraceptive uptake. Other results showed that cervical screening services increased over time. The client-exit interviews also confirmed that they received more services than they visited the facilities for.

Challenges experienced in implementing integrated services:

- Shortage of healthcare workers, deficits in healthcare workers' training, long client waiting times, poor infrastructure, and staff burnout.

- No cervical cancer services and no post-abortion care are provided for clients.
- COVID-19 challenges (results for facilities in uThukela district)
  - Decreased headcount due to lockdown, healthcare workers' infections, and the need for healthcare workers' mentorship.
  - The COVID-19 pandemic also affected supply chain and management systems leading to drug stockouts.

Key mitigating factors:

- Establishment of Technical Working Group (TWG).
- Training and use of data collection tools.
- Collaboration with the district training units.
- Mentorship.
- Lessons learned:
- Strengthening oversight by the provincial and district offices.
- Strengthening the quality of supervision, and
- Ensuring ownership of the process by the facilities.

The limitations experienced by Optidel Global included healthcare workers', staff shortages, and the duration of the project, which resulted in intermittent project implementation and ensuing gaps in service provision.

Dr Sanni concluded his presentation by noting the human stories behind the facility headcounts. These stories are contained in the report Optidel Global submitted to UNFPA.

The two presentations were followed by a question-and-answer session to engage the symposium attendees on matters arising.

Question and Answer Session

QUESTION

Does the current South African abortion law seek to align with other acts such as the Children's Act and is the administration of abortion factoring in the age of the child when it comes to consent and the role of a parent in consenting?

ANSWER

The CTOP Act does not have an age limit for accessing the service. The challenge experienced by the healthcare workers is to convince some young people to inform their parents, so they have support at home. Young people are however provided with the service even when they do not want to involve their parents.

QUESTION

Does the SRHR reach out to rural areas especially to traditional healers since people still consult with them and they do not use western medical tools or methods?

ANSWER

The department reaches out to traditional healers.

QUESTION

Is it possible for the Department of Health to include in-service educators from colleges and universities in the training of SRHR integration services, to keep everybody updated?

ANSWER

The Department is working on the abortion curriculum to be included in the nursing curriculum.

Session 3: Experiences of Sexual and Reproductive Health and Rights Integration by Districts

In this session, Prof Beksinska, presented a model used by MatCH Research in eThekwini district. Ms Thobekile Mpembe and Ms Linda Dlamini presented their experiences of implementing the UNFPA-initiated integration programme in uThukela and Ugu districts respectively. Finally, Ms Siziwe Jongizulu from the UNFPA shared insights gained from a joint programme conducted by UNFPA and UNICEF aimed at empowering young women and girls to realise their SRHR in South Africa.

The eThekwini District Reproductive Health Service Integration Model: Results from model implementation.

Prof Mags Beksinska
Deputy Executive Director, MatCH Research Unit

This 4-year project aimed to develop, implement and evaluate a service delivery model which structurally links family planning and barrier method services with HIV/AIDS services in eThekwini district. It was based in Wentworth and its six feeder clinics. Baseline assessment was conducted through key informant interviews, facility inventory, and focus group discussions. During the baseline assessment, information on what people understood integration to be, was collected. A model was developed based on the information collected during baseline. The integration focused on:

- capacity building,
- strengthening SRH services,
- integration of family planning into HIV services,
- strengthening patient and commodity monitoring,
- strengthening referral systems,
- community involvement, and
- policy contribution and dissemination.

During the pilot phase, the project introduced:

- WHO flipcharts which were easy to use.
- Health systems navigators who worked both within the facilities and in communities. They saw over 1800 clients.
- An end-line assessment was conducted in 2011. During the end-line assessment, facility, provider, and client interviews were conducted.

Before the implementation clients expressed that it was difficult to speak to healthcare workers.

Clients' perspectives on the quality of care at the end of the project revealed that 70% of the clients said services were available on the same day, and 262 of the 297 clients interviewed across all selected facilities said the consultation was private and confidential. Over 60% and 80% of clients reported that they would prefer to see the same provider at each visit, and they would prefer two services on the same day respectively. Family planning use was at 50%.

Men preferred to receive services at the health facility.

The comparison of the baseline and end-line results from the healthcare providers' side indicated that service integration had improved and that their perceptions of integration had changed to the positive side. The work was disseminated as widely as possible including to the NDoH and other organisations. The results of this study were shared through all academic platforms. This project was conducted over ten years ago.

Experiences of the programme from uThukela District

Mrs Thobekile Mpembe
Clinical District Specialist, uThukela District

The introduction of integrated services in uThukela district facilitated collaboration with traditional healers, communities, youth, and the Department of Social Development. The work with UNFPA started in 2017, during a benchmark visit to Botswana where lessons were learnt about SRH integration and implementation. At baseline, clients were only offered one service at a time (see the presentation by Dr Sanni). The baseline phase aimed to provide a minimum package of services and linkage, build the capacity of healthcare workers and explore existing community structures. Workshops were conducted to upskill healthcare workers to provide integrated SRHR services. The PDSA model of integration was used to facilitate the identification and closing of competency gaps.

The results showed that there was a marked improvement in the number of integrated services provided and the number of healthcare workers competent in providing these services. In terms of lessons learnt, integration was done from the province to the district level which strengthened links with supervisors. Clients' satisfaction with receiving SRHR integrated services improved. Integration facilitated sustainability. Best practices included the effective use of the dashboard (avoiding red indicators). SRHR was introduced in other programmes within the facilities.

Experiences of the programme

Ms Linda Dlamini
District Director: Ugu District

SRH rights need to be reflective of the demand of the clients. All projects implemented ensured that clients get what they require. Ugu's population is mostly unemployed, which leads to high crime and GBV levels. The demographics of the district determine the services offered at healthcare facilities. Eighteen facilities participated in the integration project, which was over a six-month period. The comparison of services offered/received pre- and post-implementation showed improvement even though there were several demotivating factors such as absenteeism of healthcare workers, COVID-19 infection, and other co-morbidities that resulted in staff deaths. It was observed that during the first month of implementation, there were no improvements in service delivery.

Challenges observed as hindering the integration and implementation of SRHR services included:

- Facility-based challenges included partially implemented adolescent and youth-friendly services (AYFS) staff shortages and turnover, data capturing discrepancies, and inappropriate infrastructure.
- Community challenges included low community buy-in of SRH services, poor uptake of reversible contraceptives, and myths and beliefs about implants.
- The Community-Based Model of SRH was not part of the school health package; mobile health services for those in school, utilising community health workers, pregnancy screening, and referral systems were not fully implemented. Schools were also not able to offer SRH services on-site and school governing bodies played a gatekeeping role. Ms Dlamini highlighted the high occurrence of teenage pregnancy at schools as one of the challenges faced by the districts.
- Staff negative attitudes included judgement of people visiting facilities for certain services. Judgments were based on age and behaviours, such as having multiple partners are prevalent. This resulted in clients' reluctance to seek treatment or services.
- Cross province movement of clients seeking healthcare was also highlighted. The district shares a border with Eastern Cape and clients from this province go to KwaZulu-Natal health facilities.

The district used all the lessons learnt from the implementation partners to improve the provision of services.

Ms Dlamini summarised her presentation with the following quotation:

> *"Laws have to be backed up with resources and political will. And deep-seated cultural codes, religious beliefs, and structural biases have to be changed"*
>
> – Hillary Clinton.

Joint programme between UNFPA and UNICEF funded by Canada. (No slides)

Ms Siziwe Jongizulu
Program Analyst, UNFPA

This programme was implemented by UNFPA and UNICEF in the Eastern Cape (Nelson Mandela and Alfred Nzo Districts) and KwaZulu-Natal (uThukela District). The programme was aimed at empowering young women and girls to realise their SRHR in South Africa. The duration of the programme was from 2019-2023 and had two outcomes.

- Increase availability and use of quality SRH, HIV, and SGBV prevention and response services that are free of bias and discrimination, for adolescents and young people.
- Decrease discriminatory and harmful practices and attitudes that perpetuate and validate SGBV against adolescents and young women, and therefore act as barriers to SRHR access.

The baseline study was led by UNICEF and was targeted at health and social services. Findings revealed that SRHR, HIV, and GBV services were available, however with little integration. Healthcare facilities and social services were vital entry points for GBV survivors; however, both healthcare workers and social workers were not trained in identifying and providing SRHR services for GBV victims.

At schools, there was resistance to providing SRHR programmes, especially abortion services. Four out of nine girls reported receiving SRHR education at school. However, there were uneven levels of access to such services at schools. Gatekeepers (parents, community actors) presented a challenge because of inter-generational differences. Community-level interventions were not widespread.

Traditional leaders were key to educating the communities about the challenges experienced by young women and girls. The three districts had few programmes which involved men, boys and family members.

This programme partnered with Umthombo weMpilo Institute and Optidel Global to strengthen the integration of SRHR, HIV, and GBV services. A coordinating forum that facilitates the integration of the three services was found to be functional. A theory of change for multi-sectoral services for adolescents, girls, and young women was developed focusing on the Ukhahlamba District. Healthcare workers were trained in providing youth-friendly services, offering GBV support, referral of clients, and collection of disaggregated data.

UNFPA conducted a study on knowledge, attitudes, and behaviour among adolescents, girls and young women, parents, and community actors. In addition, they analysed the prevalence, and factors affecting intimate partner violence among adolescents, girls and young women. There is also a study on harmful practices that are being conducted in collaboration with HSRC. This study is focusing on harmful cultural practices such as *Ukuthwala*, female genital mutilation, and other cultural practices that affect the rights of young girls.

Another study that is in progress, focuses on the use of dashboards by the districts. In addition, the team is working on a report for a survey looking at the behaviour and knowledge of AGYW on SRH, HIV and GBV services.

Question and Answer Session

QUESTION

Considering that KwaZulu-Natal is a place affected by migration, how did migration affect the programme, and what were the lessons?

QUESTION

Is there any policing on illegal migration?

ANSWER

In uThukela district, partners migrate to Gauteng due to work. The safer conception study is used through women, to encourage partner involvement. Women are encouraged to involve their partners. However, this takes time to yield results.

ANSWER

There is both internal and external migration. The district is on the border with the Eastern Cape province. There are noted staff attitudes that need to be changed to teach healthcare workers to treat all clients equally. Services should be offered without discrimination.

QUESTION

The Premier Mr Zikalala recently quoted that about 18 000 girl children (teenagers) were pregnant, this is worrying. Is there a strategy on how this can be curbed?

ANSWER

Some young girls get pregnant deliberately because of pressure from home. This is also exacerbated by traditions such as ukuthwala (forced marriages). The Department encourages girls to delay pregnancies. There are community strategies targeting in-school and out-of-school youth to empower young girls and young boys. Programmes are trying to include boys in education.

When looking at teenage pregnancies, one should also consider that several teenagers terminate pregnancies. There is a discrepancy between the Choice on Termination of Pregnancy which allows a 16-year-old to terminate, and the law, which says she cannot consent to sex. In KwaZulu-Natal teenagers become pregnant to prove fertility.

SRH is part of the schools' services package. Learners can be educated, but clinical services are not allowed. Some schools do not allow healthcare services because of beliefs that they encourage promiscuity, and some schools allow mobile clinics to be stationed at the school gates. There is a standard operating procedure that service providers need to adhere to before providing services to learners. There is a consent form that needs the parent's signature before receiving SRHR services. However, the issue with parental involvement and consenting is that it takes away the rights of a girl child and impedes the privacy of young people to make decisions on their sexuality. On HIV testing in schools, some parents do not want their children to be tested as they may not be ready to disclose their children's status.

QUESTION

There were a lot of descriptive statistics shared today, I would like to know if people with disabilities were reached. If so, how were accessibility measures recorded? If data does not exist, what is the stumbling block to including people with disabilities?

ANSWER

The integration programme does not document services offered/received accord-ing to disabilities or Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) communities. Services are provided indiscriminately to all who visit health facilities. Numerating disabled persons is a form of discrimination.

One of the participants added that we should be cautious of the language used around teenage pregnancy, child sexual abuse, and sexual activity. A woman's age needs to be factored in and there is a need to consult more about the girl child. There was a call from civil society to open criminal cases for child sexual abuse. There are children (10 years) who gave birth between 2020-2021. This means that they were sexually abused. We, therefore, need to differentiate between children having sex and children being abused.

Policies: A workshop conducted by UNAIDS found that young people are not aware of health policies. As a result, they are unable to negotiate their rights. There is a need for policy education workshops for young people. The symposium did not speak to clinic committees that have structures that include young people. There is a need to strengthen the clinic committees to hear young people's voices. Operation *Sukuma Sakhe* should also be included in the integration programme. There is a need to keep girls in school until they matriculate to reduce the risk of HIV acquisition.

Session 4: Reports on Sexual and Reproductive Health and Rights Services

Session 4 consisted of presentations of integration reports delivered by MatCH, the National Department of Health, Wits Reproductive Health Institute, the Desmond Tutu Foundation, and the HSRC.

Results from post ECHO contraceptive study

Prof Mags Beksinska
Deputy Executive Director, MatCH Research Unit

The goal of the ECHO study was to assess the risk of acquiring HIV following the use of one or three different contraceptive methods and to compare the benefits of the different methods. The three methods compared were depot-medroxyprogesterone acetate (DMPA), Copper intrauterine device, and Levonorgestrel (LNG) implant. The results showed that participants chose to continue using the methods they had been assigned during the study. The study enrolled 7829 women between 2015 and 2018. The results were shared in 2019.

The CUBE study was conducted as a follow-up to the ECHO study. The Cube study had four objectives, namely, to document contraceptive status over 6 to 24 months following the ECHO trial. The second objective was to describe reasons for contraceptive discontinuation and switching, describe implant and IUD removal outcomes, and document barriers to obtaining LARC removal. The study was conducted in South Africa and Zambia. Interviews were done telephonically every six months.

This presentation focused on the South African results. Surveys were conducted between 2018 and 2021. All participants had previously participated in the ECHO study. The study found that the main reasons for discontinuation were that the preferred method (DMPA) was stocked out. Participants using the implant had concerns about their health and side effects. The copper IUD was discontinued because women found it difficult to tolerate the heavy bleeding at times.

During Covid, 23% of the participants experienced difficulties accessing SRH services. A majority used contraceptives throughout the Covid lockdown period, even though there were anxieties and uncertainties about being able to access services in the future. Only 7% had unmet needs.

In-depth interviews revealed that participants preferred to continue using the contraception irrespective of the side effects they experienced. Implant and IUD methods were preferred. LARC removal results found a barrier to uptake was that women had to return to the facility where it was inserted. Participants were asked about self-care methods. In South Africa, participants were interested in learning about contraceptives, emergency pills, subcutaneous injectables, and Cycle Beads. The high uptake of contraceptives suggested that when women are supported, they do use contraceptives.

Integrated STI and HIV programming

Dr Thato Chidarikire
Director, National Department of Health

Dr Chidarikire gave an overview of the STI and HIV prevalence in the country. She noted that there was a shift from the 90-90-90 targets to the 95-95-95 treatment cascade in alignment with the new global strategy. South Africa was achieving 94-78-89 in both the public and private sectors. The country's challenge include children who were not being tested for HIV and were therefore not virally suppressed. There is also a challenge of early sexual debuts among both male and female young people. Age disparities were increasing between males and females. Therefore, the risk behaviours associated with HIV acquisition continued. Condom use at last

sex increased between 2012 to 2017, coinciding with the transition from choice condoms to max condoms. However, there was no increase in condom use among 15–24-year-old young people thereafter despite the department providing what the young people asked for, i.e., adding colour and scents to condoms. Dr Chidarikire stated that we need to focus on the relationship between young girls and older men.

In response, the Department in collaboration with UNFPA undertook the following activities:

- Updated HIV prevention strategy – know your epidemic so you know your response,
- Devised condom communication plan – the challenge here was communication,
- Increase case findings,
- Expanded PrEP and PeP services,
- Created Youth zones,
- Leave no one behind, and
- Use Max youth condoms.

Challenges of STIs

Ms Regina Maithufi
Technical advisor HIV Prevention Strategies, National Department of Health

Ms Maithufi informed the meeting that South Africa has not been doing a good job in managing STIs for the past 30 years. There are one million STI diagnoses daily, and of these most are treatable. This has an impact on the risk of HIV and neonatal syphilis. The acquisition of STIs is attributed to the lack of condom use and multiple sexual partners. Clients with herpes simplex do not present at health facilities due to fear and stigma. Healthcare workers at facilities said they were not trained in providing STI services.

Findings revealed that STI management, PeP, and PreP expansion, increased cases of HIV and STIs needed improvement. Action points include increasing awareness and decreasing negative perceptions of being infected with an STI.

The Department will be embarking on costing the effects of STIs on the health system. According to a Centre for Disease Control (CDC) funded study, youth were not screened sufficiently, they did not access the services because of confidentiality concerns, the biological makeup of young girls makes it easy for them to be infected, access to healthcare is lacking, and a majority of young people have multiple sex partners.

South Africa uses the syndromic management approach to manage STIs, which was reviewed every two years. The results showed that gonorrhoea was high in males, and bacterial vaginosis was high among girls.

Key Priority Areas for Integration and Implementation Strategies. Lesson learnt:

- STIs have not been prioritised for the past 30 years (Chlamydia, gonorrhoea, and syphilis).
- If the high prevalence of STIs is not managed, this will result in babies being born blind or with heart disease.
- The majority of STIs are preventable and asymptomatic.
- There is a need for health promoters in facilities to promote health-seeking behaviour attitudes. Engagement of clients in facility waiting areas found that patients expressed the need for health promotion at facilities. There is a need to work with peer educators.
- Cervical cancer cases are increasing. DoH will strengthen cervical cancer screening.
- There is a need for interventions for primary prevention- education and targeting of high-risk groups.
- Strengthen the syndromic approach and partner notification.
- There is a need to reach sex workers, transgender people, young people, and people living with HIV as well as to strengthen men's health and conduct surveillance among men who have sex with men.

- Priorities- by 2030 STIs need to be eradicated in South Africa. The DoH is working closely with the Department of Basic Education and the Department of Social Development in this initiative.

Project PrEP (2018-2021)

Ms Melanie Pleaner on behalf of
Ms Alison Kutywayo
WITS RHI

This project was initiated in collaboration with Unitaid and the National Department of Health. The project focused on adolescent girls and young women, in high-priority areas. It had three objectives namely, to increase the accessibility of PrEP for eligible AGYW population, demonstrate effective delivery models and appropriate use of PrEP among adolescents, and generate and disseminate evidence on the use of PrEP in real-life settings.

The project had four clusters in three provinces: Tshwane, eThekwini, OR Tambo and Gqeberha. Each cluster had two youth-friendly clinics. The achievements as of 31st December 2021 were as follows: 14 612 AGYW initiations, 22 057 combined initiations (opportunity for SRH integration) and 3 747 male initiations. The involvement of men was key to showing the importance of integrated services.

Ms Pleaner cited their published paper: *Pleaner, M., Fipaza, Z., Mabetha, K., Greener, L., Ncube, S., Butler, V., Beksinska, M. and Mullick, S., 2021. Uptake of Contraception Among Adolescent Girls and Young Women PrEP Clients: Leveraging the Opportunity to Strengthen HIV and Sexual and Reproductive Health Integration. Frontiers in Reproductive Health, 3, p.684114.*

This paper focused on using PrEP as the potential platform for improving access to contraception. A total of 5 000 clients over 21 months were recruited. The study identified the need for demand creation for PrEP services. Over 60% of women reported current use of contraception. It was noted that 32.3% of the non-users accepted a method at PreP initiation, and the method uptake increased contraceptive prevalence from 21.2% to 74.5%.

Key findings from the paper are:

- PrEP was valuable to promote SRH and improve access to contraception where both services are offered together. However, there was a need to better understand those who did not take up a contraceptive method.
- Opportunities for integration need to be leveraged and maximised including outreach and demand creation for SRHR services.
- The project focussed on PrEP initiation, hence there is a need for integrated counselling about contraception and contraception choices
- Training needs were identified and education on integrated counselling was provided.
- There is a need for adaptive health systems to facilitate integration at facility level.
- There is a need for further analyses to understand factors influencing integration, e.g., staff training and stockouts. It is important to look at programmatic integration, particularly if PrEP is located in the HIV stream which is seen as a vertical service. The language should be that SRH is an integral part of prevention.
- Find effective ways to monitor and measure integration.

Before concluding, Ms Pleaner recommended a presentation by Alison Kutywayo and Melanie Pleaner titled Girls Achieve Power (GAP) year: Building Health, Social and Educational Assets for Empowering Girls at Critical Time of Adolescent Transition which was not presented at this symposium but was flagged by Ms Pleaner. She indicated that other papers will be shared with the symposium organisers.

Healthcare Providers as Agents of Change: Integrating PrEP with other SRHR for AGYW

Dr Elzette Rousseau
Socio-behavioural scientist, Desmond Tutu Foundation

This presentation was on the role of healthcare providers as agents of change for the integration of services. The presentation was based on the paper titled: Health care providers as agents of change: integrating PrEP with other sexual and reproductive health services for AGYW. The presentation was based on two studies called Prevention Options for Women Evaluation Research (POWER) and PrEP implementation in young women and adolescents (PRIYA). The study consisted of four study sites; where three were located in South Africa and one was located in Kenya. They conducted 36 in-depth Interviews with a healthcare provider and eight focus group discussions with 50 healthcare providers. The study presented challenges and solutions to strengthen the provision of patient-centred PrEP services. Healthcare professionals had tension between their social and professional values. They had social stigma and moral concerns in providing PrEP as they felt this was encouraging sexual activity, a middle role had to be found. There were can-do and will-do attitudes. It was stated that healthcare workers needed to prioritise their professional obligation to the client.

Adolescent girls and young women were found to be sensitive to perceived judgemental attitudes and stigma. Despite PrEP being available there was minimal exposure among healthcare workers to services offered or to training in this area. It was observed that there was a lack of motivation from healthcare workers to deliver PrEP to patients and little awareness of why healthcare workers should deliver PrEP services. Healthcare workers expressed uncertainty about its safety and efficacy. A model mapping solution for motivating healthcare providers was shared.

Case study: Integrated SRHR/HIV/GBV

Dr Inbarani Naidoo
Senior Research Specialist, Human and Social Capabilities, HSRC

Dr Naidoo delivered a presentation from HSRC reporting key findings from their desktop review and synthesis of implementation project data conducted from November to December 2021 and April to June 2022. During this time the HSRC reviewed implementation reports produced by Optidel Global and Umthombo weMpilo Institute. These reports consisted of findings from the implementation of SRH integration interventions conducted in selected districts and health facilities in the Eastern Cape and KwaZulu-Natal provinces over the period 2017 to date.

Interventions were implemented based on the health facility's needs and profiles. Baseline assessments were conducted by the implementers and involved a desktop review of policies, and strategies, a review of routine data collected at the selected facilities, site visits, and stakeholder interviews. The implementers then orientated healthcare facilities to the implementation plan, mapped patient flow, trained, mentored, and supported healthcare workers, established data collection systems, used data to highlight gaps, and conducted community engagements. Scale-up of the intervention involved: continued training, mentoring of community health workers in providing integrated services, correct use of data collected in identifying gaps, monitoring indicators, and disseminating information. There was also sharing of human-interest stories and engaging clients to better understand their needs and adapt strategies to these needs.

HSRC summarised the key SRH, HIV and GBV indicators that were reported on. Overall, there were improvements and positive impacts shown in the number of healthcare workers trained and reported competence after the interventions. At baseline, clients received one service versus three services post-intervention.

Key findings and lessons learnt were described as follows:

- There was little data concerning integration from the clients' perspective.
- Missing data concerning all indicators for age groups 10-14, 15-19, and ≥50 years.
- There were gaps in the coverage of screening men for STIs.
- Implementors reviewed data collection tools, registers and dashboards. However, there were missing data for some indicators.

Recommendations:

Recommendations covered the following domains (1) training mentorship, and technical support of health personnel to deliver integrated services, (2) encouraging interaction and sharing experiences through facilitated meetings, (3) delivering on-site refresher training and identifying priority training areas, (4) client's perspective; conduct both baseline and exit interviews with clients, identify & maintain the clients' perspective when designing & implementing integrated SRH services, (5) identify reasons for data gaps, (6) enhance facility services linkages using lay councillors, lastly, (7) there is a need for standardising monitoring templates and guidelines to enhance data quality.

Question and Answer Session

Comments:

We need to engage (research and implementing) partners regarding STI reporting. Males do not go to health facilities for screening but do get tested in projects. Voluntary male circumcision is an opportunity to access males for STI screening and health promotion.

The shortage of contraceptives needs to be re-evaluated because districts would have either a lot of injectables but no implants, or the other way around. The distribution of contraceptives within a district should be managed before reporting a shortage.

The final session was followed by Dr Nompumelelo Zungu who presented a summary of the proceeding and closing remarks.

Dr Nompumelelo Zungu,
Deputy Executive Director or Strategic Lead: Identity and Belonging, Human and Social Capabilities, HSRC

Dr Zungu thanked everyone who attended the symposium both physically and virtually. She noted that it has been humbling to see the amount of support that the symposium has enjoyed. She stated that it was encouraging to also see the transformation in the room, ("...in particular colleagues who work in the SRHR field"). She acknowledged that there has been a change over time and we are now seeing women attending and leading these events talking about women's issues in line with the famous statement "nothing for us without us". It is however important to acknowledge the role of men in SRHR and these discussions. Men's issues are also important in SRHR.

Dr Zungu expressed gratitude towards UNFPA for providing a platform for partners to come together to share experiences and knowledge through this event, particularly on lessons learnt and best practices; and how these can be used in the scaling up of the intervention. Summarising the proceedings of the day Dr Zungu points to a few highlights emerging from the different presentations. She noted that Ms Thembi Zulu reminded us that the SRH services must be centred around policy, and that prevention of pregnancy must be understood within context. Dr Zungu noted the importance of hearing directly from the implementers who highlighted the importance of capacity building and the need to strengthen service delivery to avoid parallel service provision.

She also indicated that it was encouraging to hear from the representatives from the two provincial departments of health and to learn that the sustainability of the SRHR integration programme was factored into the implementation. She pointed out that there are already offshoots illustrated through the current rolling out of the SRHR Integration in health facilities beyond the districts supported by UNFPA.

Dr Zungu noted challenges experienced in integrating SRHR, HIV, and SGBV services these included:

- Stock out, changing patterns in service delivery of SRH which was also brought to the fore by the COVID-19 pandemic,
- Internal migration and the challenges experienced during lockdown i.e., restricted movement between provinces highlights the need for the country to adopt a unique identifying number for each patient accessing healthcare facilities and to move to electronic record keeping. This will enable patients to seek healthcare anywhere in the country and the service provider would be able to access their health records and patient history. Dr Zungu mentioned the importance of being able to track clients seeking services outside the province for healthcare to avoid labelling them defaulters or lost to care.
- She also noted that South Africa has two worlds. This was evident when healthcare workers could not be trained because they did not have mobile data or computers. Dr Zungu highlighted the importance of investing in technology as part of the capacity building throughout the implementation process.

These challenges should be considered when planning future service delivery and interventions particularly we should acknowledge that there might be other pandemics and even climate change-related disasters (such as recently seen in the KwaZulu-Natal floods) in the future. Dr Zungu went on to highlight some of the emerging debates from the participants at the symposium, the critical one being the role of schools in the delivery of SRHR services. She noted that the ensuing discussion highlighted the complexities and the intersection between different government departments, in this case, the Department of Health and the Department of Basic Education. The discussion also highlighted where the rights of the parents and school governing body intersect versus the right of a girl child. Disability and access to SRHR

services were also highlighted as important areas for tracking. Disability and access should be added as important indicators in measuring SRHR service delivery in health facilities.

She acknowledged the important work that UNFPA is supporting as presented by Ms Siziwe Jongizulu especially the work on SRH attitudes and knowledge, intimate partner violence among adolescents, GBV, and harmful cultural practices (currently being conducted by the HSRC in 3 South African Districts).

Dr Zungu noted the important work of other SRHR partners, especially the presentations covering PrEP, HTS, STI, access to contraception, and male involvement. Lastly, Dr Zungu pointed out how healthcare workers can be agents of change based on work done by the UNFPA.

Dr Zungu concluded the session by delivering her vote of thanks, she acknowledged Dr Manzini-Matebula and Ms Koketso Dlongolo from UNFPA, the HSRC team including Dr's Inba Naidoo and Tebogo Gumede, the support services staff coordinated by Ms Yolande Shean and Ms Jill Ramlochan, the IT team members in KwaZulu-Natal (Mr Garth Marillier) Pretoria (Mr Moses Mohlala) and Cape Town, HSRC master's intern Ms Philisiwe Ndlovu, finance manager Ms Lebo Nyawane, four HSRC interns (Ms Thembekile Radebe, Ms Sethabile Ndlovu, Ms Zinhle Shazi, and Ms Seithati Lehopa) who assisted with registration at the symposium and everyone else who assisted to make this day a success.

All papers and presentations will be shared with the permission of the presenters.

Appendix 1: **PROGRAMME**

Venue: Premier Hotel Umhlanga, 327 Umhlanga Ridge Boulevard, Durban

08:00 – 09:00 Registration		
09:00 – 09:15	Welcome & Opening Remarks	Dr Ntsiki Manzini-Matebula Programme Specialist: SRHR and HIV/AIDS Linkages: UNFPA
Moderator: Dr Thato Chidarikire, Ministry of Health		
09:15 – 09:30	Introductions	All
09:30 – 09:45	SRHR Policies	Ms Thembi Zulu, Deputy Director: SRHR, Department of Health
Presentations by Implementing Partners & Service Providers: Models of integration and Lessons learnt		
09:30 – 09:45	Umthombo weMpilo Institute	Ms Nobanzi Dana CEO, Umthombo weMpilo (Virtual)
09:45 – 10:00	Optidel Global	Dr Babatunde Sanni Executive Director & South Africa Country Lead, Optidel Global (Virtual)
10:00 – 10:15	Question and Answer Session	
10:15 – 10:45 Tea Break		
Experiences by districts		
10:45 – 11:00	The eThekwini District Reproductive Health Service Integration Model: Results from model implementation.	Prof Mags Beksinska, Deputy Executive Director, MatCH Research Unit
11:15 – 11:30	Experiences of the programme from OR Tambo District	Ms Nobanzi Dana CEO, Umthombo weMpilo Institute
11:30 – 11:45	Experiences of the programme from uThukela District	Mrs Thobekile Mpembe, Clinical District Specialist, uThukela District
11:45 – 12:00	Experiences of the programme from Alfred Nzo District	Mrs Nomkhitha Sodlula, Ministry of Health Director of Maternal Health Programmes, Alfred Nzo District (Virtual)
12:15 – 12:30	Experiences of the programme from Ugu District	Ms Linda Dlamini, District Director, Ugu District
12:30 – 12:45	Questions and Answers	
12:45 – 13:30 Lunch Break		

Moderator: HSRC Integration reports		
13:30 – 13:45	Results from post ECHO contraceptive study	Prof Mags Beksinska, Deputy Executive Director, MatCH Research Unit (Virtual)
13:45 – 14:00	Integrated STI and HIV programming	Dr Thato Chidarikire, Director HIV Prevention Strategies
14:00 – 14:30	Question and Answer Session	
14:30 – 14:45	Implementation, evidence and insights gained from The Girls Achieve Power (GAP) Year trial (on behalf of Alison Kutywayo) A brief reflection on the integration of PrEP and Contraception -Project PrEP	Ms Melanie Pleaner, Senior Technical Specialist: Implementation Science Department, Wits RHI (Virtual)
14:45 – 15:00	Healthcare Providers as Agents of Change: Integrating PrEP with other SRHR for AGYW	Dr Elzette Rousseau, Socio-behavioural scientist, Desmond Tutu Foundation (Virtual)
15:00 – 15:15	Case study: Integrated SRHR/HIV/GBV	Dr Inbarani Naidoo Senior Research Specialist, Human and Social Capabilities, HSRC
15:15 – 15:30	Question and Answer Session	
Closure		
15:30 – 15:45	Summary of proceedings & closing remarks	Dr Nompumelelo Zungu, Executive Director and Strategic Lead: Identity and Belonging, Human and Social Capabilities, HSRC

Symposium delegates

Welcome & Opening Remarks

Dr Nontsikelelo Manzini-Matebula

Programme Specialist: SRHR and HIV/AIDS Linkages: UNFPA

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

UNFPA

2gether 4SRHR

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

Symposium
8 July 2022

2gether4 SRHR Programme Overview

2gether 4 SRHR is a **regional programme** funded by the Government of Sweden **that aims to improve the sexual and reproductive health and rights** (SRHR) of all people in East and Southern Africa, **particularly adolescent girls, young people and key populations**, by promoting an integrated approach to SRHR, HIV and gender-based violence.

The 2gther4srhr Programme Provides Technical & Financial support To:

- ❑ **OBJECTIVE 1 :** Strengthen programme intervention by establishing the national status of **SRHR and HIV linkages at policy and systems level**
- ✓ Output 1.1, **Create an enabling legal and policy environment** that empowers all people to exercise their SRH rights and access quality integrated SRHR/HIV and SGBV services.
- ✓ **OBJECTIVE 2: Strengthen the provision and delivery of quality integrated SRHR services** particularly adolescent girls and young people and key populations.
- ✓ Output 2.2: Quality integrated **SRHR/HIV and SGBV services scaled up**
- ✓ Output 2.3: High quality **SRHR/HIV and SGBV data and information produced**
- ❑ **OBJECTIVE 3:** Strengthened communication, ownership, empowerment and participation
- ❑ **OBJECTIVE 4:** Amplify lessons learned

Background on 2gether4SRHR (cont.)

In South Africa the programme:

- aimed to strengthen the provision of integrated SRHR, HIV and SGBV services for all people, particularly adolescent girls, young people and key populations. Supporting the integration of these services ensured that individuals could; exercise their SRH rights, increase knowledge of SRHR/HIV and SGBV, reduce unmet need for family planning, and improve access to integrated SRHR/HIV and SGBV services.

Specific objectives were to:

1. Support South Africa's Health Department, create an enabling legal and policy environment that empowers all people, particularly adolescent girls, young people and key populations, to exercise their SRH rights and access quality integrated SRHR/HIV and SGBV services.

2. Strengthen the delivery of quality integrated and sustainable SRHR/HIV/TB and SGBV services that meet all people's needs, particularly adolescent girls, young people, and key populations.

3. Strengthen communication, ownership, empowerment and participation of all people, but focusing on adolescent girls, young people and key populations to exercise their SRH rights, adopt protective and promotive behavior, and have access to quality integrated services on time.

4. Amplify the lessons learnt from the implementation of the Joint Programme to strengthen integrated SRHR/HIV and SGBV services.

UNFPA Supported Provinces: KwaZulu-Natal and Eastern Cape

UNFPA supported two provinces which have the least progressing indicators on poverty, maternal mortality, HIV and AIDS prevalence and gender-based violence, including sexual violence and harmful cultural practices.

In KwaZulu-Natal, the programme implementation is in **Uthukela district.**

Two districts were selected for programme implementation the second province, Eastern Cape: **Alfred Nzo and OR Tambo District.**

Background on Symposium

On an annual basis UNFPA develops a workplan as part of the 2gther4SRHR programme and one of the activities in 2021 was to start the documentation process on the 2gether4SRHR programme. This led to the development of the case study on integrated SRHR/HIV/GBV as well documenting experiences of some of the beneficiaries. It is for this reason that we are gathered here today to hear from our implementing partner on the case study but also to listen to our provincial level implementing partners who have been in the coalface of implementing these programmes. We did not want to only hear from ourselves at the UNFPA, HSRC and the implementing partners but we wanted to also hear from the Department of Health on integration and how we can strengthen collaboration as partners that support the government. As a country, we are known to have progress legislations but fall short when it comes to implementation. Our colleagues from the Department of Health will share with us on some of these policies but also draw on some gaps that exist in our integration efforts. Partners will also share lessons and results from their projects, and we will get an opportunity to learn from the districts on the programmes that have been implemented in their facilities.

This symposium is not the first of its kind. One symposium which informed our current meeting was held in 2011 by the Maternal, adolescent and child health (MatCH) research unit. The meeting focused on the Integration of Sexual and Reproductive Health & HIV Services in South Africa: Progress and Challenges. Key Priority Areas for Integration and Implementation Strategies were mapped out and today we will get to hear from Prof Mags Beksinska on the integration eThekwini project.

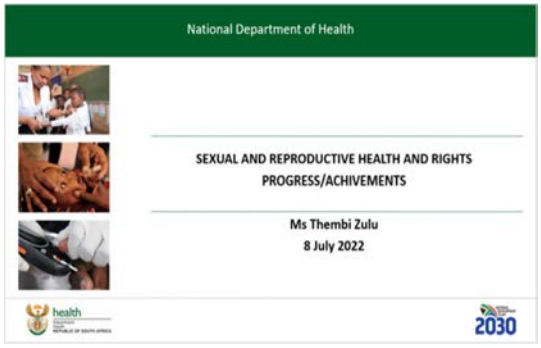
Purpose of symposium

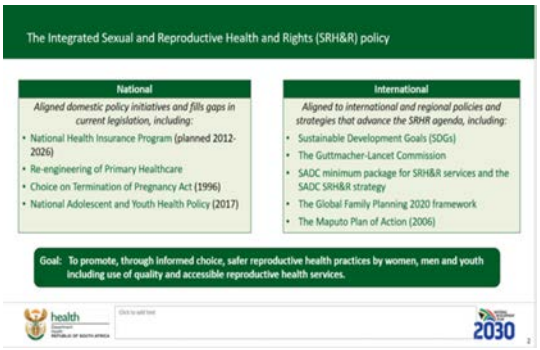
We hope this meeting will:

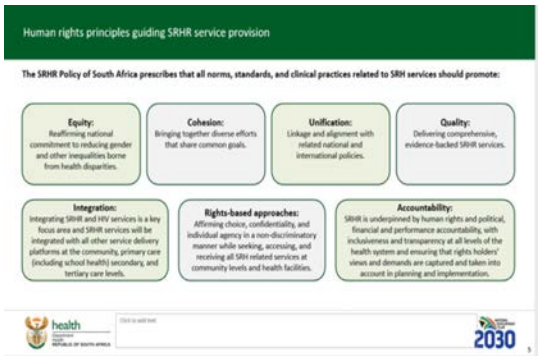
- Shed light on key components and models that work for the integration of SRH/HIV/SGBV services
- Help us learn from challenges observed to inform the sustainability of the programme
- Provide best practices to upscale the integrated SRHR/HIV/GBV in other provinces
- Lastly, identify opportunities for future collaborations and chart a way forward.

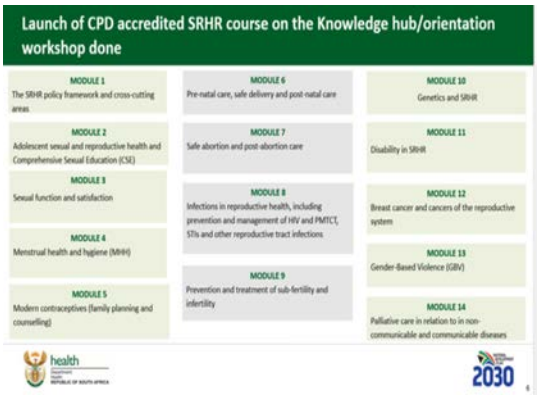
SRH Policies

Ms Thembi Zulu,
Deputy Director: SRHR, Department of Health









Implementing Partners - Models of integration and Lessons learnt

Dr Babatunde Sanni
Executive Director & South Africa Country Lead, Optidel Global

Content

1. Background and context
2. What actions were undertaken to integrate SRH/HIV and GBV
3. What are the benefits and challenges of scaling-up
4. What was the impact of COVID-19 on integrated services
5. What were the lessons learned

Background and Context -1

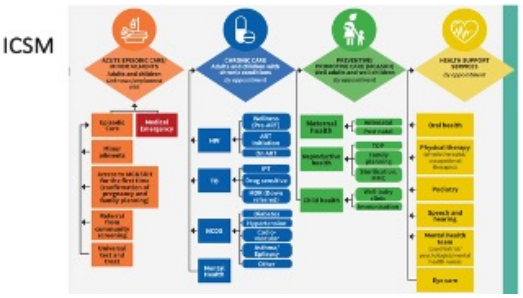
UNFPA initiated the SRH,HIV & GBV integration project & Sponsored Botswana benchmarking visit

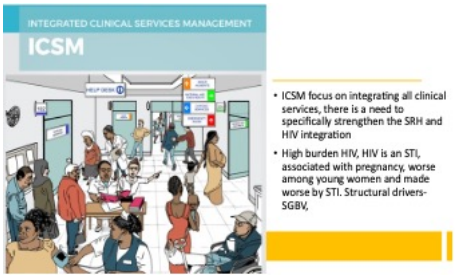
Aug-Nov 2017: Baseline Assessment conducted

Sept 2018 to Mar 2019: Pilot integration model in 5 facilities in Uthukela district

Sept 2019 to Mar 2020: Scale up integration model and documented the effectiveness in 12 facilities in Uthukela District

Sept 2021 to Mar 2022: scale up to other 53 facilities across 3 districts (Uthukela, Ethekwini and Ugu)



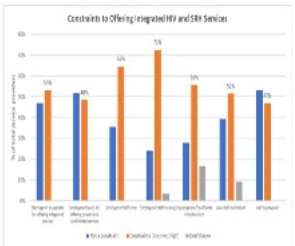


Initial Situation-1

Summary of Baseline Assessment Report on level of SRH/HIV/SGBV/TB integration (2017)

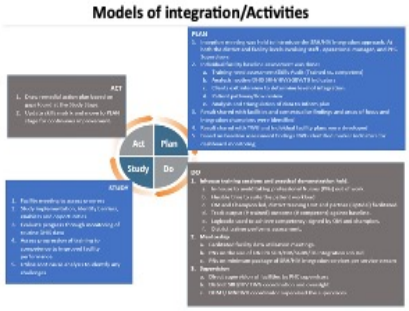
"providing a minimum package for service integration and linkages; **appropriately building the capacity of service providers;** and **exploring existing community structures** can prevent some of the missed opportunities from occurring"

- UNFPA Convened Workshop
- Development of the minimum package of Care for SRH/HIV

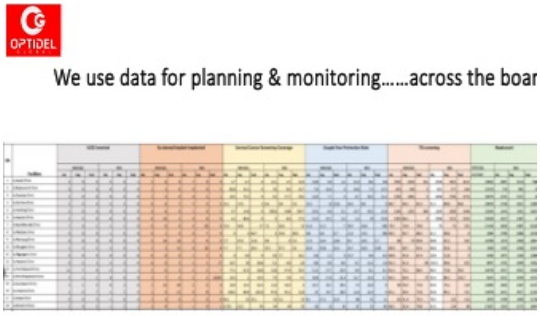


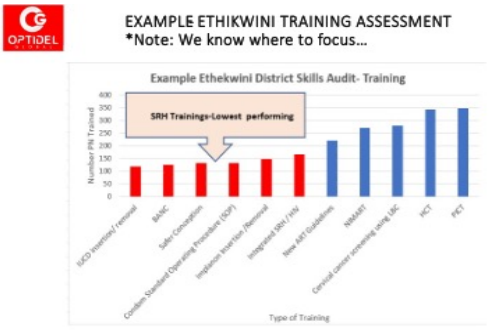

Initial Situation-2
CLIENT SURVEY
TRAINING NEEDS ASSESSMENT

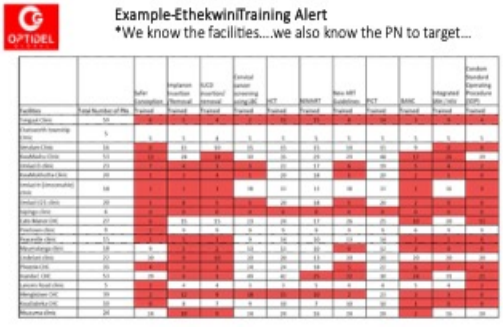

Model of Integration


Models of integration/Activities
Act
Plan
Study
Do


Highlight of Tools


We use data for planning & monitoring.....across the boar


EXAMPLE ETHIKWINI TRAINING ASSESSMENT
*Note: We know where to focus...
Example Ethekwini District Skills Audit- Training
SRH Trainings-Lowest performing
Number PN Trained
Type of Training


Example-EthekwiniTraining Alert
*We know the facilities....we also know the PN to target...


Example: Ugu's Dashboard
We monitor and support supervision.....

Technical Assistance on SRH, HIV and GBV Integration Dissemination Meeting

8th July 2022.

Dr Babatunde Sanni
Optidel-Public Health Team Lead

Tshego Monongwe
Project Director

Content

1. Background and context
2. What actions were undertaken to integrate SRH/HIV and GBV
3. What are the benefits and challenges of scaling-up
4. What was the impact of COVID-19 on integrated services
5. What were the lessons learned

Context

Background and Context -1

UNFPA initiated the SRH,HIV & GBV integration project & Sponsored Botswana benchmarking visit

Aug-Nov 2017: Baseline Assessment conducted

Sept 2018 to Mar 2019: Pilot integration model in 5 facilities in Uthukela district

Sept 2019 to Mar 2020: Scale up integration model and documented the effectiveness in 12 facilities in Uthukela District

Sept 2021 to Mar 2022: scale up to other 53 facilities across 3 districts (Uthukela, Ethekwini and Ugu)

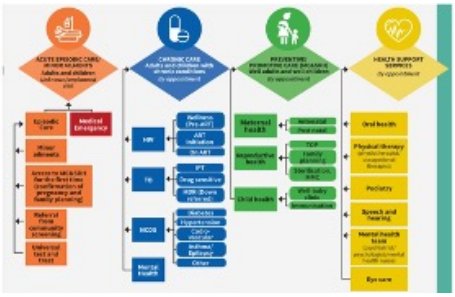
Understand the Context

- In South Africa, the foundation of service integration at Primary Health Care (PHC) facilities is enshrined in the concept of Ideal Clinic model

What is an Ideal Clinic?

- An Ideal Clinic is defined as a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and sufficient adequate bulk supplies. It uses applicable clinical policies, protocols and guidelines, and it harnesses partner and stakeholder support
- Integrated Clinical Services Management (ICSM) is a central pillar of health service delivery within the Ideal Clinic model
- ICSM reorganizes health service delivery in facilities into four broad streams; acute illness, chronic disease, and maternal and child health, and health support services streams. This phased out the previously existing multiple streams

ICSM



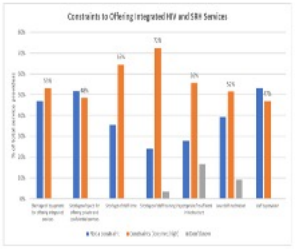
- ICSM focus on integrating all clinical services, there is a need to specifically strengthen the SRH and HIV integration
- High burden HIV, HIV is an STI, associated with pregnancy, worse among young women and made worse by STI. Structural drivers-SGBV,

Initial Situation-1

Summary of Baseline Assessment Report on level of SRH/HIV/SGBV/TB integration (2017)

"providing a minimum package for service integration and linkages; **appropriately building the capacity of service providers;** and **exploring existing community structures** can prevent some of the missed opportunities from occurring"

- UNFPA Convened Workshop
- Development of the minimum package of Care for SRH/HIV



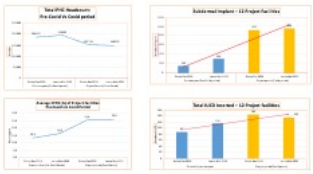
Checklist to..
Support SRH/HIV Integration at service entry points...

Results-uThukela

Before and During COVID Era

Effectiveness result

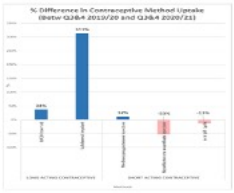
Despite drop in the headcount in COVID Era by 25%, Project sites had improved performance



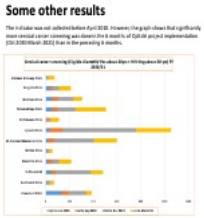
Observation

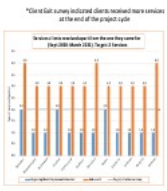
Note:
From Pre-covid to Covid era
- Short Acting contraceptive uptake dropped
- LARC uptake increased
- A need to evaluate using sensitive evaluation design

? Could it also be due to clients avoidance of short acting methods that requires frequent attendance to facilities during Covid?



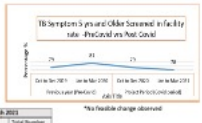
Some other results





Some other results

Training data



*No Feasible change observed

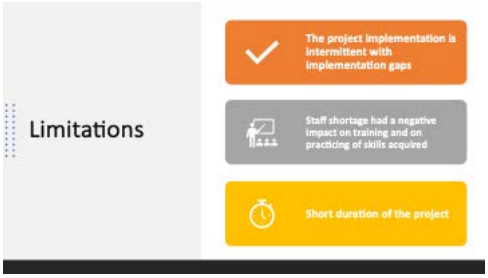
Indicator	Beginning of project Sept 2020			End of Project March 2021		
	Total Number of professional Nurses at Baseline	Total Number Trained at baseline (% of Total PHs trained)	Total Number that reported Competent at baseline (% of Total PHs competent)	Total Number of PHs at the end of project	Total Number Trained at the end of the project (% of Total PHs trained)	Total Number competent at the end of the project (% of Total PHs competent)
AJCD	329	44 (34%)	24 (19%)	193	97 (83%)	96 (38%)
Implanon		71 (55%)	57 (44%)		114 (81%)	114 (75%)
Cervical Cancer Screening		119 (92%)	119 (92%)		149 (97%)	147(98%)
GBV (GBV)		11 (9%)	10 (8)		115 (79%)	115 (75%)

Covid-19 Key Challenges

- Decreased headcount due to lockdown
- Healthcare workers getting infected
- Fear and burn-out due to fighting multiple epidemic (COVID, HIV,TB, GBV)
- The advent of COVID-19 pandemic disrupted services and made project implementation difficult (Shortage of staff)
- The pandemic also affected the supply chain and logistics management systems
  - leading to stock out of the LARC and other commodities

Mitigating the Challenges

- Established Technical Working Group with a clear TOR
- Non-Generic/facility targeted training and mentorship approach
- Employed the use of Job Aid that guides health care workers on provision of integrated services within all service delivery streams (Chronic, Acute, Maternal and Child, Acute)
- Collaborated with district training units to train healthcare workers
- Organised on-site practical sessions for competency enhancement
- Mentored trained healthcare workers on the use of logbook and organised facility specific campaigns



Human Story 1: Lerato's Life and Passion Reignited

Lerato whose dream was to become a nurse. Her dream was short-lived because she became pregnant and had to drop out of school. She received information on different family methods from Wembezi clinic and opted for an implant (one of the long-acting reversible contraceptives (LARC). She stated that "I don't need another baby now and I don't want to come to the clinic frequently and I am perfectly happy with it". Although Lerato is not a nurse as she desired, she registered a Non-For-Profit Organization (NPO) and work with her team to raise awareness in the community with a special focus on the youths to guide them on how to address their challenges and prevent teenage pregnancy, sexual abuse, HIV and COVID-19.

Human Story 2: Thabo's Future Plans Secured by Information Received During Facility Health Talks

Thabo's life changed because of the information sessions he attended at Wembezi clinic. This enabled him to access care when he experienced a condom burst while having sex with his partner. He was provided with pre and post counselling for HIV testing and thereafter tested for HIV and was offered Post Exposure Prophylaxis (PEP) and a demonstration session on how to wear the condom correctly to prevent condom bursts in the future. Thabo stated that "If not for the service provided by the clinic, this would have had a bad effect on my life because I can have HIV and I am not financially ready to have a baby".

Human Story 3: Access to Health Care Services Improved Zanele's Reproductive Health

"In 2002. I was raped and I came to Wembezi clinic for help. I was counselled, screened for STI and HIV. I was also treated and referred to the police station for further counselling. The clinic staff members were very patient with me, they worked hard and as a team to make everybody happy". This is the testimony of Zanele, a mother of two girls, aged 9- and 14-year-old who has gone through a lot in life and who is currently receiving Antiretroviral Therapy (ART) in the clinic. Zanele has been working for the Community Work Programme (CWP) as a cleaner for 6 years now.

Human Story highlights

Acknowledgements

- KZN Department of Health:
  - Province, uGu, eThekwini, uThukela
- MNCWH Coordinators, District Specialist, Operational Managers, and SRH Champions.
- UNFPA Staff
- Optidel Staff

Siyabonga

Family Planning training practical sessions with Optidel Team

Thanks
Questions and Discussion

The eThekwini District Reproductive Health Service Integration Model: Results from model implementation.

Prof Mags Beksinska,
Deputy Executive Director, MatCH Research Unit

The eThekwini District Reproductive Health Service Integration Model- Results of implementation

UNFPA -HSRC National Symposium on Integration of SRHR, HIV and SGBV services
8th July
C Milford, J Smit, M Beksinska, Z Mabude

MRU MatCH Research Unit

health Department: Health PROVINCE OF KWAZULU-NATAL

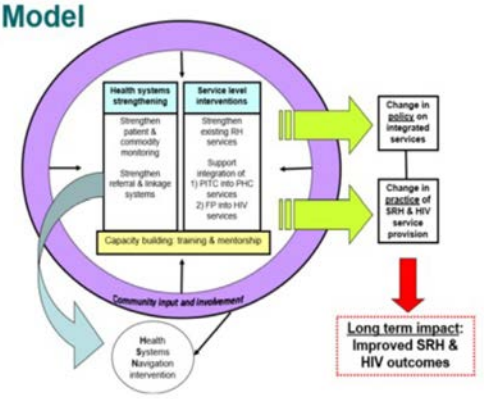
Project outline

- Aim: To develop, implement and evaluate a service delivery model which structurally links family planning and barrier method services with HIV/AIDS services in eThekwini district.
- Project sites: Wentworth Hospital and feeder clinics (Chesterville, Cato Manor, Bluff, Austerville, Lamontville and Merebank).
- Time frame: 4 year project.

Background

- Baseline research conducted in 2008 to inform model:
  - Key informant interviews:
    - On understandings of integration and current integration practices. Held with DoH (national, provincial, local), NGOs, academics (local and international).
  - Facility inventory, Provider interviews, Client interviews:
    - Baseline data on facilities, services offered, and degree of integration in practice.
  - Focus group discussions:
    - On understandings and current integration practices. Held with health care providers and community members.

Model



Integration model

- From 2010 - 2011 we completed activities one to seven within these inter-connected intervention areas:
  1. Capacity building
  2. Strengthening existing SRH services
  3. Integration of FP into HIV services
  4. Strengthening patient & commodity monitoring
  5. Strengthening referral & linkage systems
  6. Community involvement
  7. Policy contributions and dissemination

Capacity building

- Aim: To build on or enhance healthcare providers' capacity through training.
- Where: All participating facilities.
- Healthcare providers and community members were trained on the following:

Module	Module name	Total trained
Module 1	FC and dual protection	136
Module 2a	HCT and FP	128
Module 2b	HIV, ARV and FP integration	71
Module 2c	Comprehensive care	93
Module 3	Referral Systems	68
Module 4	Monitoring and Evaluation	64

Mentorship pilot

- Aim: To extend the benefit of training/capacity building through the on-going mentorship of providers.
- Where: Bluff Clinic.
- 9 staff members (4 professional nurses, 1 enrolled nurse, 1 enrolled nursing assistant, 1 counsellor, 1 clerk and 1 general assistant) were mentored over the period of six months.
- During this period further training needs were identified as well as barriers and facilitators to task shifting and service provision.

WHO Flipchart: Background

- Aim: To improve links between HIV and Family planning (FP).
- Where: At Wentworth Hospital.
- In early December 2011, interviews were held with 1 Provider and 1 Counselor who were trained to use the Flip-chart to counsel or consult with clients.
- Interviews were conducted with 5 HIV positive female clients who had been counseled using the Flip Chart.

WHO Flipchart: Results

- Preliminary results indicated that both the counsellor and provider had no difficulty using the tool and felt that it improved the quality of sessions.
- Clients reported that they:
  - enjoyed learning about the different methods of contraception available;
  - and thought that the tool should be used at subsequent FP sessions because of its ability to convey a great deal of information in one session.
- These results suggest that the tool can be used to facilitate counselling sessions with PLHIV and as well as to improve the quality of FP services received more generally.

Health Systems Navigation

- Aim: To actively assist clients in simple and various ways such as:
  - Referral assistance such as giving clients directions,
  - Information, for example, explaining how hospital systems work or,
  - Peer support such as, following-up with clients that have been referred to other services in order to minimize the loss of clients between services.
- Where: Wentworth hospital.
- How: Four HSN's were stationed at several SRH services.

Health Systems Navigation – Preliminary Results

- Preliminary analyses showed that over three months, 1853 clients (528 males, 1295 females) received:
  - referral information (n=488),
  - directions (n=765) or,
  - were escorted to services (n=875).
- Overall, this pilot was positively received by both clients and providers.
- This intervention could ease some of the burden created by staff shortages and high client loads and could improve adherence to healthcare and treatment.

Endline assessments

- Purpose: To compare service delivery now (2011) with Baseline survey findings (in 2008).
- Comprised of 3 main components:
  - Facility interviews and observations
    - Date: October 2011 – November 2011.
    - Who: Facility managers/in charge of facilities.
    - What: 1 interview & 1 observation per facility.
    - 300 Interviews in total, across the 8 facilities.

Endline assessments 2011 cont.

- Provider interview
  - Who: Health care providers, Registered nurses, Enrolled nurses, Enrolled nursing assistants and lay counselors.
  - How: 44 Interviews in total, across the 8 facilities.
- Client interviews
  - Who: Men and women attending the health facility.
  - How: 300 Interviews in total, across the 8 facilities.

Participants opinion about services and HCP	Strongly agree (%)	Somewhat agree (%)	Not sure (%)	Somewhat disagree (%)	Strongly disagree (%)
It is hard to talk to HCP because they shout at clients	24.7	9.7	10.7	17.7	37.1
Staff were friendly	76.9	13	3.3	3.7	3
The Nurses listened to me	85.6	9.3	0.6	3.7	0.6
I felt free to ask questions	84.6	8.7	1.3	2.7	2.7
I was provided with all the information I wanted during today's consultation	79	12.4	3	2	2.3
My consultation was private	85	8.7	1.7	3	0.6
The waiting time was reasonable	37.4	16.3	5.3	7.7	33
I would recommend this clinic to a friend	81.2	11.4	2.7	1.7	2.7

Client Demographics

Age			Sex		
Minimum	Maximum	Mean	Male	Female	Total
18	66	32.87	70	230	300

Service Attended	N
PHC	97
FP	27
ANC 1st visit	7
ANC follow up	50
STI	10
VCT	42
HIV/ART	101
Immunization/PNC	27
Total	361

Client's Perceptions of Quality of Care

Are all services available at this clinic all the time ?	%
Services available on same day	70
Need to come on different days	24
Don't Know/Unsure	6

Consultation with HCP private and confidential	N
Yes all of it	262
Some but not all	21
No	14
Total	297

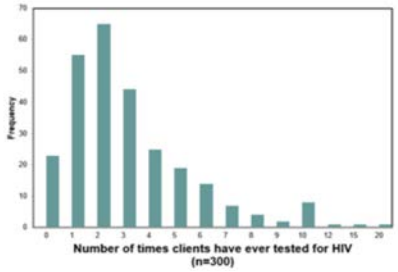
Integration: The Clients' Choice

- 62.8% of clients reported that if given the choice they would prefer to see the same provider at each visit.
- 88.7% of clients reported that they would prefer to have two services on the same day in the same consult.

Proportion of Women using Family Planning

- 51% of sexually active women reported using a method to prevent pregnancy
- 13 % of sexually active women reported they do not currently use a method to prevent pregnancy
- 74% of sexually active men reported using a method to prevent pregnancy
- 11 % of sexually active men reported they do not currently use a method to prevent pregnancy

Prevention



Men and STIs

Where would you attend for STI treatment/advice (males only)	%
This facility (facility at which the interview was conducted)	73
Another facility	2.9
Hospital	8.6
Pharmacy/chemist	1.4
Other	7.1

Health Care Providers' Referrals

How many Clients Referred for IUDs	Where referred
6	King George Family Planning
1	Commercial City
3	Hospital (Unspecified)
1	Within this facility (facility at which the interview was conducted)
10	Lancers clinic

Percentage of HCP's who referred for ToP in the last year	%
Yes	69.4
No	27.7
It is done at this service point	2.7

Training Desired by Interviewed Health Care Providers

HCP want to receive training in:	Responses (N=44)
Family Planning	15
ARV	17
VCT	10
HIV Management	28
PMTCT	15
STI	12
TB	15
ANC/MW/PN	12
Sexual Health	11
Taking sexual hx	9
TOP	11
Values Clarification	8
Other	5

Integration practices: Providers' perceptions

	Baseline (%)	Endline (%)
Service level integration		
SRH & HIV services are integrated	13	33
HCT integration	74	98
FP integration	83	95
ART service integration	48	79
Facility is a "one-stop-shop"	9	26
Providers' perceptions of integration		
Integration improves quality of care	47	84
Integration increases workload	86	48
Management supports integration	5	13

MRU

Policy contribution and dissemination of results

- After the Endline assessment & activities we conducted the following activities:-
  - overall policy recommendations,
  - dissemination at conferences & DoH/eThekwini fora,
  - publication in peer-reviewed journals,
  - Report back meeting with our DWF.
- We hope that the integration project we implemented has benefitted the public health system, and will be able to act as a best practice model to inform rollout of similar activities in other districts in KZN and elsewhere.

Acknowledgements

- William & Flora Hewlett Foundation
- Staff at Wentworth Hospital, Cato Manor, Lamontville, Chesterville, Bluff, Austerville and Merebank Clinics
- DoH (Provincial & District), and Ethekwini Municipality

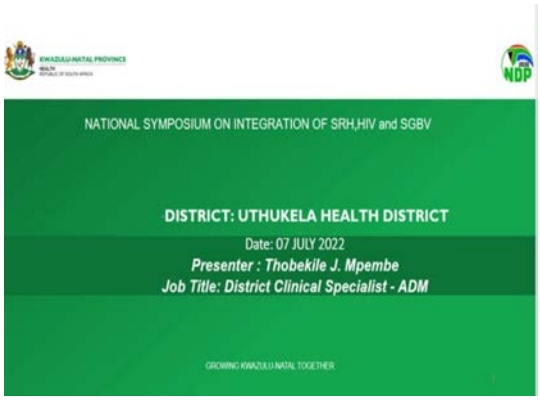
MatCH

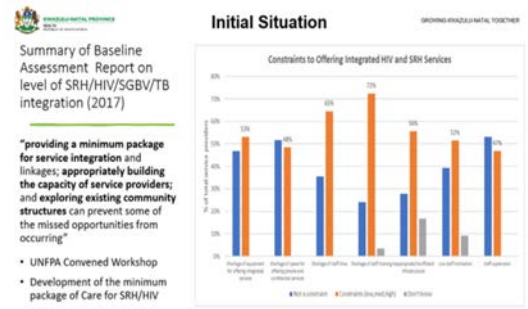
Thank you.

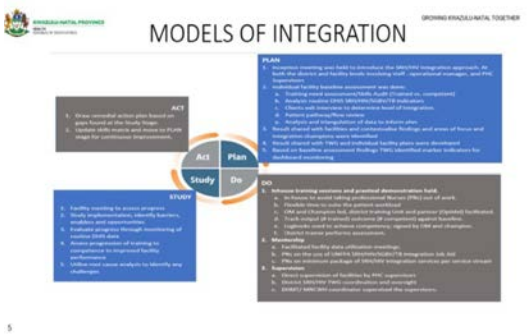
MRU

Experiences of the programme from uThukela District

Mrs Thobekile Mpembe,
Clinical District Specialist, uThukela District







Observation

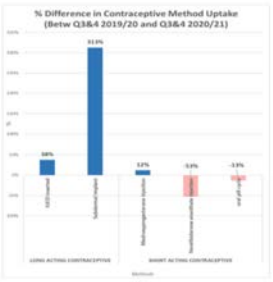
Note:

From Pre-covid to Covid era

- Short Acting contraceptive uptake dropped
- LARC uptake increased
- A need to evaluate using sensitive evaluation design

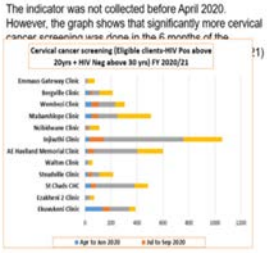
Assumptions:

- Clients avoidance of short acting methods that requires frequent attendance to facilities during Covid
- Move toward to LARC



Results

The indicator was not collected before April 2020.
However, the graph shows that significantly more cervical



*Client Exit survey indicated clients received more services at the end of the project cycle

Results

Training data

Indicator	Beginning of project Sept 2020			End of Project March 2021		
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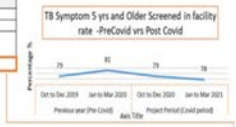


Covid-19 - Key Challenges

- Decreased headcount due to lockdown
- Healthcare workers getting infected
- Fear and burn-out due to fighting multiple epidemic (COVID, HIV,TB, GBV)
- The advent of COVID-19 pandemic disrupted services and made project implementation difficult (Shortage of staff)
- The pandemic also affected the supply chain and logistics management systems
- Stock out of certain commodities

Achievements / Sustainability

- Established Technical Working Group with a clear TOR
- Non-Generic/facility targeted training and mentorship approach
- Employed the use of Job Aid that guides health care workers on provision of integrated services within all service delivery streams (Chronic, Acute, Maternal and Child, Acute)
- Collaborated with district training units to train healthcare workers
- Organised on-site practical sessions for competency enhancement
- Mentored trained healthcare workers on the use of logbook and organised facility specific campaigns

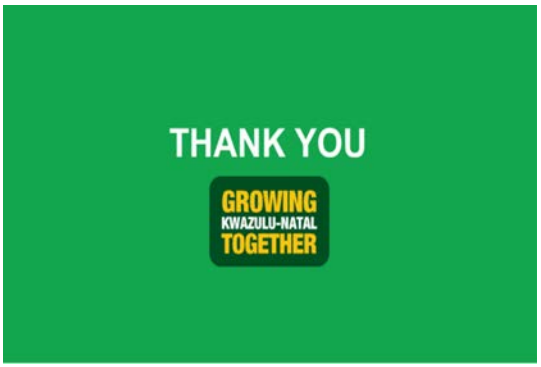
Key challenges of scaling up

- High –turnover
- Infrastructural challenges impacting on patient flow


Lessons Learned
01
Strengthening the provincial and district oversight is key
02
Strengthening the quality of supervision enhance functional and effective implementation
03
Client Satisfaction, client's ability to access more then one service at visit. Botswana study tour: Kiosk, Mall
04
Ensuring ownership by facilities facilitates sustainability

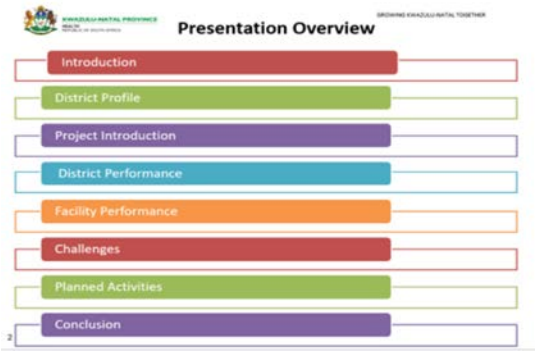

Best Practices...
A Best Practice
A Best Practice
A Best Practice

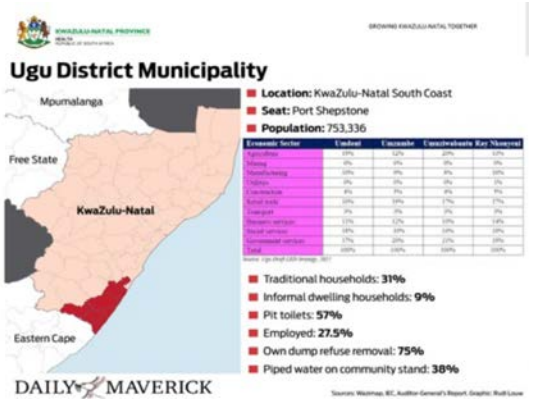

Acknowledgements
Government of Sweden
UNFPA
Uthukela District-Facilities and District Staff
Province DOH
NDOH
Optidel Global Health Staff

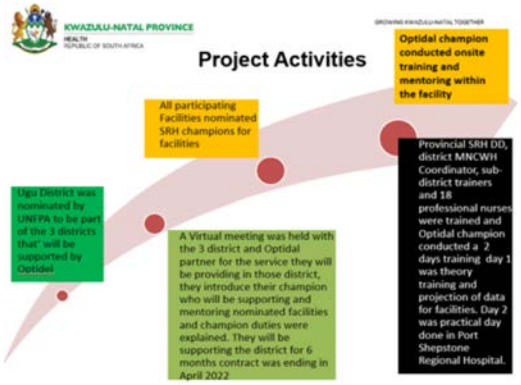

THANK YOU
GROWING
KWAZULU-NATAL
TOGETHER

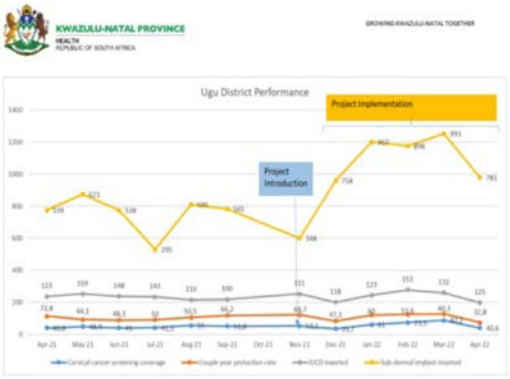
Experiences of programme from UGU District

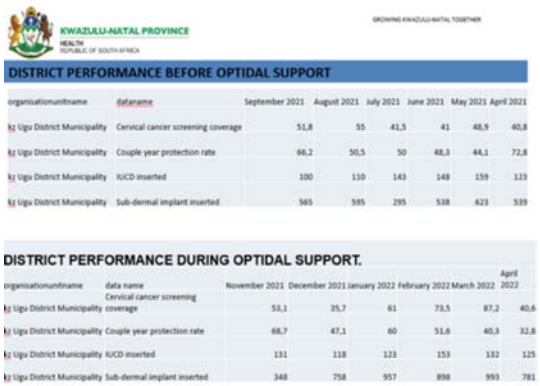
Ms Linda Dlamini,
District Director, Ugu District











KWAZULU-NATAL PROVINCE

DISTRICT PERFORMANCE BEFORE OPTIDAL SUPPORT

organisationunitname	dataname	September 2021	August 2021	July 2021	June 2021	May 2021	April 2021
Ugu District Municipality	Cervical cancer screening coverage	51,8	55	41,5	41	48,9	40,8
Ugu District Municipality	Couple year protection rate	66,2	50,5	50	48,3	44,1	72,8
Ugu District Municipality	IUCD inserted	100	110	143	148	159	123
Ugu District Municipality	Sub-dermal implant inserted	565	595	295	538	623	539

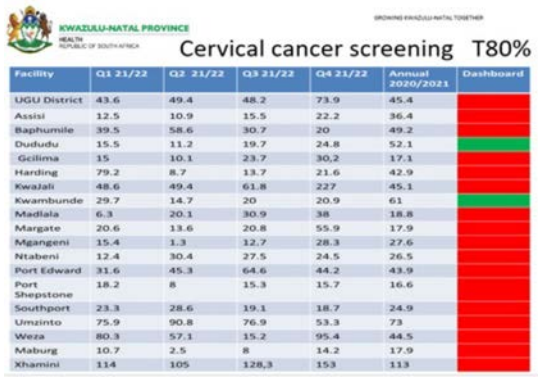
DISTRICT PERFORMANCE DURING OPTIDAL SUPPORT.

organisationunitname	data name	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022
Ugu District Municipality	Cervical cancer screening coverage	53,1	35,7	61	73,5	87,2	40,6
Ugu District Municipality	Couple year protection rate	68,7	47,1	60	51,6	40,3	32,8
Ugu District Municipality	IUCD inserted	131	118	123	153	132	125
Ugu District Municipality	Sub-dermal implant inserted	348	758	957	898	993	781

KWAZULU-NATAL PROVINCE

Couple year protection rate (T60%)

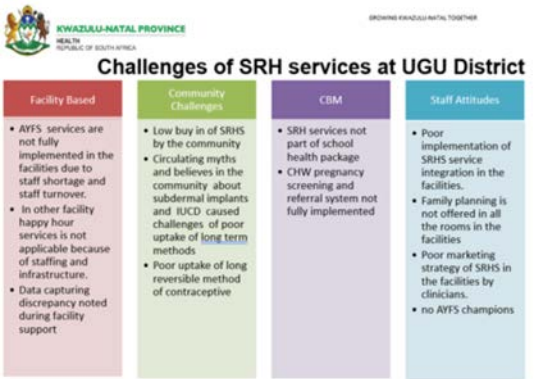
Facility	Baseline 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Annual 21/22	Dashboard
UGU District	44	55	55.5	61.2	50.6	57	
Assissi	12	33.7	18.3	84.2	85.3	15	
Bphumile	18	13.3	11.5	29.6	19.4	18	
Dududu	11	15.6	11,2	19.7	24.8	17	
Gcilima	18	7	7.6	39.1	59.3	20	
Harding	17	15.1	10.1	23.7	30.2	18	
KwaJali	15	28.6	10.1	15.6	17.7	34	
Kwambunde	22	29.7	14.7	20	29.2	22.5	
Madlala	12	6.3	20.1	30.9	38	14.3	
Margate	30	20.6	13.6	20.8	55.9	34	
Mgangeni	7	7.2	4.9	6,7	2,2	5	
Mgayi	22	18.7	20.7	19.3	30.3	22	
Ntabeni	12	11.5	11	7.1	19.6	12	
Port Edward	17	16.5	9.9	19.5	28.5	19	
South Port	17	16.7	11.6	18.1	20.9	17	
Umzinto	15	13	10.5	11.8	14.1	12,4	
Weza	42	50.1	35.7	28.5	37.1	37	
Xhamini	32	44	29.5	18.7	35.9	32	



KWAZULU-NATAL PROVINCE

Cervical cancer screening T80%

Facility	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Annual 2020/2021	Dashboard
UGU District	43.6	49.4	48.2	73.9	45.4	
Assisi	12.5	10.9	15.5	22.2	36.4	
Baphumile	39.5	58.6	30.7	20	49.2	
Dududu	15.5	11.2	19.7	24.8	52.1	
Gcilima	15	10.1	23.7	30,2	17.1	
Harding	79.2	8.7	13.7	21.6	42.9	
KwaJali	48.6	49.4	61.8	227	45.1	
Kwambunde	29.7	14.7	20	20.9	61	
Madlala	6.3	20.1	30.9	38	18.8	
Margate	20.6	13.6	20.8	55.9	17.9	
Mgangeni	15.4	1.3	12.7	28.3	27.6	
Ntabeni	12.4	30.4	27.5	24.5	26.5	
Port Edward	31.6	45.3	64.6	44.2	43.9	
Port Shepstone	18.2	8	15.3	15.7	16.6	
Southport	23.3	28.6	19.1	18.7	24.9	
Umzinto	75.9	90.8	76.9	53.3	73	
Weza	80.3	57.1	15.2	95.4	44.5	
Maburg	10.7	2.5	8	14.2	17.9	
Xhamini	114	105	128,3	153	113	



KWAZULU-NATAL PROVINCE

Challenges of SRH services at UGU District

Facility Based

- AYFS services are not fully implemented in the facilities due to staff shortage and staff turnover.
- In other facility happy hour services is not applicable because of staffing and infrastructure.
- Data capturing discrepancy noted during facility support

Community Challenges

- Low buy in of SRHS by the community
- Circulating myths and believes in the community about subdermal implants and IUCD caused challenges of poor uptake of long term methods
- Poor uptake of long reversible method of contraceptive

CBM

- SRH services not part of school health package
- CHW pregnancy screening and referral system not fully implemented

Staff Attitudes

- Poor implementation of SRHS service integration in the facilities.
- Family planning is not offered in all the rooms in the facilities
- Poor marketing strategy of SRHS in the facilities by clinicians.
- no AYFS champions

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

GROWING KWAZULU-NATAL TOGETHER

Planned Activities

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

GROWING KWAZULU-NATAL TOGETHER

Conclusion

"Laws have to be backed up with resources and political will. And deep-seated cultural codes, religious beliefs and structural biases have to be changed."

Hillary Clinton

Results from post ECHO contraceptive study

Prof Mags Beksinska,
Deputy Executive Director, MatCH Research Unit

MRU fhi360

Contraceptive Use dynamics Beyond the ECHO trial:

cube

Assessment of long-term user experiences and method continuation in South Africa and Zambia

MRU team: Jenni Smit, Busi Maphumulo, Mags Beksinska

FHI 360 team: Rebecca Callahan, Alice Cartwright

USAID

The Evidence for Contraceptive Options and HIV Outcomes (ECHO) Study

- ECHO study goal: To see if the risk of getting HIV is different with use of one of three different contraceptive methods, and also compare the benefits of those methods

MRU echo

ECHO study

- Conducted in 4 countries: Eswatini, Kenya, South Africa and Zambia.
- Nine sites in South Africa including three in KwaZulu-Natal: Durban (eThekwini), Edendale (uMgungundlovu) and Ladysmith (uThukela).
- Women had an equal chance of getting one of the three contraceptive methods through a process called 'randomisation'
- Women were followed up for 12-18 months even if they discontinued their method.

MRU echo

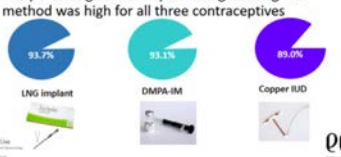
ECHO study results

- 7829 women enrolled and followed up from December 2015 to October 2018
- Study was conducted with high quality
- Mid–2019 Study results shared with participants, DoH and other key stakeholders locally, national and internationally

MRU echo

How well did women use their contraceptives ?

- 99.4% of participants accepted the contraceptive method they were assigned to
- Participants used their methods for 92% of the time they were in the study
- The percentage of time spent using an assigned method was high for all three contraceptives



MRU echo

ECHO: In conclusion

- All three methods were safe and highly effective in preventing pregnancy
- When women were using their contraceptive method, only about 1%, or 255, of 7829 participants became pregnant over one year.
- Most pregnancies (71%) happened after women stopped using their contraceptive method.
- The ECHO Study found no substantial difference in the risk of getting HIV among 7829 women randomly assigned to use one of the three reversible, highly effective contraceptives.

MRU echo

After ECHO .....

- At their final ECHO visit, participants decided if they wanted to continue with their method, receive another method, or discontinue contraceptive use. Therefore, the ECHO trial provided an opportunity to recruit a cohort of women using injectables or LARC for additional follow-up in two countries (South Africa & Zambia).
- The goal of the *Contraceptive Use Beyond ECHO (CUBE) study* was to expand the evidence base on contraceptive method discontinuation by gathering information on method experience, contraceptive use dynamics, and access to LARC removal services over an extended period.

MRU cube

CUBE objectives

- To document contraceptive status over 6-, 12-, 18-, and 24-months following exit from the ECHO trial and measure method-specific continuation rates;
- To describe reasons for contraceptive discontinuation and switching;
- To describe implant and IUD removal outcomes, including success or failure at obtaining removal and number of attempts; and
- To document any barriers to obtaining LARC removal.
- After the onset of the COVID pandemic we added an objective to assess contraceptive access and use

MRU cube

Methods

Eligibility criteria for CUBE included:

- Participation in the ECHO trial and completion of the trial exit visit, using one of the three trial methods (3 month injectable (DMPA-IM), LNG implant (Jadelle), or the copper IUD), regardless of whether it was the participant's originally randomized ECHO method;
- Access to a phone;
- Informed consent and agreement to have their ECHO data used for the CUBE study;

A total of 1,472 women were originally enrolled in ECHO at the Durban and Edendale KZN sites. We sought to achieve a combined sample size of up to 500 from these two sites.

MRU cube

Methods

- Conducted phone surveys every six months over a period of two years. A COVID module was added at the final 24 month interview.
- Also conducted semi-structured qualitative interviews with 20 participants and 16 key stakeholders to explore reasons for method continuation, discontinuation, and switching and experiences accessing implant and IUD removal.
- Study approved by FHI 360's Protection of Human Subjects Committee, the University of the Witwatersrand's Human Research Ethics Committee, the University of North Carolina at Chapel Hill Institutional Review Board, and the University of Zambia Biomedical Research Ethics Committee.

MRU cube

Qualitative questionnaire themes

- Women were asked to describe their contraceptive use experiences, including side effects and contraceptive-induced menstrual changes.
- Those who continued their contraceptive method for at least 18 months after exit from ECHO were asked what they liked or disliked about their method and whether they had considered discontinuing.
- Those who discontinued or switched were asked about method use following this event
- LARC users were asked whether they had ever wanted to remove their method and their experiences if they sought removal.
- The COVID module asked about contraceptive access experiences since the first lockdown in March 2020.

MRU cube

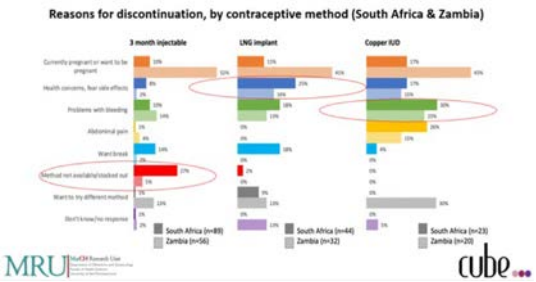
South Africa Results

- Phone surveys were conducted between December 2018 and January 2021. Qualitative interviews were completed between 2020-2021
- A total of 438 ECHO participants were contacted to participate in CUBE and 435 were eligible.
- Most women (96.8%, n=421) had used a method before ECHO.
- Mean age was 25.9 years, and most (89%, n=387) reported a partner but were not living with them.
- Three-quarters (74%, n=322) wanted a child in future.

MRU cube

Contraceptive use at CUBE enrolment

Method	% N
DMPA-IM	42.1 (183)
LNG Implant	33.1 (144)
Copper IUD	24.8 (108)



Results of the COVID survey

- 345 CUBE participants completed the COVID survey between Sept 2020-March 2021.
- Almost a quarter (23.2%, n=80) had experienced difficulties accessing SRH services. Of the 80 women services affected were :-
  - Contraception 55% (n=44)
  - HCT 23.8% (n=19)
  - PrEP 10% (n=8)
  - STI testing 3.8% (n=3)
  - Pap smear 3.8% (n=3)
  - Pregnancy test 2.5% (n=2)
  - Other (contraceptive side effects) 5.0% (n=4)

COVID survey

- Although many had no need of contraception resupply at the time of the survey due to LARC use, almost two-thirds (60.9%, n=210) were worried about access to contraceptive services in future.
- Of seven women who became pregnant during COVID, four did not want the pregnancy at the time. Three of these women cited restricted service access to contraception as reason for pregnancy.
- However the good news is that 90.1% (n=311) were using a method at the time of the survey. Of those not using only 7% (n=24) had an unmet need

Results: In-depth interviews

- Most of the method continuers said that they either do not experience or can tolerate method side effects (such as weight gain and headaches), and that their method is highly effective.
- Although some reported contraceptive side effects (such as heavy and/or irregular bleeding) when they first started using their method, these changes either resolved over time or participants were able to obtain help from their provider.

MRU cube

Access to DMPA during times of stock outs and COVID-19

When I arrived at the clinic, they told me that there was no three months one [DMPA]. There is two months one [*norethisterone enanthate*]. I said, 'it was OK instead of using nothing, please give it to me.' I then went back in April. When I got there in April, they told me they were not giving injections because of COVID. I went back home and I stayed without using anything. I went back to get the injection when services open. (28 year old)

I came back in March [2020], before lockdown, for a visit, visiting my children and everything and then there was lockdown from the 27th [*referring to 27 March 2020*]. Time went by trying to get my injectables, you see, going back to [*a pharmacy*], I could not go there. Oh, I went there once, and it was closed, you see, only food shops were open. That is how I stopped using the injection. (25 year old)

MRU

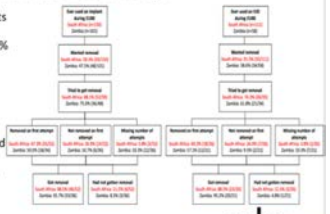
LARC use

- Implant and IUD users liked these methods as they could use them long term and did not have to go for regular clinic visits as this participant explains:

> I do not have time where I work. The implant I am having now is for five years. Yes so, what made me like it is that I would not have to frequently ask to be excused from work to go and get prevention. I will stay with it for a long time knowing that if I ever need to ask for time off, it would be when it is due to be removed and has expired. That is what makes me like it. (25 year old)

LARC removal: Quantitative surveys

- Among South African participants who reported *any* interval of LARC use across the surveys, 88% wanted and tried to get implant removal and 74% IUD removal.
- Two-thirds removed on first attempt and 89% ultimately got removal.
- Barriers to removal: provider said they needed to return to where the method was inserted (n=11) or a qualified provider was not available (n=5)



LARC removal

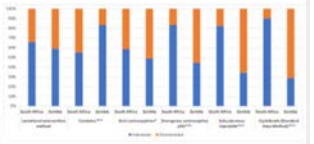
- Some participants were also concerned about LARC removal after ECHO.
  - An LNG implant user decided to switch to the 3-month injectable because:

> "at the local clinics they tell you to go back where you have inserted it, if you want to remove the implant"

  - Even though participants were told that they could still have LARC removals at the study clinic, she still decided to remove her implant to be on the safe side.
- Other participants switched from the 3-month injectable to the LNG implant at the end of ECHO so that they would not have to return to their local clinics every three months for an injection.

Self-care methods

- "Self-care" refers to contraceptive methods and other sexual and reproductive health (SRH) supplies that people can use with or without the guidance of a healthcare provider. One of the objectives of the COVID-19 survey module was to assess women's current demand for and use of SRH and FP self-care and explore key informants' opinions of self-care.



- South African participants more interested in learning about oral contraceptives, emergency contraceptive pills, subcutaneous injectable, and CycleBeads.

Conclusion

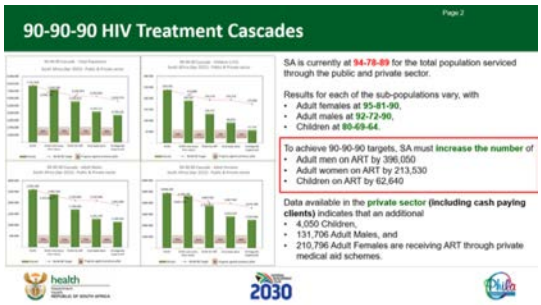
- This study is one of the few to look at long-term contraceptive continuation rates, particularly of LARC, in sub-Saharan Africa . We found that LNG implant continuation was particularly high over 44 months (ECHO and CUBE) at 60%, slightly lower for the copper IUD 52% and lowest for the 3-month injectable (47%).
- The majority of respondents who sought implant and IUD removal obtained removal on their first attempt, but room for improvement in accessing these services still exists. In particular, providers telling women that they have to go back to where their LARC was inserted to obtain removal was mentioned more frequently than expected.

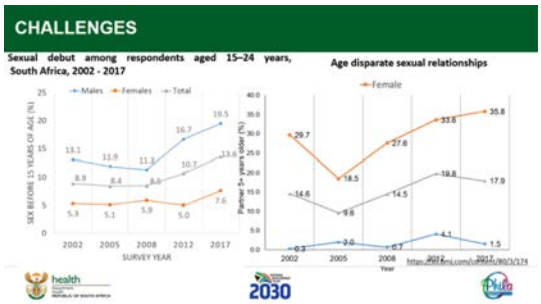
Thank you

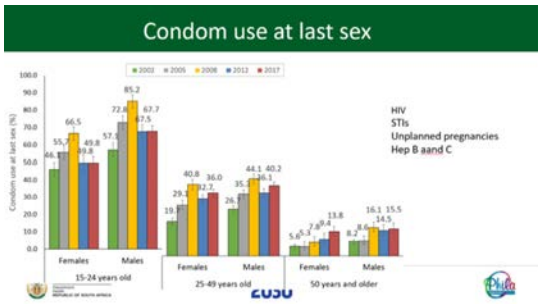
- We are grateful for support from the Department of Health in South Africa in facilitating the in-depth interviews and we acknowledge and appreciate all the women who agreed to participate in the CUBE study.
- CUBE was funded by the United States Agency for International Development (USAID), Cooperative Agreement AID-OAA-A-15-00045.

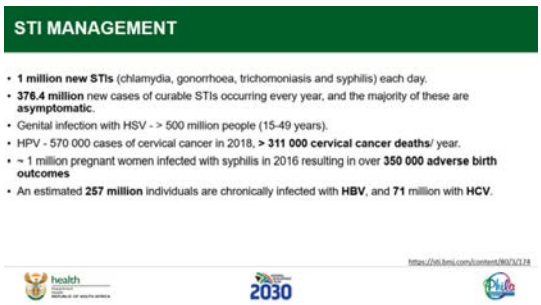
Integrated STI and HIV programming

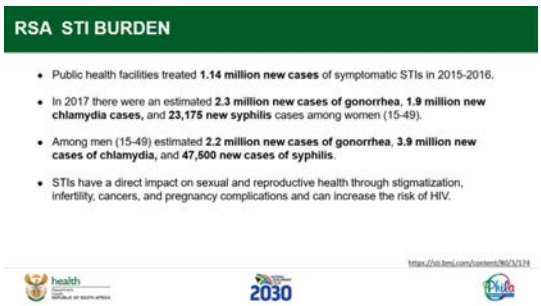
Dr Thato Chidarikire,
Director HIV Prevention Strategies











STI Overview

- Sexually transmitted infections constitute huge health and economic burden for developing countries.
- The importance of STIs has been more widely recognised since the advent of the HIV/AIDS epidemic, and there is good evidence that **the control of STIs can reduce HIV transmission**.
- The main interventions which could reduce the incidence and prevalence of STIs include:
  - **primary prevention** (information, education and communication campaigns, condom promotion, use of safe microbicides, and vaccines),
  - screening and case finding among **vulnerable groups** (for example, pregnant women),
  - STI case management using the **syndromic approach**,
  - targeted interventions for populations at **high risk** (for example, sex workers)
- The challenge is not just to develop new interventions, but to **identify barriers to the implementation of existing tools, and to devise strategies for ensuring** that effective STI control programmes are implemented in the future.

https://sti.bmj.com/content/80/3/174

Impact of STIs

Association with HIV: STIs increase the risk of transmission and acquisition of HIV up to 3-fold. Hence, a high STI burden compromises control of the HIV epidemic.

Vertical Transmission: Several STIs may be transmitted to the fetus during pregnancy and/or delivery, resulting in poor pregnancy outcomes or congenital infection and complications for the neonate. An estimated 200,000 fetal and neonatal deaths each year is associated with syphilis.

Sequelae: Untreated STIs are associated with severe complications, such as:

- Compromised fertility (for males & females), ectopic pregnancy and pelvic inflammatory disease.
- Cellular changes increasing the risk of genital cancers.
- Neurological manifestations, such as meningitis, dementia and decreased motor function.
- Hepatic complications and malignancy.
- Renal and cardiac complications.

Cost to the Healthcare System: Whilst the cost of STIs on the health sector has not been definitively quantified, the severity of morbidity resulting from STIs alludes to a significant cost to the healthcare system.

STIs in youth

Unique factors place youth at risk for STIs

Insufficient Screening	Confidentiality Concerns	Biology	Lack of Access to Healthcare	Multiple Sex Partners
Many young women don't receive the chlamydia screening CDC recommends	Many are reluctant to disclose risk behaviors to doctors	Young women's bodies are biologically more susceptible to STIs	Youth often lack insurance or transportation needed to access prevention services	Many young people have multiple partners, which increases STI risk

http://www.iwannaknow.org/statistics/

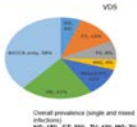
Etiological surveillance in South Africa 2019 - 2020

- MUS

Fig. Relative prevalence of **STI in MUS** (N = 768)

Mixed aetiology (n = 129)
Mostly **NG + CT (78%)**
Overall prevalence (single and mixed infections)
NG: 88%, CT: 21%, TV: 1.6%, MG: 3%

VDS



Overall prevalence (single and mixed infections)
NG: 18%, CT: 20%, TV: 12% MG: 7%
STI only: 14% (52/381)
BV: 45.2% (163/361) - Overall BV with STI 19.7% (71/361)
Of those with BV: 43.8% had STI (71/163)
CA: 28.8% (103/361) - Overall CA with STI 9.4% (34/361)
Of those with CA: 33% had STI (34/103)

(Kularatne, Maseko et al. 2022) (P… Venter et al. 2022)

Chlamydia, gonorrhoea, trichomonas

Data	Impact	Key interventions/objectives
• Most cases remain untreated (<50% is treated) • Incidence and prevalence unchanged for last 30 years • Unquantified challenges with partner notification • Lack of age-stratified data; limited programme indicators • Lack of burden of disease data	• Genital tract morbidity • Reproductive tract complications • Adverse pregnancy outcomes • Enhanced HIV transmission	• Raising awareness (demand) and system strengthening including service integration • Diagnostic screening for high-risk populations • Expand and implement partner management options • Enhanced clinical surveillance and burden of disease establishment (target setting)

SERVICE DELIVERY MODELS HAVEN'T CHANGED, AND ARE NOT BASED ON CURRENT USER PREFERENCES

INFORMATION AND LINKAGE TO SERVICES	INTEGRATED STI SCREENING AND SRH SERVICES	STI MANAGEMENT – SYNDROMIC APPROACH	PARTNER NOTIFICATION AND TREATMENT
• Limited access to accurate information • Integration Challenges – AGYW, KP, HIV services and PHC	• Routine syndromic screening not consistently implemented • Services siloed • No M&E indicators for integration, service integration not routinely monitored at the clinic level	• Syndromic approach misses asymptomatic infections and may overtreat VDS • Implementation of aetiological testing is limited	• Use of notification slips and HCP contact tracing are not preferred by young people • Challenges in documenting partner notification and return for treatment

Recommendations

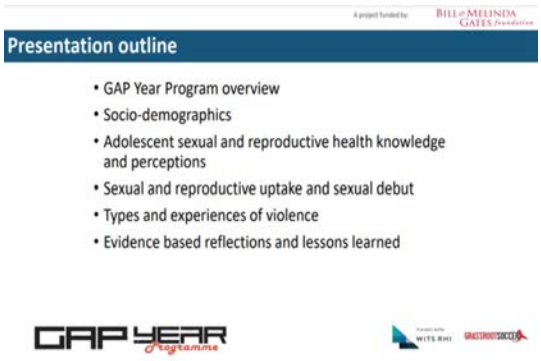
We need to **improve the basics**, including health system infrastructure, supply chain, availability of routine commodities.	**Ongoing capacitation** and **quality improvement interventions** must be implemented to ensure guidelines are implemented and gaps addressed.	**Routine monitoring systems** need to be strengthened to ensure gaps are identified across the cascade and addressed and that programme adaptations are informed by quality data.	We need to focus on ensuring **primary prevention** is strengthened, including use of existing available interventions such as HPV and Hepatitis B vaccination.	We need to **implement and evaluate novel interventions** that are client centred and include partner management.

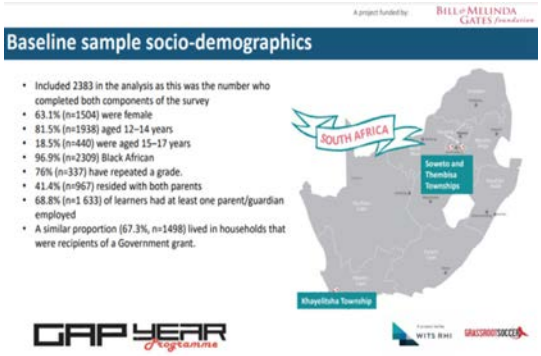
Priorities

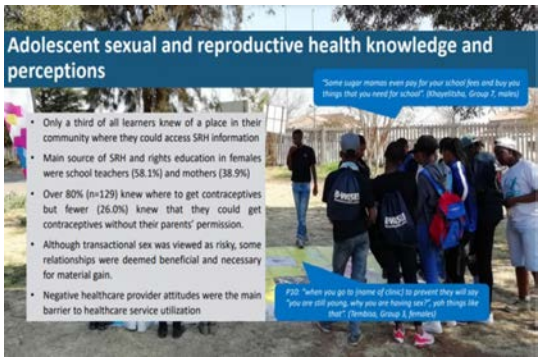
- **Priority 1** – Capacity building of staff
- **Priority 2** – Implement STI diagnosis & treatment in FP, PrEP and antenatal programs *Potential to reach large # of women, KP , AGWW , Men's Health*
- **Priority 3** – *Evaluate Syndromic Management Approach*
- **Priority 4** – *strengthen: R&D , Surveillance, M&E*
- **Priority 5** – *Strengthen Messages, Social Media Platform*
- **Priority 6** – *strengthen: Partner Notification*

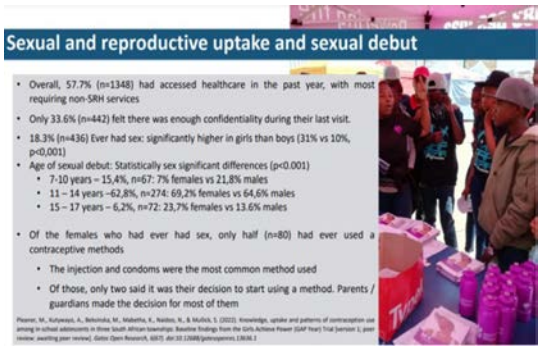
Implementation, evidence and insights gained from The Girls Achieve Power (GAP) Year trial

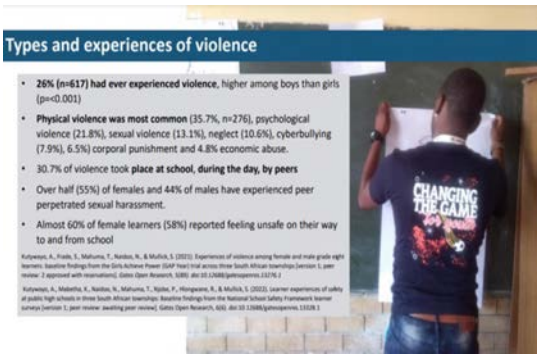
Ms Melanie Pleaner (presented on behalf of Ms Alison Kutywayo)



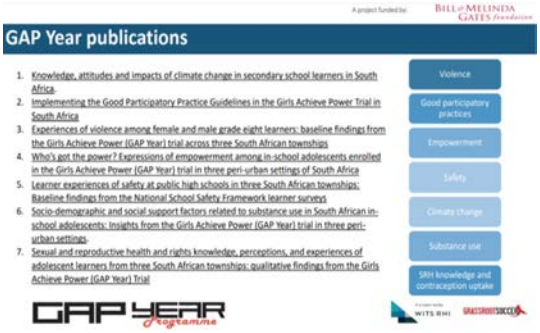







Types and experiences of violence
26% (n=617) had ever experienced violence, higher among boys than girls (p=<0.001)
Physical violence was most common (35.7%, n=276), psychological violence (21.8%), sexual violence (13.1%), neglect (10.6%), cyberbullying (7.9%), 6.5%) corporal punishment and 4.8% economic abuse.
30.7% of violence took place at school, during the day, by peers
Over half (55%) of females and 44% of males have experienced peer perpetrated sexual harassment.
Almost 60% of female learners (58%) reported feeling unsafe on their way to and from school
CHANGING THE GAME


NIKEFOOTBALL
Evidence-based reflections and lessons learned
1. Violence is common: primary violence prevention interventions are critical – involving a wide range of stakeholders – parents, community gatekeepers and men (ecological approach)
• High rates of sexual harassment, GBV prevention needs to focus on men and boys
• Strengthen the implementation of violence prevention protocols to create a safer school environment
2. Adolescents need holistic care: closer links with health services need to be constantly fostered and reinforced
3. CSE to develop age-appropriate content that is segmented
4. Early sexual debut: age appropriate SRH information be provided to ensure adolescents, including very young adolescents, are equipped with the knowledge around safe sexual practices, rights and gender awareness
5. School teachers and mothers were noted as the most common source of SRH information: need to equip parents with the knowledge and skills to communicate effectively with their children about sex, as well as the need to provide teachers with the knowledge and skills to provide information, supported by comprehensive curricula and policies.


A project funded by: BILL & MELINDA GATES foundation
GAP Year publications
1. Knowledge, attitudes and impacts of climate change in secondary school learners in South Africa.
2. Implementing the Good Participatory Practice Guidelines in the Girls Achieve Power Trial in South Africa
3. Experiences of violence among female and male grade eight learners: baseline findings from the Girls Achieve Power (GAP Year) trial across three South African townships
4. Who's got the power? Expressions of empowerment among in-school adolescents enrolled in the Girls Achieve Power (GAP Year) trial in three peri-urban settings of South Africa
5. Learner experiences of safety at public high schools in three South African townships: Baseline findings from the National School Safety Framework learner surveys
6. Socio-demographic and social support factors related to substance use in South African in-school adolescents: Insights from the Girls Achieve Power (GAP Year) trial in three peri-urban settings.
7. Sexual and reproductive health and rights knowledge, perceptions, and experiences of adolescent learners from three South African townships: qualitative findings from the Girls Achieve Power (GAP Year) Trial
Violence
Good participatory practices
Empowerment
Safety
Climate change
Substance use
SRH knowledge and contraception uptake
GAP YEAR Programme
WITS RHI
GRASSROOTSOCCER


A project funded by: BILL & MELINDA GATES foundation
References
1. Pleaner, M., Kutywayo, A., Beksinska, M., Mabetha, K., Naidoo, N., & Mullick, S. (2022). Knowledge, uptake and patterns of contraception use among in-school adolescents in three South African townships: Baseline findings from the Girls Achieve Power (GAP Year) Trial [version 1; peer review: awaiting peer review]. Gates Open Research, 6(67). doi: 10.12688/gatesopenres.13638.1
2. Kutywayo, A., Yah, C., Naidoo, N., Malotana, M., Dyani, S., & Mullick, S. (2018). Implementing the Good Participatory Practice Guidelines in the Girls Achieve Power Trial in South Africa. SAGE Open, 8(4). 2158244018809149.
3. Kutywayo, A., Frade, S., Mahuma, T., Naidoo, N., & Mullick, S. (2021). Experiences of violence among female and male grade eight learners: baseline findings from the Girls Achieve Power (GAP Year) trial across three South African townships [version 1; peer review: 2 approved with reservations]. Gates Open Research, 5(89). doi: 10.12688/gatesopenres.13276.1
4. Kutywayo, A., Frade, S., Gordon, K., Mahuma, T., Naidoo, N., & Mullick, S. (2021). Who?s got the power? Expressions of empowerment among in-school adolescents enrolled in the Girls Achieve Power (GAP Year) trial in three peri-urban settings of South Africa [version 1; peer review: awaiting peer review]. Gates Open Research, 5(104). doi: 10.12688/gatesopenres.13336.1
5. Kutywayo, A., Mabetha, K., Naidoo, N., Mahuma, T., Njobe, P., Hlongwane, R., & Mullick, S. (2022). Learner experiences of safety at public high schools in three South African townships: Baseline findings from the National School Safety Framework learner surveys [version 1; peer review: awaiting peer review]. Gates Open Research, 6(6). doi: 10.12688/gatesopenres.13328.1
6. Gordon, K., Kutywayo, A., Frade, S., Naidoo, N., & Mullick, S. (2021). Socio-demographic and social support factors related to substance use in South African in-school adolescents: Insights from the Girls Achieve Power (GAP Year) trial in three peri-urban settings [version 1; peer review: 1 approved]. Gates Open Research, 5(154). doi:10.12688/gatesopenres.13422.1
7. Pleaner, M., Milford, C., Kutywayo, A., Naidoo, N., & Mullick, S. (2022). Sexual and reproductive health and rights knowledge, perceptions, and experiences of adolescent learners from three South African townships: qualitative findings from the Girls Achieve Power (GAP Year) Trial [version 1; peer review: awaiting peer review]. Gates Open Research, 6(60). doi:10.12688/gatesopenres.13588.1
8. In draft: full trial manuscript
GAP YEAR Programme
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A project funded by: BILL & MELINDA GATES foundation
Acknowledgements
• The Funder: Bill & Melinda Gates Foundation
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• Key stakeholders within the Department of Education and Department of Health
• Implementing partners and data collection company
• The GAP Year Study Team
GAP YEAR Programme
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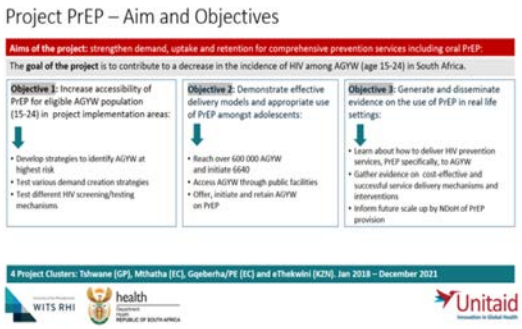
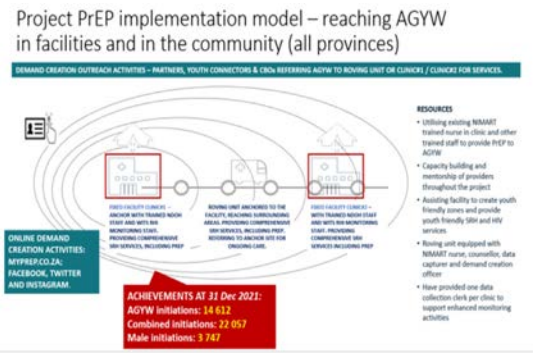
Thank you!
KICK IT!

A brief reflection on the integration of PrEP and Contraception -Project PrEP

Ms Melanie Pleaner





Integration of PrEP and Contraception

- As part of Implementation Science, we looked at potential of leveraging oral PrEP as an opportunity to provide contraceptive services.
- Used monitoring data from across the four project clusters, and 4,949 clients, over a 21-month period,
- Analysed baseline routine monitoring data to examine contraceptive uptake in AGYW initiating PrEP at project sites.
  - Two-thirds of women (62.3%, n = 3,083) reported the current use of contraception at baseline, with the most commonly used methods being hormonal injectables (61.9%, n = 1,829) and male condoms (19.4%, n = 575).
  - A third (32.3%, n = 603) of the non-contraceptive users accepted a method at PrEP initiation.
  - The method uptake at PrEP initiation increased the overall contraceptive prevalence by **12.2 to 74.5%.**

Key findings and recommendations:

- The acceptance of a method by a third of non-users was promising; however, *more understanding of those who did not take up a method is required.*
- Opportunities presented for integration need to be leveraged and maximized—including:
  - **Entry points: Out reach and demand creation:** Ensure that key SRH services sPrEP is a valuable entry point to promote SRH –especially STI and contraception.
  - Such as contraception are combined and integrated at all levels of outreach and demand creation.
  - **Integrated counselling:** Counselling about contraception and contraceptive choices need to be part of the core PrEP package.
  - **Health systems to support integration:** Further analysis needs to be undertaken to look at the factors influencing integration —such as commodity supply and availability, staff training, to support the one-stop model, and IEC material
  - **Programmatic integration**: contraception, SRH part of combination prevention and HIV prevention
  - **Monitoring and data collation:** More effective ways to monitor and measure integration.

Pleaner M, Fipaza Z, Mabetha K, Greener L, Ncube S, Butler V, Beksinska M and Mullick S (2021) Uptake of Contraception Among Adolescent Girls and Young Women PrEP Clients: Leveraging the Opportunity to Strengthen HIV and Sexual and Reproductive Health Integration. Front. Reprod. Health 3:684114. doi: 10.3389/frph.2021.6841

Acknowledgements

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- Department of Health
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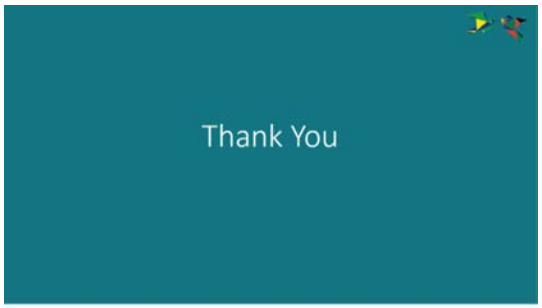
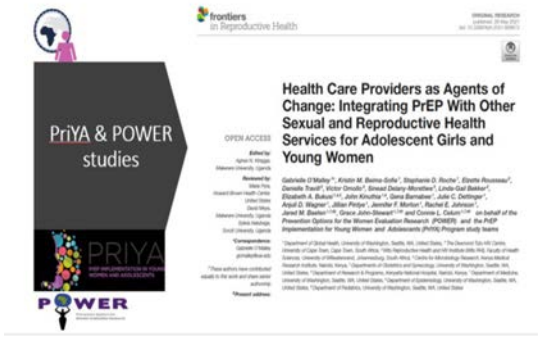
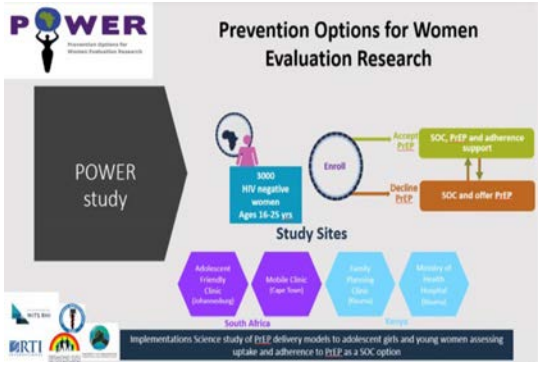
- Prof Saiqa Mullick (Director: Implementation Science); Vusile Butler (Technical Head Programme Implementation) and the Project PrEP team
- Co-authors: Melanie Pleaner, Zuki Fipaza, Kuthala Mabetha, Letitia Greener, Sydney Ncube, Vusile Butler, Mags Beksinska and Saiqa Mullick

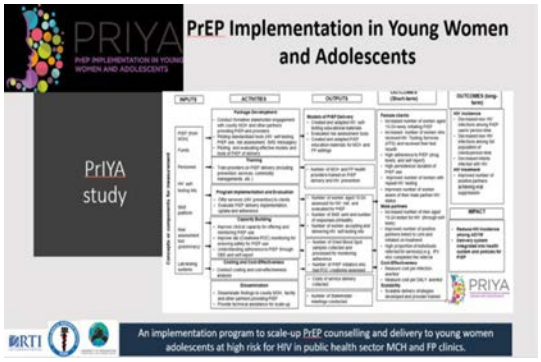


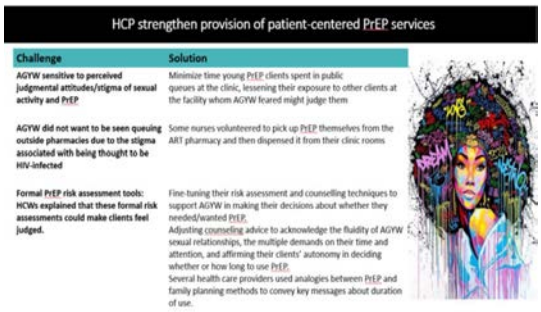
Healthcare Providers as Agents of Change: Integrating PrEP with other SRHS for AGYW (Virtual)

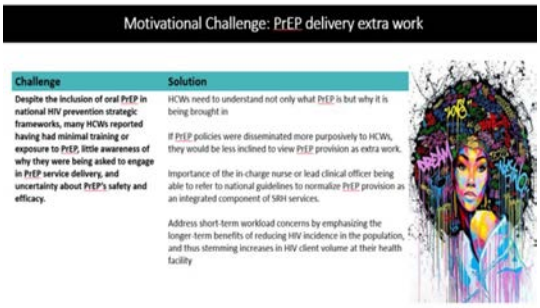
Dr Elzette Rousseau,
Socio-behavioural scientist, Desmond Tutu Foundation

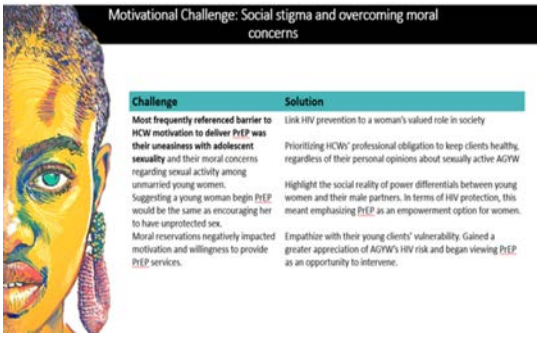


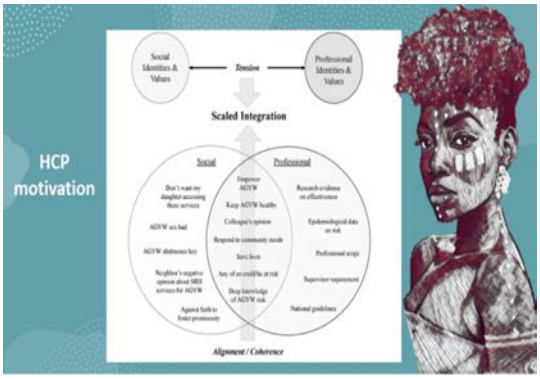












Acknowledgments

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Prevention Options for Women Evaluation Research
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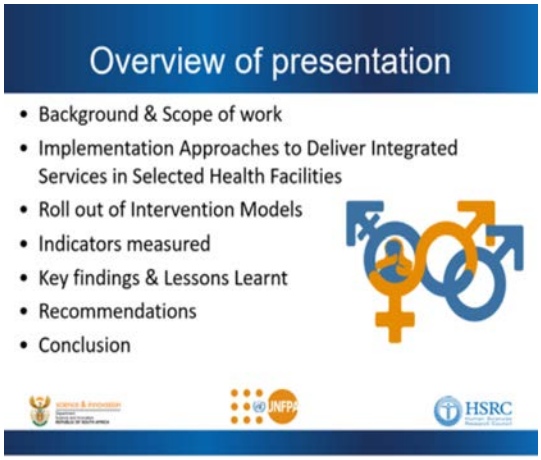
PrEP IMPLEMENTATION IN YOUNG WOMEN AND ADOLESCENTS
RTI INTERNATIONAL
GILEAD

Case study: Integrated SRHR/HIV/GBV

Dr Inbarani Naidoo
Senior Research Specialist, Human and Social Capabilities, HSRC



List of indicators

In OR Tambo, the monthly forms had 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

Total number of clients attending antenatal care clinics

Table: List of indicators reported for uThukela and Alfred Nzo

Indicator	Description	uThukela	Alfred Nzo
2	Percentage of clients receiving services at HIV service delivery points who received modern family planning services	Y	Y
3	Percentage of clients receiving services at HIV service delivery points who were screened for STI	Y	Y
4	Percentage of clients accessing services at family planning service delivery points who were tested for HIV	Y	Y
5	Percentage of clients accessing services at family planning service delivery points who were screened for STI	Y	Y
6	Percentage of clients accessing services at family planning service delivery points who were screened for cervical cancer	Y	Y
7	Percentage of clients attending antenatal clinics who were tested for HIV		Y
8	Percentage of clients attending antenatal clinics who were screened for STI		Y
9	Percentage of pregnant women living with HIV who received ARV to reduce the risk of mother-to-child transmission of HIV		Y
17	Percentage of clients who received two or more services		Y

Roll out of Intervention Models

Intervention model & implementing partner	Location (districts & health facilities)	Activities & Time Period
2gether 4SRHR (also referred to as Optidel PDSA SRH/ HIV/SGBV Integration model) Implementing partner: Optidel	uThukela District (13 health facilities): AE Haviland, Bergville, Ekuvukeni, Emmaus Gateway, Ezakheni No 2, Inibsuthi, Ncibidwane, Ntabamhlophe, St Chads, Steadville, Waltons Street & Wembezi	August-October 2017: Baseline assessment September 2018 to March 2019: Pilot integration model applied in five facilities September 2020 to March 2021: Scale up in 12 facilities in Uthukela District September 2021 to March 2022: Scale up to 53 health facilities in three KwaZulu-Natal districts (uThukela, eThekwini and Ugu)
Supermarket model also referred and One stop shop/kiosk approach, which is based on the Ideal Clinic Model. Implementing partner: Umthombo Wempilo Institute	Alfred Nzo District (five health facilities): Amantshangase, Lubaleko,Mangoamzeni, Ndela & Rhode	August-October 2017: Baseline assessment January – March 2018: Implementation
	OR Tambo District (three health facilities): Libode, Ntaphane, & Tombo	August-October 2017: Baseline assessment January – March 2018: Implementation

Key findings & Lessons Learnt from interventions

What was measured in intervention	Key findings & Lessons Learnt
Training of health care workers and community health care workers: number of individuals trained & their competency in providing client-centred integrated services on the following: o comprehensive sexuality education (including AYFS); o antenatal & postnatal care; o contraceptive insertion, o safe & post abortion care; o HIV & STI treatment and care; o prevention & treatment of reproductive cancers; o sexual & gender based violence prevention (SGBV), mitigation & response; o tuberculosis management	Most facilities did not train CHWs in all training areas identified. This impacted on HCW and HCW competency & confidence in delivering the integrated SRH services to the required standard. Gaps & therefore training needs were found in the following areas: contraceptive methods, condom communication strategy, SGBV prevention, safe & post abortion care, & cervical cancer screening. Reasons for gaps in training of HCWs: COVID-19 related lockdown & restrictions, shortage of trained HCWs (few trained & competent HCWs available per facility, overworked HCWs), high staff turnover rate. HCWs held the view that service integration may take time when clients present at the facility & this may also burden current service delivery.

Key findings & Lessons Learnt from interventions: example of training indicator

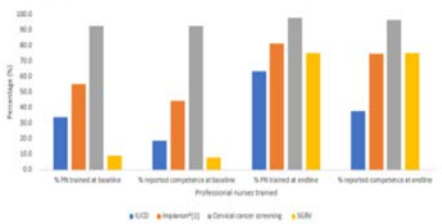


Figure: Training coverage for marker indicators in uThukela district, 12 facilities

Source: Model of SRH/HIV/SGBV/TB integration Optidel Report April 2021

PN: professional nurse
At baseline: 129 PN
At endline: 153 PN

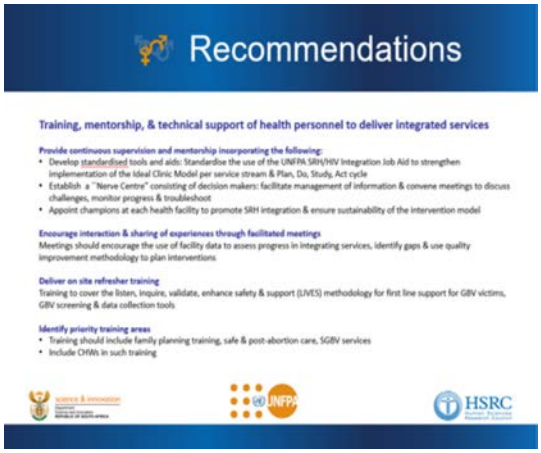
Key findings & Lessons Learnt from interventions

What was measured in intervention	Key findings & Lessons Learnt
The number of **clients accessing and receiving integrated services** (stratified by age and sex) through interviews about number of services received in one visit pre- and post- intervention as follows: Service delivery indicators: HIV: Number of clients receiving modern family planning, services, screening for STIs. Family planning: Number of clients receiving HIV testing and counselling, STIs screening, cervical cancer screening. Antenatal clinics: Number of clients received HIV testing and counselling, antiretroviral treatment (ART) for prevention of mother-to-child transmission. GBV: Number of clients receiving ≥ 2 SRH, HIV and SGBV services.	No/scarce data found prior to integration of services on clients' perspectives. Limited services were offered or mentioned to clients during consultations at facilities. Areas with missing, limited data: Coverage of clients aged 10-14, 15-19 and ≥50 years. Cervical cancer screening & ART uptake in some age groups were low. Missing data for: age groups 10-14, 15-19 , ≥50-year-olds with regard to family planning and screening for STIs. Gaps in coverage of males screened for STIs & males who tested for HIV. SRH integration led to an increase in number & range of services received by clients in one consultation. Most clients preferred receiving integrated services at one facility. Ley counsellors were helpful in guiding clients to service points.

Key findings & Lessons Learnt from interventions

What was measured in intervention	Key findings & Lessons Learnt
Data collation tools including facility registers & dashboards	Observed missing data from record keeping tools such as registers. Observed variations in completeness of reporting in registers at health facilities.

Figure: SGBV Client Data Collection Tools (Source: Optidel, 2020: 10)


Recommendations
Training, mentorship, & technical support of health personnel to deliver integrated services
Provide continuous supervision and mentorship incorporating the following:
• Develop standardised tools and aids: Standardise the use of the UNFPA SRH/HIV Integration Job Aid to strengthen implementation of the Ideal Clinic Model per service stream & Plan, Do, Study, Act cycle
• Establish a "Nerve Centre" consisting of decision makers: facilitate management of information & convene meetings to discuss challenges, monitor progress & troubleshoot
• Appoint champions at each health facility to promote SRH integration & ensure sustainability of the intervention model
Encourage interaction & sharing of experiences through facilitated meetings
Meetings should encourage the use of facility data to assess progress in integrating services, identify gaps & use quality improvement methodology to plan interventions
Deliver on site refresher training
Training to cover the listen, inquire, validate, enhance safety & support (LIVES) methodology for first line support for GBV victims, GBV screening & data collection tools
Identify priority training areas
• Training should include family planning training, safe & post-abortion care, SGBV services
• Include CHWs in such training
UNFPA
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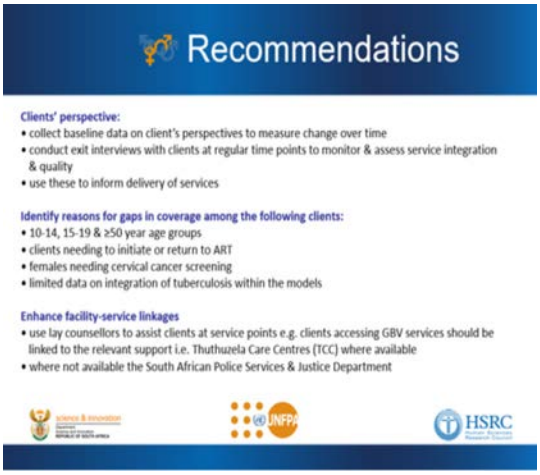
Recommendations
Clients' perspective:
• collect baseline data on client's perspectives to measure change over time
• conduct exit interviews with clients at regular time points to monitor & assess service integration & quality
• use these to inform delivery of services
Identify reasons for gaps in coverage among the following clients:
• 10-14, 15-19 & ≥50 year age groups
• clients needing to initiate or return to ART
• females needing cervical cancer screening
• limited data on integration of tuberculosis within the models
Enhance facility-service linkages
• use lay counsellors to assist clients at service points e.g. clients accessing GBV services should be linked to the relevant support i.e. Thuthuzela Care Centres (TCC) where available
• where not available the South African Police Services & Justice Department
UNFPA
HSRC


Recommendations
Data collation tools & monitoring processes:
• Facilities should keep verifiable registers for all indicators for reporting & monitoring e.g. abortion related admissions, SGBV clients & males who tested for HIV.
• Dashboards should be developed & implemented to monitor (1) indicators & track progress in achieving integration targets in real time (2) stock at facilities.
• Data collection should include compulsory key demographic variables that will allow for stratification by gender & by age to support (1) targeted interventions for these groups in communities & (2) reporting standardisation across facilities & districts.
• Facilities should address missing data in data collection tools for males & abortion related admissions.
Standardise monitoring templates & guidelines:
For implementers:
• Standardise the processes, methods & reporting templates for monitoring progress of integration in each health facility
• Continue to work closely with each facility during implementation
• Gather baseline data prior to implementation at each health facility
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Conclusion
Integration model should be agile to incorporate clients' needs & perspectives throughout the implementation process in each health facility
baseline assessments to inform adaptation of SRH model adopted in districts
For sustainability, each facility should identify SRH champions, facilitate the delivery of continuous training, mentorship programmes & technical support to HCWs & CHWs
quality data collection & standardisation of reporting templates; adopt a standardised data collection tool
capacitate HCWs in using standardised data collection tools at their health facility. Includes using relevant registers for abortion & GBV where applicable, & monitoring aids such as dashboards to track indicators in real time
UNFPA
HSRC


Thank you
HSRC Project Team
Dr Nompumelelo Zungu
Dr Tebogo Gumede
Dr Inbarani Naidoo
Ms Sinovuyo Takatshana
Ms Noloyiso Vondo
Ms Philisiwe Ndlovu
Ms Jill Ramlochan
Ms Yolande Sean
Ms Claudia Nyawane
UNFPA Representatives
Dr Nontsikelelo Manzini-Matebula
Ms Koketso Dlongolo
UNFPA
HSRC

Appendix 3: **List of participants**

Attendee Report – In-person

NAME OF ATTENDEE	ORGANISATION
Manzini-Matebula, Nontsikelelo	UNFPA
Dlamini, Linda	National Department of Health
Zulu, Thembi	National Department of Health
Chindankire, Thato	National Department of Health
Matsitimane, Gertrude	National Department of Health
Maithufi, Regina	National Department of Health
Mpembe, Thobekile	Department of Health, uThukela District
Mphalandwa, Muthupei	Department of Health
Makhanya, Sizwe	Health Metro Services
Gumede, Tebogo	Human Sciences Research Council
Gordon, Tanja	Human Sciences Research Council
Lehopa, Seithati	Human Sciences Research Council
Likoti, Mosa	Human Sciences Research Council
Marillier, Garth	Human Sciences Research Council
Naidoo, Inbarani	Human Sciences Research Council
Ndlovu, Philisiwe	Human Sciences Research Council
Ndlovu, Sethabile	Human Sciences Research Council
Shazi, Zinhle	Human Sciences Research Council
Radebe, Thembekile	Human Sciences Research Council
Ramlochan, Jill	Human Sciences Research Council
Zungu, Mpumi	Human Sciences Research Council
Palesa Likoti	University of KwaZulu-Natal
Nzuza, Ayanda	South African Medical Research Council
Hancock, Jill	South African Medical Research Council
Lima Limashamba	Health Systems Trust
Magubane, Sibusiso	Department of Basic Education
Sigida, Salome	Department of Basic Education
Matshoba, Siphiwe	Department of Women, Youth and Persons with Disabilities
Stevens, Sylvia	Department of Women, Youth and Persons with Disabilities
Zama, Petra	Provincial Department of Health
Beksinska, Mags	MatCH Research Unit
Milford, Cecilia	MatCH Research Unit

NAME OF ATTENDEE	ORGANISATION
Sebabatso, Tsoare	Black Woman Arise Women's Health Foundation
Zuma, Zanele	Female Academic Leaders Fellowship NPC (University of Witwatersrand)
Sebebela, Basesatsana	SMS
Skhambule, Sibongiseni	Masiqhakaze

Attendee Report - Virtual Platform

NAME OF ATTENDEE	ORGANISATION
Couch, Marilyn	Human Sciences Research Council
Khuzwayo, Nonkululeko	Human Sciences Research Council
Madonsela, Thandanani	Human Science Research Council
Makusha, Tawanda	Human Sciences Research Council
Manaka, Mbali	Human Sciences Research Council
Mohlabane, Neo	Human Sciences Research Council
Mpya, Mahlatse	Human Sciences Research Council
Reygan, Finn	Human Sciences Research Council
Shean, Yolande	Human Sciences Research Council
Sifunda, Sibusiso	Human Sciences Research Council
Vondo, Noloyiso	Human Sciences Research Council
Zuma, Khangelani	Human Sciences Research Council
Dunjwa, Viwe	UNFPA
Dlongolo, Koketso	UNFPA
Jongizulu, Siziwe	UNFPA
Magogodi, Precious	UNFPA
Dzimiri, Christina	Department of Basic Education
Ngqele, Xolelwa	Department of Basic Education
Pillay, Managa	Department of Basic Education
Lokwe, Anele	Department of Women, Youth and Persons with Disabilities
Mabelebele, Phuti	Department of Women, Youth and Persons with Disabilities
Mavuso, Noni	Department of Women, Youth and Persons with Disabilities
Sanni, Babatunde	Optidel Global
Dana, Nobanzi	Umthombo weMpilo Institute

NAME OF ATTENDEE	ORGANISATION
Rousseau, Elzette	Desmond Tutu Foundation
Beksinska, Mags	MatCH Research Unit
Jonas, Mu-arfia	The Health Foundation
Prince, Bridgette	The Health Foundation
Motloung, Ming-han	The Health Foundation (Bill and Melinda Gates Foundation)
Ntuli, Tabita	UNAIDS
Sekgobela, Marumo	Save the Children
Gititu, Wambui	International Organization for Migration
Rapatsa, Teenage	International Organization for Migration
Nqeketo, Sithembile	World Health Organisation
Andrews, Yolaan	NACOSA
de Vos, Marieta	NACOSA
Sobele, Nkosinathi	NACOSA
Anderson, Bronwynne	University of KwaZulu-Natal
Dunn, Shanaaz	University of KwaZulu-Natal
Maharaj, Pranitha	University of KwaZulu-Natal
Nkabinde, Gloria	University of KwaZulu-Natal
Zondi, Zanele	University of KwaZulu-Natal
Pleaner, Melanie	Wits Reproductive Health and HIV Institute
Magasana, Vuyolwethu	South African Medical Research Council
Mmotsa, Tshiamo	South African Medical Research Council
Mthethwa, Ncengani	South African Medical Research Council
Ncengani Abigail	South African Medical Research Council
Nsibande, Duduzile	South African Medical Research Council
Mantashe, Zihle	Beyond Zero
Malinga-Hlanganyana, Nomlindo	Beyond Zero
Mjijelwa, Vuyo	Beyond Zero
Bhengu, Sanele	
Chueng, Maphuti	
Jugmohun, Sandesh	
Kamanyane, Kentse	

NAME OF ATTENDEE	ORGANISATION
Khosa, Tinyiko	
Likoti, Mosa Precious	
Mkhize, Ayanda	
Mononyane, Tshego	
Moti, Yuval	
Ngcubuka, David	
Shunmugam, Clyde	
Tobo, Jabulile	
Zuma, Zanele	

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