Satellite Session on the Integration of SRHR, HIV and GBV Services

8 December 2021

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Satellite Session on the Integration of SRHR, HIV and GBV Services

8 December 2021

PRESENTER: Dr. Mugahi Richard; Asst Commissioner RH & Infant Health
Dr. Ntegeka Sylvia; Hospital Medical Superintendent

ORGANISATION: MOH Uganda & BUDUDA Hospital
Background/ Context

- Country commitments following the 2017 South to South intercountry Learning exchange on SR/HIV/GBV integrated programming – focus on policy, systems, service delivery and community empowerment
- Conducted reviews & capacity assessment on SRH/HIV/GBV integrated services in 24 HFs, 8 districts, national level:
  - Weak Coordination between relevant MoH departments, across sectors and major funding streams
  - Low Integration EFFORT at programming, systems levels and in practices
  - Weak HR capacity both skills sets and numbers, outdated yet unmet staffing norms, high attrition
  - Non-integrated service delivery tools - more disease/platform specific
  - Lack of integrated mentorship and support supervision approaches for SRHMCH and HIV
  - Lack of harmonized Commodity system - frequent Stock outs of RH and HIV commodities
  - Weak M&E systems, DHIS2 not picking integration indicators, lack of HMIS tools, poor data quality, limited data utilization for decision making
  - Weak community awareness about SRHR, lack of community competence to hold duty bearers accountable
  - Generally, Health System More Curative as opposed to Preventive Health care
- The National SRH/HIV/GBV integration strategy guides on integration models but MoH has not compelled standardized models for specific HF categories
Approaches & Models of integration implemented 2017-2021

Upstream focus
- Constituted coordination structures: a Multi-sectoral MoH Task Team SRH/HIV/GBV under the National MCH cluster and a National Multi-partner Steering Committee for policy/strategic advice, harmonization & compliance.
- Establishment of an Integrated eLMIS for Ordering and reporting of SRH/HIV/TB & Lab supplies
- Influenced Inclusion of Integration indicators in the HMIS and Data collection tools and supported introduction of simplified Data analysis and Use tools in the DHIS2 (since 2019). Now influencing the roll-out of the EMR
- Introduced Integrated Mentorship Model for integrated SRH/HIV/GBV utilizing the MoH mechanism
- Supported review of the National HR Strategy to enhance capacity of lower level HFs for integrated service delivery
- Supported institutionalization of a domestic financing model for HIV that can support SRH/GBV priority activities

Health Facility level
- A mix of Integration Models applied as found suitable for different levels of care
- Skills training on MNH, FP, PAC, CaCX mgt, GBV, AYSRH, KP, male engagement, QI and general orientation on integrated services
- Definition of patient flow designs within contexts of HFs
- Quarterly application of the developed SRH/HIV/GBV scorecard
- Quarterly integrated mentorships and support supervision based on scorecard findings
- Development of action plans to address gaps utilizing resources from various sources
- Prioritizing focus on community linkages through VHTs, peers, YAPs, expert clients and beneficiary groups
CASE OF BUDUDA GENERAL HOSPITAL-UGANDA
(One of the 27 Model Health facilities Under the program)
Models of integration implemented

Adopted the kiosk model of integration - all the services are offered in one room

- E.g. in the HIV clinic women are screened for GBV, given family planning and also screened for cancer of the cervix in the clinic not referring them to other clinics

More actions taken towards integration include:

- Orientation on integration of all HWs, village health teams and Members of the HF Management Committee including Community leaders and beneficiaries
- Skills training in FP (8), PAC (8), GBV (4), PMTCT(8),
- Data quality assurance training and support supervision
- Consistent support supervision and mentorship by MOH/Regional Referral Hospital, district health team
- Integrated service delivery outreaches especially targeting AYP at schools & community hotspots
- Holding performance review meetings monthly at HF and quarterly at HSD level
- Participation in community barazas to promote awareness and mobilize for access
- Partnerships with other sectors including police, community development, education to strengthen linkages and referral
- Radio talk shows for mass sensitization about services offered at the facilities to create demand
<table>
<thead>
<tr>
<th>Overall Indicator trend scores (%) per Intervention category</th>
<th>July_Sept 2020</th>
<th>April_June 2021</th>
<th>July_Sept 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>HUMC Functionality</td>
<td>50%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Client flow Design</td>
<td>33%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Signpost and directions Available</td>
<td>67%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Staff_trained/Oriented on Integration</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Staff with Multiple Skills in the Focus areas</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>QI initiatives on SRH/HIV/GBV integration</td>
<td>80%</td>
<td>60%</td>
<td>100%</td>
</tr>
<tr>
<td>Community Linkage for Demand generation</td>
<td>100%</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>Data review and Utilization</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Appropriate Facility Reporting</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Logistic Management systems</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Availability_HMIS tools.</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Availability_commodities.</td>
<td>0%</td>
<td>76%</td>
<td>100%</td>
</tr>
<tr>
<td>Overall Average score</td>
<td>64%</td>
<td>75%</td>
<td>84%</td>
</tr>
</tbody>
</table>
Achievements of SRH Service integration in Bududa Hospital

### Trends in Integrated service Utilisation

<table>
<thead>
<tr>
<th>Service</th>
<th>2019</th>
<th>2020</th>
<th><strong>Jan-June 2021</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC - % Male partners screened for STI (Syphilis)</td>
<td>10,1</td>
<td>23,8</td>
<td><strong>22,7</strong></td>
</tr>
<tr>
<td>ANC - % Pregnant Women screened for STI (Syphilis) in ANC</td>
<td>65</td>
<td>69,5</td>
<td><strong>98,4</strong></td>
</tr>
<tr>
<td>ANC - % of pregnant women with partners tested for HIV</td>
<td>18,3</td>
<td>23</td>
<td><strong>22,4</strong></td>
</tr>
<tr>
<td>ANC - % ANC clients tested for HIV</td>
<td>86,6</td>
<td>94,4</td>
<td><strong>96,6</strong></td>
</tr>
</tbody>
</table>

### Trends in Integrated service Utilisation

<table>
<thead>
<tr>
<th>Service</th>
<th>2019</th>
<th>2020</th>
<th><strong>Jan-June 2021</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PNC - % of PNC Clients screened for Cervical Cancer</td>
<td>0</td>
<td>7,1</td>
<td><strong>14,7</strong></td>
</tr>
<tr>
<td>FP - % FP clients that were screened for STI</td>
<td>5,6</td>
<td>38,2</td>
<td><strong>71,4</strong></td>
</tr>
<tr>
<td>FP - % of mothers who received family planning in postpartum (Timing)</td>
<td>0</td>
<td>1,7</td>
<td><strong>19,9</strong></td>
</tr>
<tr>
<td>FP - % of FP clients accessing screened for cervical cancer</td>
<td>0,3</td>
<td>21,9</td>
<td><strong>62,8</strong></td>
</tr>
<tr>
<td>FP - % FP clients that tested for HIV</td>
<td>0</td>
<td>19,1</td>
<td><strong>32,1</strong></td>
</tr>
</tbody>
</table>
Some outcomes

**FAMILY PLANNING UTILIZATION**

- ORAL CONTRACEPTIVES
- INJECTABLES
- IUDs
- IMPLANTS
- BTL
- VASECTOMY

**GBV AND ITS EFFECTS**

- STIs DUE TO GBV
- INJURIES DUE TO GBV
- ABORTIONS DUE TO GBV
- ANXIETY DISORDER DUE TO GBV

**DELIVERIES AND POSTnatal**

- FACILITY DELIVERIES
- POSTNATAL 60DAYS
- POSTNATAL 6WKS
Observations/ Lessons learnt

- HF now maximizing opportunities to provide a range of SRH/HIV/GBV services
  - Improved focus on GBV at HF including improved screening and reporting, and management
  - Improved uptake of some services e.g. FP in the HIV clinic especially the long term methods, ANC cascade improving,
- Documentation of SRH/HIV/SGBV improved and data utilization has improved
- Management, referrals within facility and outside facility of SRH/HIV/SGBV improved
- Involvement of community structures (VHTs, Champions, CDOs, CBOs, Police and politicians) has strengthened our community referral system and increased access to SRH/HIV/GBV services
- Consistent Internal & external Support supervision and Mentorship is key to internalization of GBV/SRH/HIV service guidelines at HF level.
- Consistent community mobilization including Radio talk shows and Community dialogs brings the community on Board to increase access to services
- Political will is very important in driving the agenda of SRH/HIV/GBV integration
Effects of COVID 19 on integration

Uganda experienced 2 severe lockdowns March-July 2020, June – Aug 2021 that caused considerable disruptions:

• Diversion of attention from SRH/HIV prevention interventions
• Disruptions in service delivery due to intermittent access to PPEs by HWs
• Difficulty in accessing health services including SRH/GBV/HIV services by community members due to travel restrictions and also fear of contracting Covid-19
• Constrained outreaches to take services closer to the people
• Closure of the school platform for 2 years has constrained access to the majority of adolescents and young people at the school platform
• Increase in gender based violence cases and increase in teenage pregnancies
Satellite Session on the Integration of SRHR, HIV and GBV Services

8 December 2021

Case Study SRHR, HIV and GBV Integration- uThukela District KwaZulu-Natal, South Africa

PRESENTER: Thobekile Mpembe

ORGANISATION: Department of Health- Uthukela District
## 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 2020 to Mar 2021: 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)

“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
CLIENT SURVEY
- Low level of service integration (Clients offered average 1 additional service apart from the one they came for)
- Eligible Female clients indicated that they were not offered cervical/breast cancer related services during the time of their encounter with service providers

TRAINING NEEDS ASSESSMENT
- Disproportionately low level of PN training (SGBV-9%, IUCD-37%, Implanon-54%, Post Abortion care-3%)
- Gaps between trained and competent: Lack of confidence in implementation

 Those that claimed to have been trained were not mentored to competency, even though there is a logbook that was designed to support this

 A perception that implementing the insertion of LARC is time consuming and complicates the already busy schedule especially in chronic stream
Models of integration/Activities

PLAN
1. Inception meeting was held to introduce the SRH/HIV integration approach. At both the district and facility levels involving staff, operational manager, and PHC Supervisors.
2. Individual facility baseline assessment was done:
   a. Training need assessment/Skills Audit (Trained vs. competent)
   b. Analysis routine DHIS SRH/HIV/SGBV/TB Indicators
   c. Clients exit interview to determine level of integration.
   d. Patient pathway/flow review
   e. Analysis and triangulation of data to inform plan
3. Result shared with facilities and contextualise findings and areas of focus and Integration champions were identified
4. Result shared with TWG and individual facility plans were developed
5. Based on baseline assessment findings. TWG identified marker indicators for dashboard monitoring

DO
1. Inhouse training sessions and practical demonstration held.
   a. In-house to avoid taking professional Nurses (PNs) out of work.
   b. Flexible time to suite the patient workload
   c. OM and Champion led. district training Unit and partner (Optidel) facilitated.
   d. Track output (# trained) outcome (# competent) against baseline.
   e. Logbooks used to achieve competency; signed by OM and champion.
   f. District trainer performs assessment.
2. Mentorship
   a. Facilitated facility data utilization meetings.
   b. PNs on the use of UNFPA SRH/HIV/SGBV/TB Integration Job Aid
   c. PNs on minimum package of SRH/HIV integration services per service stream
3. Supervision
   a. Direct supervision of facilities by PHC supervisors
   b. District SRH/HIV TWG coordination and oversight
   c. DHMT7/MNCWH coordinator supervised the supervisors.

ACT
1. Draw remedial action plan based on gaps found at the Study Stage.
2. Update skills matrix and move to PLAN stage for continuous improvement.

STUDY
1. Facility meeting to assess progress
2. Study implementation, identify barriers, enablers, and opportunities
3. Evaluate progress through monitoring of routine DHIS data
4. Assess progression of training to competence to improved facility performance
5. Utilise root cause analysis to identify any challenges
Despite drop in the headcount in COVID Era by 20%, 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

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 cancer screening was done in the 6 months of the technical support through Optidel (Oct 2020-March 2021) than in the preceding 6 months.

Cervical cancer screening (Eligible clients-HIV Pos above 20yrs + HIV Neg above 30 yrs) FY 2020/21

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

### Training data

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Beginning of project Sept 2020</th>
<th>End of Project March 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Number of professional Nurses at Baseline (%) of Total PNs trained</td>
<td>Total Number that reported Competent at baseline (%) of Total PNs competent</td>
</tr>
<tr>
<td>IUCD</td>
<td>44 (34%)</td>
<td>24 (19%)</td>
</tr>
<tr>
<td>Implanon</td>
<td>71 (55%)</td>
<td>57 (44%)</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>119 (92%)</td>
<td>119 (92%)</td>
</tr>
<tr>
<td>GBV (SGBV)</td>
<td>12 (9%)</td>
<td>10 (8%)</td>
</tr>
</tbody>
</table>

*No feasible change observed*

### TB Symptom 5 yrs and Older Screened in facility rate - PreCovid vs Post Covid

- Oct to Dec 2019: 79%
- Jan to Mar 2020: 81%
- Oct to Dec 2020: 79%
- Jan to Mar 2021: 78%

*Previous year (Pre-Covid) vs Project Period (Covid period)*

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**ICASA 2021**
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 enhances functional and effective implementation

03 Client Satisfaction, client's ability to access more than one service at visit. Botswana study tour: Kiosk, Mall

04 Ensuring ownership by facilities facilitates sustainability
A Best Practice

The TWG initiated the use of a dashboard to monitor and report on the marker indicators that were introduced to the Nerve center reporting. The dashboard was designed to give an overview of the following all on a slide per indicator with a summary page for the three marker indicators:

- Ranked performance of the facilities
- Reward the best performing with a mention and colour code Green and Red for lowest performing group of facilities
- Introduced the Nurse to Indicator performance ratio; linking the staff strength with performance. This also helps in bringing shortage of staff to district and provincial management focus
- It also highlights stock out and lack of equipment whenever it occurs

This tool facilitated performance monitoring and intervention planning for the 12 supported facilities in uThukela district. It is a product of the district oversight and brought about immediate acceptance across all the facilities

- It uses the data reported to the Nerve Center for analysis and feed back and did not use a parallel data collection process
- The tool enables weekly feedback to facilities and sent monthly to district and all members of the TWG including province to facilitate the implementation of supervision of supervisors’ concept

A Best Practice

The Nerve center is a weekly meeting convened to drive the implementation of the HIV programme, the meeting helps to monitor progress and address key challenges faced at facility level with a focus on HIV indicators. In the course of the implementation of the SRH/HIV/SGBV integration model, uThukela district introduced the SRH marker indicators to strengthen the SRH and HIV integration performance monitoring at the facility level. This helped in bringing district focus on the facility performance of all facilities and not only on the project facilities only. This is a best practice of how existing platform could be used to strengthen SRH/HIV implementation. It engendered sustainability and draws attention to integration of services.

A Best Practice

Facilitated in-facility service linkage was established at supported facilities to ensure that patents that are referred from one service delivery point to the other will not be loss to care by exiting the facility without getting the comprehensive service. This was done by engaging lay counselors in ensuring clients are successfully linked to internal referral sites without falling through the cracks.
Acknowledgements

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

Family Planning training practical sessions with Optidel Team
Satellite Session on the Integration of SRHR, HIV and GBV Services

8 December 2021

PRESENTERS: Ms. Galaletsang Mudongo and Ms. Seitshiro Galeage

ORGANISATION: Ministry of Health and Wellness, Botswana
Background/ Context

- Sparsely populated land-locked country in Southern Africa
- Total population - 2.25 million
- Youthful population: 30.3% aged 10-24 years, 4% aged 65 years +
- Contraceptive Prevalence Rate: 53% (married women 64%)
- Total Fertility Rate: 3.1 births per woman
- High early & unintended pregnancies
- Unmet need for FP – 17.3%
- MMR - 166.3 deaths per 100,000 live births, ~8% among 15-19yrs
- The HIV prevalence: general population is 25.2%
- Adolescent girls and young women account for 24% new infections in 2020
- Comprehensive knowledge of HIV - below 50% of young people
- Low & declining condom use among adolescents – 75.6% (2010) to 69% (2016)
- High Prevalence among key populations (SW 61.9%, MSMS 13%)
- 1 in 3 women have experienced GBV
- IPV - 36.5% (Women of reproductive age more likely to experience IPV
- GBV experience during pregnancy - 15%
- Women with disabilities 2 - 3 times more vulnerable to GBV
- 1/10 girls’ first sexual experience was forced or pressured

Enabling Environment

- Detailed policy frameworks that place improvement of SRHR and HIV/AIDS and addressing gender equality at the center of the development agenda

- Effective service coverage of the population: 84% of Batswana live within 5 km of health facilities; 95% live within 8km of health facilities;
- The IHSP 2010-2020 developed to facilitate a shift from vertical programming to an integrated approach;
- Scaling up and enhancing the provision of comprehensive integrated HIV, TB, RMNCAH/ SRH and NCDs services is a key strategy of Botswana’s national strategic documents;
- The piloting of SRH/HIV integration through the Linkages Project (2011-2015) provided an opportunity for testing delivery of integrated services and demonstrate models that can work at different levels of the health care system.
- The strategic framework and service packages developed by the Linkages Project are aligned to the IHSP.
SRH/HIV Linkages Pilot Project  2011-2015
Joint initiative of UNAIDS/UNFPA in partnership with the Government of Botswana

Rationale
• To promote efficient and effective linkages between HIV and SRHR policies and services as part of strengthening health systems
• To increase access to and use of quality services to achieve the goals of universal access to reproductive health, & HIV prevention, treatment, care and support
Implementation Process

Scale up Process

- **Decision**: Policy Decision by MoHw to Scale-up
- **Plan**: 2 Year Costed Scale-up Plan Developed
  - RR, National & District Level Actions
- **Funds**: Resource Mobilization - Global Fund and Government and 2gether 4 SRHR
- **Governance**: Oversight Structures - NRC and TWG
- **Cascade**: Sensitization and Communication to Health Care Workers
- **Roll Out**: Roll-out to the districts

Sensitisation and Training approach

<table>
<thead>
<tr>
<th>National Level - Program Managers + Coordinators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitization of District Health Management Teams</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Program Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training of District Program Coordinators (South)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District Program Coordinators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training of District Based HCW: Nurses, HCW, HCA</td>
</tr>
</tbody>
</table>

Rationale

- **Increasing access** to and use of a broad range of quality services to achieve the goals of universal access to reproductive health and HIV prevention, treatment, care and support.
- **Sustaining relevant linkages** with the education, gender and legal sectors.

*Image reference*
Rationale

- **Increasing access** to and use of a broad range of quality services to achieve the goals of universal access to reproductive health and HIV prevention, treatment, care and support.
- **Sustaining relevant linkages** with the education, gender and legal sectors.
- **Strengthening and accelerating** efforts that have been tested in the pilot project to reach more people.
Models of integration implemented
Lessons learnt

• An enabling environment through policy frameworks and strategies, guidelines is critical to increasing awareness and empowering health care workers.

• Task shifting/sharing enhances provision of integrated services at the primary care level.

• On-site mentoring and support especially at District level is critical for successful integration at health facility level

• Provision of integrated services de-stigmatizes all stigma related conditions and services (HIV, STI, ASRH, mental health, key population)

• Understanding integration by all stakeholders AT all levels is key to breaking the barriers to integration and promotes appropriate resource allocation

• A robust functional Monitoring and Evaluation system is important for capturing and documenting evidence on what works or otherwise

• Effective Partnerships– Male involvement, GBV, AGY, FP, utilization of health services Service Delivery- AGY, CB for HCW for KP Friendly delivery

• Demand Creation- Community Mobilization and Engagement

• Phased integration Scale-up approach – Guided and followed process with clearly defined Roles & Responsibilities, Defined actions at National & Sub-National levels Roll-out Steps providing for sustained oversight, coaching and M&E
Experience from an implementer at district and health facility level

Ms. Seitshiro S. Galeage
Nurse/Midwife, Mahalapye District Hospital
Master Trainer: Family Planning
National ToT: NCCPP
Mentor Trainer: Integration Curriculum

a) Provider of integrated package of services at every entry point
b) Advocated to be trained on HTS to expand skill set in the provision of minimum service packages to all clients - Trained on HTS 2020
c) Runs high risk clinic for pregnant women and girls, provides linkages to further care
d) Provides FP outreach services to women in hard to reach areas to close the gap on access to Implants & IUCD; and integration of HTS and STI management and onsite cervical cancer screening
e) Provider of prevention and management of SGBV services
f) Provides extensive health education on FP that empowers women to make informed choices on contraceptive methods
Questions and Discussion
Satellite Session on the Integration of SRHR, HIV and GBV Services

8 December 2021

PRESENTER: Ms Maria Emma N. Lucas
ORGANISATION: Ministry of Health and Social Services, Namibia
Background/ Context

- Namibia has a population of 2.5 million. Upper Middle Income country with per capita income of $5842 (2019)
- Contraceptive prevalence rate (NDHS 2013):
  - 50% of women (15-49) use contraceptives, injectables being the commonest (21%)
  - Unmet need for FP is 12% (NDHS, 2013).
- 97% ANC coverage. HIV in Pregnant (15-49) - 14.8% (2019), syphilis in Pregnant - 1.7% (2019)
- Maternal mortality is 385:100,000; teenage pregnancy rate of 19%
- HIV prevalence is 12.7% (15.7% among females, 9.3% among males)
- Country has achieved UNAIDS targets; 86:96:91 (NAMPHIA Report 2017)
- HIV and SRH services were provided in silos (HIV clinic, FP services, ANC)
- The country developed National Guidelines on Health Services Integration (July 2016)
Namibia Model of integration

Namibian Primary Healthcare Integration Model

- The country adapted the “one stop shop” approach
- This model is flexible with facilitated referral within and outside the facility
- It is person focused care (same nurse provides care to the same patient over time)
Reasons the country scaled up the model

• Rapid Assessment undertaken countrywide to assess level of integration. Findings from the assessment revealed services were provided in silos, integration was happening by default in smaller facilities.
• Time motion study conducted in seven pilot sites pre and post assessment. Post assessment revealed integration contributed to:
  • Improved accessibility to services (all services provided daily)
  • Improved nurse productivity and workload distribution.
  • Reduced patient waiting times (time patients waited to receive a service).
  • The new model focused on the “persons” not diseases
  • Improved provider client communication and minimized stigma (continuum of care)
  • Improved uptake of services such as first ANCs, HIV, TB and first Family Planning visit.
  • Client satisfactory survey undertaken in 5 pilot sites and both clients and providers recommended scale up.
Process for scaling up the integrated model countrywide

• Mobilization and sensitization conducted to illustrate the benefits of integration:
  ➢ Policy makers (onsite visits to illustrate the model)
  ➢ Regional Management Teams (RMTs)
  ➢ District Coordinating Committees (DCCs)
  ➢ Healthcare workers
  ➢ Clients, Gate keepers/ Community members
• National and regional committees established to oversee the implementation process
• Development of National integration guidelines on integration of health services
• Regions and Districts development of regional scale up implementation plans
• Capacity building of health care providers on both priority areas on SRH and HIV
• Rearranging and equipping facilities with minimum basic equipment and data capturing tools
• South to south learning between facilities
• Supportive Supervisory Visits conducted to assess readiness of selected facilities
• Conduct follow up visits to monitor progress
• Implementation of the integrated model based on facilities readiness
Mobilisation and sensitisation at all levels

- Policy makers
- Healthcare workers
- Clients/Community
Current Status

• A total of 173 out of 291 facilities are providing integrated services in target regions (2019)

• This represents 59% of integrated facilities countrywide.

• COVID-19 Pandemic has negatively impacted provision of integrated services (e.g. decongestion centers), repurposing of facilities and health care workers due to emergency, High staff turnover (movement of trained staff)

• MoHSS has developed guidelines on Continuation of Essential Services in the context of COVID-19.

• A pillar on continuation of Essential Services constituted and meets on a regular basis

• MoHSS with support of CSOs has intensified mobile outreach teams
Lessons learnt

• Moving from disease-focus to person-focus PHC services in Namibia is possible. Significant improvements were achieved in Namibia following person-centred integrated model.

• A participatory approach raised awareness, understanding, interest and commitment among health workers in the clinic and empowered them to lead the change to a patient-centred integrated model.

• Good leadership and management at all levels was critical to reduce “change resistance” and to motivate regions to implement the model.

• Documentation and addressing challenges as they emerged was very critical.

• A good preparation before starting the implementation of the model is a must.

• Understanding of roles by providers, provision of basic training, basic equipment, M&E and medicines is essential for effective service delivery.

• Support / supervision of integrating facilities at all levels
THANK YOU!

Put People First!!!
Arrange your services around the needs of people – not around diseases, programs and funding priorities.
Questions and Discussion