EVALUATION OF THE UNITED NATIONS POPULATION FUND (UNFPA) AND THE JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS) PROJECT ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND HIV LINKAGES IN SEVEN COUNTRIES IN SOUTHERN AFRICA: REGIONAL REPORT

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CONTENTS

APPENDICES

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral (Medication)
BCIC	Behaviour Change Intervention Campaign
COEs	Centres of Excellence
CSO	Civil Society Organisations
CHWs	Community Health Workers
ESARO	East and Southern Africa Regional Office
EU	European Union
FGDs	Focus Group Discussions
GBV	Gender-Based Violence
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
ICASA	International Conference on HIV/AIDS and Sexually Transmitted Infections in Africa
ICF	ICF International
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
IRB	Institutional Review Board
KIIs	Key Informant Interviews
LGBTQI	Lesbian, Gay, Transgender, Bisexual, Queer, Questioning, and Intersex
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGOs	Nongovernmental Organisations
PITC	Provider-Initiated Testing and Counselling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission
RPSC	Regional Project Steering Committee
RST-ESA	Regional Support Team for Eastern and Southern Africa
SADC	Southern African Development Community
Sida	Swedish International Development Cooperation Agency
SRH	Sexual and Reproductive Health

SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TB	Tuberculosis
TV	Television
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USD	U.S. Dollar
VMMC	Voluntary Medical Male Circumcision

1 EXECUTIVE SUMMARY

Linking efforts to improve sexual and reproductive health and rights (SRHR) with human immunodeficiency virus (HIV) services is vitally important. HIV is sexually transmitted or associated with pregnancy, childbirth, and breastfeeding, and the presence of certain sexually transmitted infections further increases the risk of HIV transmission. Sexual and reproductive ill health and HIV often share root causes, including poverty, gender inequality, and the social marginalisation of vulnerable groups. Linking HIV and SRHR is expected to improve health outcomes by improving access to and uptake of services, reducing stigma and discrimination, streamlining services and reducing duplication of efforts, increasing the efficient utilisation of human resources, and increasing the cost-effectiveness of efforts.

The United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) HIV and SRHR Linkages in Seven Countries in Southern Africa Project (hereafter referred to as "the project") was undertaken in response to this need. The project, funded by the European Union (EU) and the governments of Sweden and Norway, has supported seven countries in Southern Africa (Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia, and Zimbabwe) to strengthen linkages between HIV and SRHR. The project focused on three main result areas: provision of support to allow full linking of HIV and SRHR in national health and broader development strategies, plans, and budgets; enabling countries to link HIV and SRHR services better and scale them up effectively; and stimulation of formulation and dissemination of lessons learned, formulation of best practices, and facilitation of South-South cooperation in this field.

ICF International, with support from a South Africa-based regional partner, OtherWISE Research and Evaluation, worked with the UNFPA East and Southern Africa Regional Office and UNAIDS to conduct an evaluation of the project using a mixed-method approach. The quantitative approach included three components: (1) secondary analysis of HIV/SRHR linkages indicator data, (2) secondary analysis of facility-level service utilisation data from select facilities, and (3) client exit interviews at select facilities. The qualitative study included: (1) a desk review, (2) focus group discussions (FGDs) with clients at select facilities, and (3) key informant interviews (KIIs). The specific objectives of the evaluation of the project were to assess whether HIV/SRHR Linkages Project was **relevant** to the country contexts; to assess the **effectiveness** of the HIV/SRHR linkages; to assess the **efficiency** of the HIV/SRHR linkages; and to assess the **ownership** of the project by stakeholders and the **sustainability** of HIV/SRHR linkages beyond the project tenure.

1.1 *Relevance*

The evaluation investigated (1) the degree to which the HIV/SRHR project was and is aligned to national priorities and needs, policies, and client needs in each country and (2) how the project addressed changes within the national context. The desk review and KIIs suggest that the project was relevant to the seven countries and the broader Southern African Development Community region, as prior to the project there was no linkage between HIV and SRHR within national policies. The project contributed to changing this discourse thorough successfully advocating for the adaptation of existing policies, guidelines or other documents to integrate HIV/SRHR.

Client exit interviews and FGDs suggest that clients find integrated HIV/SRHR services relevant to their needs and circumstances. For many clients family planning services and primary health care services were a common entry point for receiving integrated services. However, slightly less than a third of clients in all countries reported that they received additional services, which indicates that more should be done to generate demand for additional services.

1.2 *Effectiveness*

The evaluation measured the extent to which the project achieved HIV/SRHR integration at the service delivery level. The project was effective in improving access to services through integrating HIV/SRHR

services and increasing the uptake of those services. Client exit interviews suggest that this was primarily due to health care providers communicating to clients about available services, but KIIs suggest that information, education, and communication materials; media campaigns and efforts by civil society organisations played a greater role in raising awareness of integrated services. However, men's awareness of integrated services was not high overall.

Data from the project indicators in various countries, even when limited by incomplete reporting, suggest that scaling up the provision and marketing of integrated services, may contribute, together with complementary programmes, to improved uptake of services and health outcomes. These include increased knowledge of HIV, antenatal care and contraceptive coverage, HIV testing and receipt of results, as well as concomitant decreases in HIV and sexually transmitted infection prevalence, adolescent birth rates and unmet need for family planning. On the whole, this suggests that continued expansion of integrated services to other sites in each country, and to other countries in the region and beyond, can have similar impacts in terms of increased access to services and increased uptake of services. However, more robust and site level monitoring data are necessary to monitor the extent to which the implementation of integrated services results in increased site and commodity utilisation that can result in improved human resource and stock flow management, but also to differentiate the impact of the project from other similar programmes, which national level monitoring data masks.

The project achieved mixed success in reducing stigma and discrimination—in some instances clients and key informants reported decreases in stigma and discrimination. In one country, they described that the labelling of services, such as HIV counselling and testing, on the doors of the rooms contributed towards stigma and limited access to HIV services. There were also concerns that changes in local by-laws made in one country to support the linkage of HIV and SRHR services by promoting couples access to services may violate privacy and confidentiality for individual community members.

1.3 *Efficiency*

The evaluation sought to understand the extent to which project resources (human, time, financial, etc.) were used to achieve results. Facilities renovated through the project improved the efficiency and quality of services, especially in terms of reducing stigma and discrimination. Clients who accessed integrated services reported decreased cost and waiting times.

However, in some countries pharmacies still had separate antiretroviral medication queues, and in one, HIV services were clearly marked on the doors of specific consultation rooms. This led to concerns relating to privacy and confidentiality, and increased clients perceived risk of stigma and discrimination. Therefore, when planning for facility upgrades or the scaling up of integrated services in other sites, planners should consult with community members so as to take into account their needs in relation to space, privacy, confidentiality and prevention/reduction of stigma and discrimination.

Training and staff motivation are important to ensuring that providers' are able to deliver integrated services. However, staff rotation and shortages (which may be a feature of all national health systems in the region) and perceived increased workloads (as a result of integration) can undermine staff morale. This tension can be mitigated by task shifting, as demonstrated in a few countries. Providers in most countries described a significant reporting burden, a lack of harmonisation of linkage indicators into national monitoring and evaluation systems and a lack of analysis of collected data, because of staff shortages.

1.4 *Country Ownership and Sustainability*

The evaluation assessed whether project stakeholders in the seven project countries were likely to sustain interest and resources to continue with HIV/SRHR integration beyond the tenure of the project. In this regard, the project succeeded in encouraging country ownership of integration at multiple levels. A number of policy documents across all countries were adapted to incorporate language on HIV/SRHR

integration. Key informant's noted political and senior management support for integration including from the permanent secretaries and division directors within the ministries of health in each country. The project encouraged a sense of ownership even at the facility level—key informants in all seven countries saw the value of delivering integrated services despite an initial increased workload and a need to continue offering integrated services regardless of whether resources were available.

As a result of the perceived relevance of the project and the strong sense of country ownership, national governments provided support for infrastructure, health care worker salaries, commodities and equipment that underpinned the support provided by the EU and the governments of Sweden and Norway. However, while the project may well have encouraged country ownership, not all stakeholders were aware of tangible government support for the project and thus, may have perceived that there was little sustainability without external funding. As a result, stakeholders at the local level reported that high-level political support does not always translate into national budget allocations to support continued HIV/SRHR linkages/integration. Further, at the facility level, key informants in only two of the seven countries reported that the country could continue to sustain and scale up integrated services without external funding, due to the size of the country in one instance, and due to significant investments in initial capacity-building in the other. In all other countries, key informants reported that external technical and financial support was necessary to continue project implementation and to scale up service integration.

Therefore, the project has been successful in encouraging a sense of ownership at the country level, but more needs to be done to promote awareness of opportunities sustainability. Two strategies to promote sustainability include national governments using the results from this project to develop national scale up plans for integration and inform a broader roll out that saturates all districts in a country and strong initial capacity-building.

1.5 Recommendations

1. UNFPA and UNAIDS country and regional representatives should continue their efforts to advocate for policies, programmes and services to integrate HIV and SRHR because integrated services are relevant to:
    - strengthening the countries' health system and achieving the sustainable development goals.; and to
    - individual clients' healthcare needs
2. UNFPA and UNAIDS at regional and country level, together with the Governments of Sweden and Norway and the EU, should advocate with bilateral and multilateral donors to move from funding vertical HIV and SRHR interventions to integrated service delivery at the national level.
3. MOHs should lead in ensuring that all policies, guidelines, and health systems integrate HIV/SRHR and to scale up integrated HIV and SRHR services using various entry points, such as youth friendly clinics, family planning; maternal, child and women's health and primary healthcare because clients visit health facilities for a variety of reasons.
4. Health care providers should offer integrated HIV and SRHR services to all clients that visit health facilities, irrespective of the nature of the services they are seeking to as:
    - one means of generating demand for integrated services; and as
    - a means to ensure that health risks are detected early, that clients are provided with appropriate treatment, and to ensure that no-one is left behind.
5. MOHs should build upon the project to continue to provide and scale up the delivery of integrated HIV and SRHR services to other sites in each country.

6. MOHs in each country should strengthen the implementation of integrated HIV and SRHR services by developing a multi-pronged approach that supports CSOs to undertake community mobilisation and demand generation activities. These include using community media, distributing IEC materials, and promoting demand generation that is linked to integrated services. These activities will complement the efforts of health care providers in referring clients for available services.
7. UNFPA, UNAIDS and MOHs should undertake additional research to understand the barriers to the uptake of services by men, their awareness and utilisation of such services and to use these findings to develop community mobilisation and demand creation efforts that promote the uptake of HIV and SRHR services that meet the needs of men.
8. UNFPA, UNAIDS and MOHs should examine existing data collected by clinics that can be used to more effectively monitor and evaluate the uptake of integrated services at sites to better evaluate and differentiate the impact of the project from other similar initiatives.
9. Facilities should consult with their communities that they serve about how integrated services should be provided, to ensure quality and reduce stigma and discrimination.
10. MOHs in each country expanding the implementation of integrated HIV and SRHR services should collaborate with external donors to support the renovation of facilities that will deliver these services.
11. MOHs should involve local communities when planning for the renovation of facilities to deliver integrated HIV and SRHR services around space, privacy, and stigma and discrimination.
12. MOHs should develop a human resources plan for health care providers to scale up the implementation of integrated HIV and SRHR services that does the following:
    - Prepare all health care providers to deliver all integrated services.
        - Offer comprehensive initial training for all providers.
        - If comprehensive initial training can only reach select providers at the district level or per facility
            - include training of trainer components in the comprehensive training so that those select health care providers can disseminate knowledge and skills to other health care providers they work with and/or provide annual, in-service, follow-up training on a rolling basis to reach all facilities.
    - Incorporate task-shifting to reduce workload, for instance by engaging lay health workers in community follow-up, initial screenings and so forth, so that health care providers' workloads are more manageable and they can focus on delivery of services that require more technical skills.
    - Minimise staff turn-over and rotation, and addresses staff motivation, such that trained staff are less likely to move away from facilities and thus contribute to shortages of staff trained to provide integrated services.
13. MOHs in each country expanding the implementation of integrated HIV and SRHR services should collaborate with external funders to develop a robust M&E system that:
    - Harmonises project indicators with national indicators, so that M&E data elements gathered by the project align with, feed into and support broader national M&E efforts;
    - Minimises reporting burden across multiple services; and
    - Maximises opportunities for using the data at different level (for programme improvement at the facility level, for commodity forecasting at facility and national levels, and for national level planning and allocation of resources) in order to encourage analysis and use of the data.
14. MOHs should renovate facilities and prepare providers to deliver integrated HIV and SRHR services using a model where all services are provided by all providers in all rooms and where rooms are not marked according to services.

15. UNFPA and UNAIDS should continue advocating for integration of HIV and SRHR services with all country stakeholders.
16. MOHs should advocate for allocations of the national budget to support integration of services while also collaborating with UNAIDS, UNFPA and external donors to develop sustainability plans or apply for grants that promote sustainability.
17. UNFPA and UNAIDS should host a workshop with UNFPA and UNAIDS country representatives to discuss and distil lessons learned about how to successfully advocate for adoption of integration by MOHs and to encourage country ownership in order to inform the implementation of integration in other settings.
18. UNFPA and UNAIDS should facilitate the sharing of policy documents and strategies like Botswana's HIV and SRHR & AIDS Linkages Integration Strategy and Implementation Plan, as examples of what could emerge from advocacy and engagement with MOHs.

2 INTRODUCTION

Key international and regional agreements, such as the African Unions, Maputo Plan of Action on Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa, recognise the importance of linking[1] sexual reproductive health and rights (SRHR) and human immunodeficiency virus (HIV). HIV in east and southern Africa is primarily sexually transmitted associated with pregnancy, childbirth, and mixed infant feeding. Sexually transmitted infections (STIs) further increases the risk of HIV transmission. The structural drivers of HIV, such as poverty, gender inequality, and the social marginalisation of vulnerable groups also undermine sexual and reproductive health outcomes.[1] Linking HIV and SRHR is intended to improve health outcomes by increasing access to and uptake of services, reducing stigma and discrimination, streamlining services, reducing duplication of efforts, optimising the efficient utilisation of human resources[2,] and increasing the cost-effectiveness of efforts.

3 OVERVIEW OF THE HIV/SRHR LINKAGES PROJECT

The United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Project on Linking HIV and Sexual and Reproductive Health and Rights and in Southern Africa (hereafter referred to as "the project") was implemented to undertake catalytic actions in seven Southern African countries (Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia, and Zimbabwe) to address the barriers to efficient and effective linkages between HIV and SRHR policies and services as part of strengthening health systems. The project's ultimate objective was to increase access to and use of a broad range of quality services. The project was designed to support Millennium Development Goals (MDGs) 3, 4 and 5, to achieve universal access to reproductive health and to support MDG 6, to promote the uptake of HIV prevention, treatment, care and support.

The project was initially, funded by the European Union (EU) through its Thematic Programme, Investing in People, theme 1.2 Good Health for All. The governments of Sweden and Norway, provided additional support (via Swedish International Development Cooperation Agency [Sida], Lusaka office). The total funding provided between 2011 and 2015 was approximately U.S. dollars (USD) $10,646,996.[3]

The project focused on three main result areas:

1. Linkages between HIV and SRHR integrated into national health and development strategies and plans;
2. Improved uptake and delivery of integrated quality services for HIV and SRHR; and
3. Best practice models disseminated to support strengthening linkages between HIV and SRHR.

Each of the seven participating country conducted a rapid assessment prior or at the inception of the project to establish the extent to which HIV/SRHR were linked at the policy, system, and service delivery levels.[1] These assessments informed the design, development and implementation of the project in each country. Countries also drew upon lessons learned from the INTEGRA Initiative, an earlier project in which three different models of integrated HIV/SRHR services were evaluated in "real-world" settings in Kenya, Malawi, and Swaziland.[4] The HIV/SRHR project pilot-tested two monitoring and evaluation

[1] Linkages are the bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV. It refers to a broader human rights based approach, of which service integration is a subset.

[2] International Planned Parenthood Federation, United Nations Population Fund, World Health Organisation, Joint United Nations Programme on HIV/AIDS, Global Network of People Living with HIV, International Community of Women Living with HIV/AIDS, & Young Positives. (2009). *Rapid assessment tool for sexual & reproductive health and HIV linkages: A generic guide.* Retrieved from http://www.unfpa.org/sites/default/files/pub-pdf/rapidassessmenttoolsrhlinkages_2009_en.pdf

[3] All fiscal amounts are listed in U.S. dollars.

[4] INTEGRA Initiative. Retrieved from http://www.integrainitiative.org/

(M&E) indicators, identified by the Global Inter-Agency Working Group on Sexual and Reproductive Health (SRH) and HIV, to measure integration of HIV and SRHR at service delivery levels.[5]

3.1 *Governance*

Regional Governance and Coordination

A regional project coordinator located in the UNFPA East and Southern Africa Regional Office (ESARO) and a Strategic Information Advisor at the UNAIDS Regional Support Team for Eastern and Southern Africa (RST-ESA) jointly oversaw the project management, coordination, administration, M&E for the project. The roles and responsibilities of UNFPA and UNAIDS were defined through a regional memorandum of understanding:

- UNFPA: Project management, coordination and administration of the project, capacity building, procurement of commodities, and supply chain management.
- UNAIDS: Advocacy relating to HIV, strategic information management, monitoring, and evaluation
- Joint Activities: Advocacy relating to policy dialogues.

A Regional Project Steering Committee (RPSC) that met annually or as need be provided policy and strategic guidance for the implementation of the project, made strategic decisions regarding implementation, validated annual work plans budgets, facilitated the sharing of knowledge and best practices. The RPSC was chaired by the Deputy Regional Directors of UNFPA and UNAIDS. Members of the RPSC included:

- representatives from the ministry of health (MOH) in each country,
- EU and SIDA representatives,
- the UNFPA country representatives and the UNAIDS country directors from Botswana and Zambia, and
- representatives from the International Planned Parenthood Association (IPPF).

The project worked closely at the regional level with the Southern African Development Community (SADC) and regional nongovernmental organisations (NGOs) such as Southern Africa HIV and AIDS Information Dissemination Service.

Country Governance and Coordination

A national project coordinator was appointed in each country to coordinate and oversee the implementation of the project. The project coordinator was employed by UNFPA, but in some instances was located within the MOH (Botswana, Namibia and Zimbabwe) and in others, within UNFPA (Lesotho, Malawi, Swaziland and Zambia).

A national technical committee oversaw the coordination and implementation of the project in each country. The MOH in each country chaired and led the Committee. Members included UNFPA, UNAIDS, the World Health Organisation, the EU, and local civil society organisations (CSOs) with demonstrated expertise in HIV and SRHR. It was intended for the national technical committees to meet at least twice a month to:

- ensure effective and functional linkages between HIV and SRHR at the national and service delivery levels,
- monitor project progress,

[5] International Planned Parenthood Federation, United Nations Population Fund, & the World Health Organisation on behalf of the Interagency Working Group on Sexual and Reproductive Health and HIV Linkages. (2014). SRH and HIV Linkages Compendium: Indicators & Related Assessment Tools. Retrieved from http://www.unfpa.org/sites/default/files/pub-pdf/SRH%20HIV%20Linkages%20Compendium_rev.pdf

- provide overall technical guidance for the national implementation of the project, and
- agree upon the annual progress report, set priorities, plan and adopt the work plan for the following year.

The work of the technical committee was supported by M&E committees in six of the seven participating countries that met twice a month. This committee was co-chaired by the UNFPA and UNAIDS country representatives. Members included: national project coordinators, M&E officers from UNFPA and UNAIDS, representatives from MOH, and representatives of the CSOs. The role and mandate of this committee was to provide M&E support to:

- collect and analyse data to improve project design and inform decision-making,
- document and disseminate best practices and lessons learned,
- supervise the baseline survey for the HIV/SRHR linkages pilot project, and
- test the HIV/SRHR linkages indicators.

Each country developed a national visibility frameworks/communication plan and one country established a visibility committee to support implementation of their plan. These plans were developed based on a regional communication framework and training was provided by the regional offices of UNFPA/UNAIDS in operationalising their plans.

The leadership of the MOH at the national level ensured close monitoring and interaction, facilitated joint planning between HIV and SRHR departments of the MOH, and joint capacity building efforts for health care providers on HIV/SRHR linkages and integration.

3.2 *Activities*

The following describes some of the activities undertaken under each of the Results Area .[6]

Result Area 1: Linkages between HIV and SRHR integrated into national health and development strategies and plans (Policy)

All participating countries conducted a rapid assessment to prepare for implementation of the project. The rapid assessment reviewed the extent to which existing national policies and guidelines integrated HIV/SRHR. The findings of the rapid assessments were used to further engage national, sub-national and civil society leaders to integrate HIV/SRHR into existing policies and guidelines. Activities included meetings with various ministries, parliamentarians, local leaders, elected officials, religious leaders, traditional leaders, CSOs, parastatals, and representatives of people living with HIV (PLHIV)-organisations. These meetings were focused on outlining the benefits for the health system and clients on integrating HIV/SRHR to improve health outcomes for individuals and communities.

From 2012–2015, the project collaborated with SADC to develop minimum standards at a regional level for integrating HIV and SRH, drawing upon the lessons learned and experiences of the seven participating countries. The development of these guidelines will assist other member states to adapt other guidelines so they help to inform the integration of HIV/SRHR within countries.

Result Area 2: Improved uptake and delivery of integrated quality services for HIV and SRHR (Service Delivery and Scale-Up)

The project was designed to pilot different models to integrate HIV/SRHR into health services in three countries. The models piloted and services provided are included in the findings section of this report. Additional funding from the Governments of Sweden and Norway enabled this activity to be expanded to all seven countries.

[6] The activities above are summarised from the Final Narrative report for Phase 1 2011 – 2015 that provides an in-depth report on the activities undertaken.

Technical support was provided to the MOH and CSOs to develop in-service training programmes for health care providers and to adapt existing pre-service curricula to include content on integrating HIV/SRHR. Training was provided to transfer technical skills to health care providers in participating facilities to provide integrated HIV/SRHR services.

Community mobilisation events targeting communities, young people, faith-based organisations, and community leaders were held to sensitise local communities around issues relating to HIV/SRHR and to generate demand for services. Community mobilisation activities were complemented with information, education, and communication (IEC) materials, including radio programmes, television (TV) advertisements, videos, billboards, posters, pamphlets, and cards (like Botswana's Know Your Rights cards) to support demand creation for services.

All countries participated and benefited from Phase II (2013–2020) of UNFPA's Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS).[7] Through this programme, participating countries procured commodities such as, male and female condoms, testing kits to diagnose and manage reproductive tract infections, STIs, and HIV, drawing upon UNFPA resources. The two projects worked in close collaboration to strategically leverage of resources. For example, GPRHCS procured the commodities and the project supported additional equipment needed for delivering integrated services in the demonstration sites.

Client satisfaction studies were undertaken in five countries to measure the extent to which clients were satisfied with the integrated services being offered. These studies showed that clients perceived integrated clinics to be less stigmatising, and health care providers more client friendly than non-integrated clinics. Clients overall were of the opinion that the integration of HIV/SRHR services at health facilities is a good model of service delivery.

Result Area 3: Best practice models disseminated to support strengthening linkages between HIV and SRH.

The project supported a number of activities intended to gather and share lessons learned and best practices. The facilitation of intercountry exchanges assisted in enabling countries to learn from best practices. A team of MOH officers from Botswana undertook a benchmarking tour to Nairobi, Kenya, in 2012 to learn about different integration models. Similarly, teams from Lesotho, Malawi, and Zimbabwe visited facilities in Swaziland to exchange knowledge and share hands-on experiences on the project, to learn from a NGO–led and government-led HIV and SRHR linkages facility. This exchange was intended to strengthen approaches and to inform the development of strategies to scale up the project in other countries.

The project undertook a Midterm review[8] in 2013 to assess the overall performance of the project in the seven countries against the agreed activities and objectives as outlined in the regional and country log frames as well as country annual work plans. This review included a document review and stakeholder interviews as well as country visits to three countries (Namibia, Botswana and Swaziland), and identified gaps and resulting recommendations on how to improve the project.

[7] The UNFPA GPRHCS programme adopts an integrated approach to address national priorities and contexts within 46 target countries to ensure universal access to reproductive commodities, family-planning services, information and the prevention of HIV and other sexually transmitted infections. For the GPRHCS programme, Malawi, Lesotho, Zambia, and Zimbabwe were considered priority "target countries" with the potential of receiving up to $3 million USD in capacity strengthening in addition to reproductive health commodity support. Botswana, Namibia, and Swaziland were considered "Strategic Support" countries and received targeted support to advance and/or maintain ongoing progress towards Reproductive Health Commodity Security.

[8] Health and Development Africa. (2013). *Mid-Term Review of the Project "Linking HIV and Sexual and Reproductive Health and Rights in Southern Africa" Project Report*. Johannesburg, South Africa.

The Regional Office of UNFPA ESARO convened a regional capacity building workshop for participating countries to assist them in developing national visibility and communication guidelines. Countries developed these guidelines based on the regional communication framework and on the EU visibility and communication guidelines.

The project encouraged documentation of lessons learned and dissemination of good practice models via One-pagers and "good practice" documents developed and shared within and between the countries. Experiences from the integration of HIV/SRHR was shared with other stakeholders through a number of presentations at international conferences, including the:

- *Integration for Impact*—Reproductive Health & HIV Services in Sub-Saharan Africa in 2012,
- 5th Africa Conference on Sexual Health and Rights in 2012,
- *Models of Service Delivery Workshop* organised by the Inter-Agency Task Team in Tanzania in 2013,
- International Conference on AIDS and STIs in Africa (ICASA) in South Africa in 2013, and
- Satellite session on integrating SRH and HIV services in collaboration with IPPF at ICASA 2015.

Finally, the project participated in global and regional efforts to capture and distil lessons learned in M&E by participating in the Global Inter-Agency Working Group on SRH and HIV Linkages, led by IPPF in 2012. Members of this work group contributed to the development of a compendium of indicators that was used across participating countries to monitor and evaluate the implementation of the project.

3.3 *Resources*

The project received $9,902,658 USD from the EU over the course of the implementation period, and $1,931,135 USD from the Governments of Sweden and Norway in 2014. EU provided direct financial support to UNFPA and the Governments of Sweden and Norway provided financial support through UNAIDS to UNFPA. In terms of resource flows 90.2% of EU funding and 88.6% of funding from the Governments of Sweden and Norway went directly to support country level implementation (90/0% overall).

Exhibits 1 and 2 below show the actual costs and percentages across all countries and the regional office by input types (through EU funding) and activity types (funding from the Governments of Sweden and Norway).

Exhibit 1. Costs and Distribution of Costs Across Input Types — EU, 2011 to 21 April 2015 (Financial Costs, USD) — All Countries and Regional Office Combined

Input Types	Total Cost	Percentage of Total Cost
Personnel	$4,677,410	52.3%
Publications, research, and evaluations	$591,029	6.6%
Administrative costs	$579,094	6.5%
Local offices	$529,249	5.9%
Other	$493,601	5.5%
Conferences/seminars	$479,887	5.4%
Medical equipment and commodities	$481,235	5.4%
Travel	$428,385	4.8%
Visibility actions	$325,317	3.6%
Translation/interpreters	$177,581	2.0%
Furniture and computer equipment	$147,798	1.7%
Purchase or rent of vehicles	$58,841	0.7%
Banking services	$21,210	0.2%
Financial reporting support	$4,815	0.1%
Total	**$8,936,058**	**100.0%**

Exhibit 2. Costs and Distribution of Costs Across Activity Types — Governments of Sweden and Norway, 2014 (Financial Costs, USD) — Overall Project (Including All Countries and Regional Office)			
Activity Types		Total Cost	Percentage of Total Cost
Activity Costs	Civil society organisations models	$582,044	34.0%
	Health service providers capacity building	$275,060	16.1%
	Review and procurement of reproductive health commodities	$180,875	10.6%
	Policy and planning reviews	$14,182	0.8%
	High-level meetings	$431	0.03%
	Civil society organisations capacity building	-	-
	ALL ACTIVITY COSTS	**$1,052,592**	**61.5%**

Exhibit 2. Costs and Distribution of Costs Across Activity Types — Governments of Sweden and Norway 2014 (Financial Costs, USD) — Overall Project (Including All Countries and Regional Office) Continued			
Activity Types		Total Cost	Percentage of Total Cost
Monitoring and Evaluation Costs	Regional consultations	$190,865	11.2%
	Operational research	$155,443	9.1%
	Support to harmonise health management information systems	$148,006	8.7%
	Best practice documentation	$73,744	4.3%
	Monitoring & evaluation assessment	$10,006	0.6%
	Assessment of non–health sector contributions to linked/integrated models	$5,441	0.3%
	Pilot compendium SRHR indicators	$805	0.1%
	Regional staff	-	-
	ALL MONITORING AND EVALUATION COSTS	**$636,902**	**34.2%**
Indirect Costs		$74,037	4.3%
Total Costs		**$1,710,938**	**100%**

Exhibits 1 and 2 are also included in Appendix A along with other exhibits that provide further breakdown of funding for each country and for the regional office according to each of these line items.

4 OVERVIEW OF THE EVALUATION

ICF and its South Africa-based regional partner, OtherWISE Research and Evaluation, conducted the evaluation in close collaboration with UNFPA ESARO and UNAIDS RST-ESA. The objective of the evaluation was to assess:

- the **relevance** of HIV/SRHR linkages to each country's context;
- the **effectiveness and efficiency** of HIV/SRHR linkages across all seven countries; and
- the **ownership and sustainability** of HIV/SRHR linkages in each country.

Exhibit 3 presents a list of the key questions the evaluation addressed, along with the relevant area of investigation.

Exhibit 3. Key Questions and Areas of Investigation	
Key Question	Area of Investigation
1. Was and is the HIV/SRHR Linkages Project aligned to the priorities or needs of the seven project countries?	**Relevance:** Relates to national priorities and needs, policies, client needs, and how the project addresses changing national contexts.

Exhibit 3. Key Questions and Areas of Investigation, Continued

Key Question	Area of Investigation
2. To what extent did the project achieve HIV/SRHR linkages at the policy, system, and service delivery levels and other results areas?	**Effectiveness:** The extent to which the results were achieved.
3. To what extent were the project resources (human, time, financial, etc.) used to achieve the three results areas of HIV/SRHR Linkages Project?	**Efficiency:** How funding, personnel, administrative arrangements, partnerships, governance arrangements, time, and other inputs contributed to or hindered the achievements of results.
4. Have project stakeholders in the seven project countries sustained interest and resources to continue with HIV/SRHR integration beyond the tenure of this project?	**Country Ownership and Sustainability:** The extent to which the benefits from the project are likely to continue after completion, while taking into account the existing partnerships and the capacity required for maintaining consistent levels of delivering HIV/SRHR integration services.

The evaluation is intended to enable key stakeholders to better understand barriers and solutions to strengthen the link between HIV and SRHR policies, systems, and services, assess how resources were utilised; and determine how health outcomes have been improved for populations served by linked HIV and SRHR country programs. The findings of the evaluation are intended to:

- strengthen the next phase of implementation through proposing changes to the overall structure of the initiative;
- enhance and improve critical components of the comprehensive package of HIV and SRHR interventions; and
- provide a basis for developing and sharing best practices with other countries beyond the region to promote more widespread adoption or encourage replication.

4.1 *Evaluation Design*

The evaluation comprised the use of primary and secondary data sources. Secondary data comprised of a desk review, an analysis of the HIV/SRHR linkage indicator data for seven countries and facility service utilisation data. The primary data collection comprised of quantitative and qualitative research methods to gather information on the context of HIV and SRHR linkages in each country, including client exist interviews, focus group discussions (FGDs) and key informant interviews (KIIs). Ethical approval was provided by the ICF internal institutional review board (IRB) and from IRBs or ethics boards/committees in each of the seven countries. Primary and secondary data collected for each country was synthesised and re-analysed to provide an overall picture of the project at the regional level.

Secondary Data Sources

The desk review comprised of 96 project- and administrative-specific documents (Appendix B) about the context, strategies, policy, and best practices specific to HIV/SRHR linkages in each country and regionally. The desk review was used to (1) inform the evaluation design, (2) develop data collection instruments and tools, and (3) inform interpretation of the quantitative data described below including the KIIs and FGDs. Each document was reviewed and strategic information abstracted that describe:

- changes in discourse, development or adoption of policies, guidelines or other documents specific to HIV/SRHR linkages;
- contribution of country HIV/SRHR linkages initiatives to health systems strengthening (partnerships capacity building initiatives, task-shifting, infrastructure upgrades, acquisition of commodities);
- access to services (demand generation and community mobilisation activities), efficiency of services, and client satisfaction; and

- lessons learned and best practices model, and how these were disseminated and facilitated south-to-south learning across the region.

A rapid thematic review was undertaken of the documents provided to identify, code, analyse and summarise key themes, given the short timeframe for the evaluation, and given the significant volume and size of additional documents stakeholders provided during the data collection and analysis phases. Previously identified deductive codes were used, based on the evaluation questions, to provide greater insights into implementation of the project and at national and regional levels.

A secondary analysis was conducted of the HIV/SRHR linkage indicator data for the seven countries. This analysis compared the latest results (2015) for each country to their established targets in order to determine the effectiveness of the project by the three results areas (Appendix C).

While the indicator data for Lesotho, Swaziland, and Zambia were more complete, data from Botswana, Namibia, Malawi, and Zimbabwe were incomplete, which was a significant limitation to this analysis. Complete data for an indicator included a description, a target, an indication of what had been achieved by 2015, and a reference to a document or note intended to verify the achievement. In many cases, however, there was either no 2015 achievement cited, no target listed, or no data source corroborating the 2015 achievement.

Indicator data should also be carefully considered in light of the fact that they represent findings that are likely due to the success of multiple national programmes, not just the project. While it is plausible that the implementation of the project contributed to the countries' ability to meet targets, this evaluation is not able to establish causality between the HIV/SRHR linkages and these indicators. To minimise these limitations, ICF used the documents included in the desk review to identify whether additional achievements had been made or could be corroborated.

Service utilisation data were collected from participating facilities in Malawi and Swaziland to measure and better understand the uptake of integrated services before and after the intervention. In Malawi, indicator data were collected on the HIV and SRHR services clients used in Malawi to determine the percent increase in the period 2011 – 2014.[9] In Swaziland, data were obtained on four key indicators of integration from the five Centres of Excellence (COEs) where the project was implemented to determine changes in the period 2011 - 2015. While these data tells a compelling story, the findings cannot be generalised to other countries where environmental conditions may be different. Data from both Malawi and Swaziland are presented in the findings section.

Primary Data Sources

The primary data sources gathered for this study are summarised in the table below (Exhibit 4) with information provided on each method.

Exhibit 4. Overview of Primary Data Sources

Country	Client Exit Interviews		Focus Group Discussions				Key Informant Interviews
	# of Health Facilities	Client Exit Interviews	# of Health Facilities	# of Groups	# of Female	# of Males	
Botswana	3	60	2	4	15	15	16
Lesotho	1	21	1	1	10	0	9
Malawi	2	41	1	2	11	11	8
Namibia	2	40	1	1	8	0	8
Swaziland	2	36	1	2	16	0	11

Exhibit 4. Overview of Primary Data Sources, Continued

Country	Client Exit Interviews	Focus Group Discussions	Key

[9] 2015 data were not yet aggregated and verified.

	# of Health Facilities	Client Exit Interviews	# of Health Facilities	# of Groups	# of Female	# of Males	Informant Interviews
Zambia	2	48	2	5	37	29	15
Zimbabwe	2	19	1	1	9	0	7
Regional	-	-	-	-	-	-	6
Totals	**13 Facilities**	**265**	**10**	**16**	**106**	**55**	**80**

Client Exit Surveys were conducted by local data collectors recruited in each country to obtain information from clients about their perceptions of the relevance, effectiveness, and efficiency of integrated HIV/SRHR services. Local data collectors conducted brief client exit interviews with a convenience sample of 265 clients as they exited 13 facilities. A close-ended survey instrument was used (Appendix D) that included Likert-type scale items to obtain client demographic information, services sought and received on the day of the visit to the facility, awareness of services, and overall client satisfaction services (quality, cost, and time). The survey instrument was translated into the appropriate local language at the selected facilities in each country. To the greatest extent possible, local data collectors administered the survey to clients of the same gender. A limitation is that ICF was not always able to match the gender of the local data collector with the gender of the client being interviewed, which may have impacted the clients' willingness to share. Given the use of a convenience sample, data are not nationally representative, and thus are not generalizable beyond those clients or those facilities. Further, following IRB guidance, ICF only collected data from clients older than 18 years of age, which may limit the generalizability of the findings, given the project's focus on youth.

FGDs were facilitated by moderators used a facilitation guide (Appendix E) to explore perceptions of the utility of integrated services at the facility visited, recent experiences, and suggestions for improving services. Per direction from the EMs, FGDs were conducted with female clients in all countries (as women are expected to be the primary consumers of SRHR services) and male clients in three countries (Botswana, Malawi, and Zambia). A moderator who spoke the local language around the facility, supported by a note taker of the same gender facilitated the group discussions. This helped to mitigate potential gender power imbalances that may occur in mixed groups, and encouraged participants to freely share their experiences of HIV and SRHR issues. All FGDs were audio recorded.

Cash incentives of between $5-10 USD were provided to participants in Zambia and Namibia at the recommendation of the national project coordinator or clinic staff for their participation in the FGDs, In Malawi, Lesotho, Zimbabwe, and Swaziland incentives comprised of mobile phone airtime vouchers or basic foodstuff. In Botswana, no incentives were provided as per the direction of MOH.

There are several limitations with the FGDs. In six countries, FGDs were conducted on the same day as the client exit surveys, as clients could not typically return to the facility on a second day just for the FGD. This led to first-time clients being recruited who were unable to participate in the discussion on some questions. The intent was for FGD participants to be randomly selected, some deviations from the general design were necessary to accommodate local conditions. For example, at one facility in Botswana, participants were recruited by the facility staff and exit interviews were not conducted, which means that the FGD participants had not participated in client exit interviews. In Zambia, a large number of clients volunteered to participate in the FGDs at two facilities. All participants were allowed to participate based on the recommendations of the health care providers, leading to a larger than ideal group.[10] The larger group may have hampered participation, potentially limiting the richness of the discussion.

The FGDs used a thematic analysis approach and findings are presented as aggregate summary statements in the findings section.

KIIs were conducted by the ICF team who interviewed 80 key informants in English in-person. Key

[10] Ideally, there should be 8-10 participants in an FGD.

informants comprised of persons who were mostly knowledgeable about the project. The purpose of the KIIs was to collect information about their perceptions of the relevance, effectiveness, efficiency, and sustainability of the project in each of the three results areas. A semi-structured discussion guide (Appendix F) was used to elicit informants' perceptions on these issues, tailored to their role and the level of inquiry. ICF conducted a thematic analysis of the qualitative data, employing inductive and deductive analytic coding techniques. Recordings of the KIIs were used to supplement or clarify the notes. We used both pre-determined and emergent codes to identify themes in the data.

Not all key informants initially identified were available at the time of data collection. Some substitutions were made from within invited organisations before the list of key informants were finalised. However, all key informants had adequate levels of knowledge about the project.

The findings below are presented as summarised statements from key informants and not attributed to a given key informant type to protect their confidentiality.

5 FINDINGS

The demographics for the client exit surveys for all countries (Exhibit 5) are presented below. The sample was predominantly female (79.6%), and most were between the ages of 20 and 39 (63.4%), single (56.6%) and unemployed (58.8%). Similarly, most had at least attended secondary school (61.5%) and had been visiting the clinic for more than a year (74.0%).

Exhibit 5. Overall Client Exit Interview —Demographics

		Botswana (N=60)		Lesotho (N=21)		Malawi (N=41)		Namibia (N=40)		Swaziland (N=36)		Zambia (N=48)		Zimbabwe (N=19)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Sex	Female	48	80.0%	15	71.4%	32	78.0%	35	87.5%	31	86.1%	33	68.8%	17	89.5%
	Male	12	20.0%	6	28.6%	9	22.0%	5	12.5%	5	13.9%	15	31.3%	2	10.5%
Marital Status[11]	Single	39	65.0%	8	38.1%	33	80.5%	29	72.5%	25	69.4%	14	29.2%	2	10.5%
	Married/living together	21	35.0%	10	47.6%	6	14.6%	11	27.5%	11	30.6%	31	64.6%	10	52.6%
Education	Did not attend school	10	16.7%	0	0.0%	32	78.0%	1	2.5%	4	11.1%	0	0.0%	0	0.0%
	Primary	13	21.7%	3	14.3%	5	12.2%	9	22.5%	5	13.9%	13	27.1%	7	36.8%
	Secondary	33	55.0%	4	19.0%	3	7.3%	28	70.0%	13	36.1%	31	64.6%	11	57.9%
	More than Secondary	4	6.7%	14	66.7%	1	2.4%	2	5.0%	14	38.9%	4	8.3%	1	5.3%
Employment	Unemployed	45	75.0%	9	42.9%	21	51.2%	19	47.5%	20	55.6%	34	70.8%	6	31.6%
	Work at home	1	1.7%	0	0.0%	9	22.0%	5	12.5%	1	2.8%	1	2.1%	7	36.8%
	Part-time	6	10.0%	2	9.5%	7	17.1%	0	0.0%	0	0.0%	10	20.8%	4	21.1%
	Employed	8	13.3%	10	47.6%	4	9.8%	16	40.0%	15	41.7%	22	45.8%	2	10.5%
Age	18–19 years old	2	3.5%	0	0.0%	9	22.0%	1	2.5%	1	2.8%	13	27.1%	1	5.3%
	20–29 years old	16	28.1%	8	38.1%	21	51.2%	15	37.5%	19	52.8%	3	6.3%	3	15.8%
	30–39 years old	19	33.3%	9	42.9%	7	17.1%	9	22.5%	12	33.3%	20	41.7%	7	36.8%
	Older than 40 years of age	20	35.1%	4	19.0%	4	9.8%	15	37.5%	4	11.1%	3	6.3%	8	42.1%

Exhibit 5. Overall Client Exit Interview —Demographics, Continued

	Botswana (N=60)	Lesotho (N=21)	Malawi (N=41)	Namibia (N=40)	Swaziland (N=36)	Zambia (N=48)	Zimbabwe (N=19)

[11] Does not include those who identified as widowed or divorced.

Exhibit 5. Overall Client Exit Interview —Demographics, Continued															
		Botswana (N=60)		Lesotho (N=21)		Malawi (N=41)		Namibia (N=40)		Swaziland (N=36)		Zambia (N=48)		Zimbabwe (N=19)	
Use of Clinic over Time	First Visit	2	3.3%	0	0.0%	3	7.3%	3	7.5%	5	15.6%	7	14.6%	0	0.0%
	Less than 1 year	8	13.3%	8	38.1%	2	4.9%	2	5.0%	9	28.1%	1	2.1%	5	26.3%
	1–5 years	23	38.3%	10	47.6%	15	36.6%	10	25.0%	11	34.4%	14	29.2%	7	36.8%
	5–10 years	5	8.3%	1	4.8%	5	12.2%	6	15.0%	6	18.8%	10	20.8%	7	36.8%
	More than 10 years	22	36.7%	2	9.5%	16	39.0%	3	7.5%	1	3.1%	22	45.8%	0	0.0%

Care should be taken on over-interpreting subsequent figures given the small sample size overall. However, despite that limitation, certain observations can be made. It is not surprising that the sample is predominantly female given that male clients do not often seek health care services. Only 11% of the sample was younger than 20 and thus findings related to youth may not adequately represent the target audience of the project in some of the seven countries. The length of time that most clients have been visiting facilities may allow for clients to compare services pre-and post-integration, but may also suggest that they are accustomed to attending a particular clinic and may not be seeking services from a given clinic because the quality or range of services has improved.

The results of the analysis regarding client perceptions are presented later in the findings section.

5.1 *Relevance of the HIV/SRHR Linkages Project*

As mentioned earlier, a key area of investigation for the evaluation was the relevance of the project. More specifically, the evaluation investigated (1) the degree to which the HIV/SRHR project was and is aligned to national priorities and needs, policies, and client needs in each country and (2) how the project addressed changes within the national context. If a given country adopted linkages and integration and worked to include these concepts in national policy documents, this was assumed to represent relevance at the national level. At the facility or client level, integration was assumed to be relevant if clients reported that the integrated services met their needs.

Policy

Prior to the Project, only Botswana and Zambia had any existing policy documents that specifically referred to integration of HIV and SRHR services. Prior to the project, there were no regional efforts to develop policies that integrated HIV and SRHR services. According to key informants, this was partly owing to external donor funding that supported SRHR or HIV separately, leading to vertical programmes, often with a lack of coordination between those responsible for HIV and SRHR. This continues to be a concern as major funders such as U.S. President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria focus exclusively on SRHR or HIV rather than promoting the integration of efforts. Key informants said that where integration was mentioned in policy documents prior to the implementation of the project, this tended to refer to integration of all services via primary health care.

The project was also relevant to the regional context. At the regional level, the project successfully collaborated with SADC on a set of Minimum Standards for integrating Sexual and Reproductive Health and HIV and AIDS in the SADC Region, and on the development of the SADC HIV, SRH, tuberculosis (TB), and Malaria Programmes Integrated Strategy 2016-2020, both based on participating countries' experiences of integrating HIV and SRHR services.[12]

[12] The inclusion of language on integration in policy documents in all countries and at the regional level indicates relevance of the project to national and regional agendas but also demonstrates that advocacy for policy changes

At the national level, the project in each country contributed to the adaptation and/or development of at least one policy, set of guidelines or other programme document that specifically links HIV and SRHR services. Twenty-one (21) of the twenty-nine (29) policy documents reviewed (see Appendix G) include language that describe the link between HIV and SRHR as being aligned to the national context, priorities and client needs. Nine (9) of these policy documents specifically speak to HIV/AIDS and seven (7) of them focus on SRHR. These included the following:

- Lesotho's National SRH Strategic Plan 2015-2020
- Zambia's National Guidelines for SRH, HIV, and GBV Services Integration, National Adolescent Health Strategic Plan 2011–2015, the Maternal, Neonatal and Child Health Roadmap 2013–2016, and the National HIV/AIDS Strategic Framework 2014–2015
- Swaziland's 2013 National Policy on Sexual and Reproductive Health,[6] the country's first-ever national SRH policy
- Malawi's National Sexual and Reproductive Health and Rights and HIV and AIDS Integration Strategy, 2015-2020 (2015)
- Botswana's HIV and SRHR & AIDS Linkages Integration Strategy and Implementation Plan (2014)

Key informants noted that while there has been progress in terms of incorporating language on integration into existing policies, there are still gaps in laws and policies that can strengthen the link between HIV and SRHR and increase access to integrated services. These include: decriminalising sex work in one country; harmonising the age of consent for sex and accessing SRH services in another country; legalising abortion or increasing access to post-abortion care in four countries; and further increasing the legal age for marriage in one country. Enforcement is another challenge when laws and policies are changed. Key informants in one country expressed concerns around enforcement of approved laws and policies such as young people having difficulty accessing contraception due to health care provider stigma although the age of consent has legally been reduced to 14.

Service Delivery

Clients find integrated HIV/SRHR services relevant to their health care needs. Across the countries, 87 – 94% of clients said that they received the services that they sought, and the largest proportion of clients overall (28%) reported that they came for family planning services (Exhibit 6).

Most clients in Malawi (48.8%) and Zimbabwe (56.3%), and the largest group of clients in Namibia (50.0%) reported receiving other, non-HIV or SRHR services. This may suggest that HIV and SRHR services should be integrated into other primary care services.

Clients in all countries reported receiving additional services, which suggests that services were integrated in all countries However, this ranged from over 50% in Malawi (51.2%) and Zimbabwe (57.9%) to 11.1 % in Swaziland, with most other countries ranging between 22.8 and 35% in Botswana, Lesotho, Namibia and Zambia, This may not reflect the level of integration in each country, but may rather be an artefact of the client exit interviews which were conducted on a single day at only specific sites, and thus lack generalizability across each country. Of those who had received additional services, the largest group of clients reported receiving HIV testing.

Exhibit 6. Client Exit Interviews—Services Sought and Received

		Botswana (N=59)		Lesotho (N=21)		Malawi (N=41)		Namibia (N=40)		Swaziland (N=36)		Zambia (N=48)		Zimbabwe (N=19)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Services	Family	5	8.5%	8	61.9%	5	12.2	4	11.8	18	50.0%	29	60.4%	0	0.0%

were both effective and efficient. Therefore, further discussion on policy has not been included in the following sections on effectiveness and efficiency.

Sought	Planning						%		%						
	Other	6	10.2 %	0	0.0%	20	48.8 %	17	50.0 %	7	19.4%	6	12.5%	9	56.3%
	Child Welfare	26	44.1 %	0	0.0%	3	7.3%	7	20.6 %	0	0.0%	2	4.2%	0	0.0%
	HIV Testing	7	11.9 %	6	21.6%	4	9.8%	1	2.9%	7	19.4%	11	22.9%	3	18.8%

Exhibit 6. Client Exit Interviews—Services Sought and Received, Continued

		Botswana (N=59)		Lesotho (N=21)		Malawi (N=41)		Namibia (N=40)		Swaziland (N=36)		Zambia (N=48)		Zimbabwe (N=19)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Services Sought, Continued	Antenatal	4	6.8%	2	9.5%	12	29.3 %	3	8.8%	3	8.3%	1	2.1%	7	36.8%
	Antiretroviral therapy (ART)/Antiretroviral medication (ARVs)	11	18.6 %	0	0.0%	3	7.3%	2	5.9%	8	22.2%	0	0.0%	9	56.3%
	STI Screening	0	0.0%	4	19.0%	1	2.4%	0	0.0%	0	0.0%	4	8.3%	1	5.2%
	Volunteer Medical Male Circumcision (VMMC)	0	0.0%	4	19.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Was Service Received?	Yes	51	86.4 %	20	95.2%	38	92.7 %	39	97.5 %	35	100%	48	100.0 %	16	84.2%
	Partially	4	6.8%	0	0.0%	2	4.9%	1	2.5%	0	0.0%	0	0.0%	2	10.5%
	No	4	6.8%	0	0.0%	1	2.4%	0	0.0%	0	0.0%	0	0.0%	1	5.3%
Additional Services Received	Yes	13	22.8 %	6	28.6%	21	51.2 %	14	35.0 %	4	11.1%	12	25.0%	11	57.9%
Type of Other Services	HIV Testing	6	46.2 %	6	100.0 %	10	24.4 %	2	14.3 %	2	25.0%	5	41.6%	4	36.4%
	Other	1	7.7%	0	0.0%	7	17.1 %	11	78.6 %	1	12.5%	3	25.0%	9	81.9%
	Family Planning	2	15.4 %	5	83.3%	5	12.2 %	6	42.9 %	2	25.0%	2	16.7%	2	18.2%
	STI Screening	3	23.1 %	4	66.7%	4	9.8%	1	7.1%	0	0.0%	2	16.7%	4	36.4%
	Child Welfare	3	23.1 %	0	0.0%	1	2.4%	5	35.7 %	0	0.0%	3	25.0%	0	0.0%
	ART/ARVs	2	15.4 %	1	16.6%	2	4.9%	2	14.3 %	3	37.5%	1	8.3%	1	9.1%
	VMMC	0	0.0%	4	66.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Antenatal	1	7.7%	1	16.6%	1	2.4%	0	0.0%	0	0.0%	2	16.7%	8	72.8%

FGD participants in all countries typically viewed integrated HIV/SRHR services as a benefit to them and thus relevant to their circumstances. FGD participants reported increased access to services and information. They highlighted the proximity of multiple services as well as the opportunity to learn about the benefits of integrated services, not only for themselves but also their partners and families.

FGD participants noted that integration led to strengthened privacy and confidentiality procedures at facilities, which reduced stigma and discrimination toward PLHIV. This included more private reception procedures in waiting rooms and provision of HIV testing and counselling (HTC) services by all providers in all rooms. They also noted that providers were doing a good job sensitising the community

about HIV such that stigma and discrimination have been reduced within communities as well as facilities. However, FGD participants reported that some clients in one country were apprehensive about seeking HTC and STI services because the doors of the clinics' rooms were labelled with the services provided including a room for HTC. Male clients reported that men are afraid of going in this room and being seen by other people in the community.

Key informants echoed the benefits reported by clients in terms of availability of multiple services in one facility or on one day, as well as reduced stigma and discrimination and ease of navigation. Key informants also described increased opportunities to provide comprehensive care to PLHIV and to provide client-centred, rather than objective-focused, care.

Recommendations

UNFPA and UNAIDS country and regional representatives should continue their efforts to advocate for policies, programmes and services to integrate HIV and SRHR because integrated services are relevant to:

- **strengthening the countries' health system and achieving the sustainable development goals.; and to**
- **individual clients' healthcare needs**

The desk review and KIIs suggest that the project was relevant to the seven countries and the broader SADC region, contributing to changes in the discourse about linking HIV and SRHR primarily through integration into existing policies, guidelines or other documents, rather than creating new policies. Previously, there had been no linkages between HIV and SRHR at the national level, partly due to separate funding streams supporting different activities.

UNFPA and UNAIDS at regional and country level, together with the Governments of Sweden and Norway and the EU, should advocate with bilateral and multilateral donors to move from funding vertical HIV and SRHR interventions to integrated service delivery at the national level.

MOHs should scale up integrated HIV and SRHR services using various entry points, such as youth friendly clinics, family planning; maternal, child and women's health and primary healthcare because clients visit health facilities for a variety of reasons.

Health care providers should offer integrated HIV and SRHR services to all clients that visit health facilities, irrespective of the nature of the services they are seeking to as:

- **one means of generating demand for integrated services; and as**
- **a means to ensure that health risks are detected early, that clients are provided with appropriate treatment, and to ensure that no-one is left behind.**

Less than a third of clients in all countries reported that they receive additional services, and the additional service most commonly reported was that of HTC. This suggests that when clients are offered an additional service they more inclined to take up the service. This is supported by the client exit interviews and FGDs where clients reported that integrated HIV/SRHR services are relevant to their needs. A first step to scaling up integration may be through family planning and primary health care services as they are a common entry point for clients in some countries. This could also assist countries in reaching the United Nations' (UN) Sustainable Development Goal 3, to "Ensure healthy lives and promote well-being for all at all ages."

5.2 *Effectiveness of the HIV/SRHR Linkages Project*

As noted in the overview of the evaluation, the evaluation measured the extent to which the project achieved HIV/SRHR linkages at the policy, system, and service delivery levels and other results areas. The effectiveness of the project in terms of policy and systems has already been discussed under the

Relevance section. In this regard, it may be presumed that if national governments found linkages to be relevant and if the project was successful in advocating for changes in national SRHR and HIV policies, then the project has been effective in these areas.

Thus, the results below focus on the effectiveness of the project in terms of service delivery. In this regard, the effectiveness of linkages between HIV and SRHR is expected to improve health outcomes by increasing awareness of and demand for integrated services, improving access to and uptake of those services, and increasing the quality of those services.

Service Delivery

Access to Services

One of the objectives of the evaluation was to measure the degree to which the project was effective by examining the extent to which it contributed towards increasing access to services. Each country implemented different models in 52 health facilities that participated in the piloting of the project between 2011 and 2015. Botswana tested three models. These include the "kiosk" model at health posts and smaller clinics, where services are provided by a single health care provider in the same room; the "supermarket" model at larger clinics, where services are provided in a number of rooms by different health care providers; and the "mall" model at hospitals, where clients are referred to different rooms within the same health facility to be provided different services by different health care providers.

Key informants reported that the project strengthened the package of services offered at facilities. The service package offered at facilities in each country varied, but typically comprised of SRHR services such as family planning, antenatal care, labour and delivery, postnatal care, child welfare. It also included STI testing and treatment. HIV services included provider-initiated testing and counselling (PITC), HTC, prevention of mother-to-child transmission (PMTCT) of HIV, HIV prevention (e.g., condom provision), care and treatment, and psychosocial support. In three countries, NGOs operated mobile clinics that provided a selection of these integrated services.

Key informants highlighted that prior to the project most facilities in all seven countries did not offer the entire package of integrated HIV and SRHR services and did not systematically refer clients to those services in facilities that did. Rather the package comprised of a smaller set of verticalised SRHR and/or HIV services and often delivered in separate rooms. Some services such as ARV dispensing were only offered on specific days.

The project contributed towards standardising a core package of HIV and SRHR services that were offered to clients in all seven countries. In six countries, providers delivered these services on all days that the facility was open, in the same room, and by the same provider. In larger facilities, clients were referred internally for services typically on the same day. Three countries, integrated their pharmacies and dispensaries within the services being offered, allowing clients to receive all their services and medications at the same location on the same day. However, in one country, this had an unintended consequence of female clients not collecting their STI medication from the hospitals pharmacy because the lines became too long. This happened even though the pharmacy prioritised clients who came for HIV/SRHR services.

Uptake of Services

The extent which the project was effective can be measured through the degree to which it helped to increase the uptake of services. In Swaziland the counselling and support to clients who had experienced gender-based violence (GBV) increased from 49 in 2010 to 5,340 survivors in 2015[13], according to a desk review of the final narrative report for the regional project.

[13] Final Report Narrative - Phase 1: 2011-2015, UNAIDS/UNFPA joint project on "Linking HIV and Sexual and Reproductive Health and Rights in Southern Africa" (2016)

Service utilisation data collected by participating facilities in Malawi (Exhibit 7) and Swaziland (Exhibit 8) show an increase in the uptake of integrated services SRH/HIV in almost all services. In Malawi the project contributed towards a sharp increase in female clients being screened for reproductive cancers, receiving information and communication programmes and a large increase in the number of youth attending adolescent and youth programmes. The declines in GBV cases and post-abortion care may require further research as it could be as a result of improved community outreach, referral and service delivery, including the provision of contraceptives and condoms. However, alternately, the reduction could be attributed to under reporting of GBV cases and of provision of post-abortion care, but regardless, these are two important indicators in which a decrease indicates improved SRHR in Malawi.

Exhibit 7. HIV and SRH Services Provided in Malawi, 2012–2014

Indicator	2012	2014	Percentage Increase
SRH Services			
Number of family planning services provided	16,415	22,523	37%
Number of women registered in antenatal clinics	12,317	15,557	26%
Number of women delivered by skilled attendants	6,374	8,709	36%
Number of women provided with postnatal care	4,572	8,505	86%
Number of breastfeeding women	3,173	6,217	96%
Number youths attending adolescent and youth programmes	9,782	19,673	101%
Number of women provided with post-abortion care	75	67	-11%
Number of GBV cases treated	13	7	-46%
Number of clients screened for reproductive cancers	20	155	675%
Number of STI cases treated	1,759	2,514	43%
Number of clients under IEC/behaviour change intervention campaign (BCIC) programmes	4,036	10,633	163%
HIV Services			
Number of women enrolled in PMTCT	469	931	99%
Number of HIV tests performed	19,459	21,858	12%
Number of HIV tests performed through PITC	2,876	7,480	160%
Number of clients on ART	2,140	2,867	34%
Number of paediatric clients on ART	136	173	27%
Number of STI syndromic cases treated	1,463	2,097	43%
Number of clients provided with psychosocial support	1,419	3,013	112%
Number of clients in BCIC programme	4,092	10,696	161%
Number of condoms provided	193,083	213,371	11%

Service utilisation data averaged across the five COEs in Swaziland (Exhibit 8) show that the project positively contributed towards improved health outcomes between 2011 and 2015. Of significance is the huge increase in the uptake in HTC by clients accessing family planning services which can be attributed to the effective integration of HTC into family planning services.

Exhibit 8. Service Utilisation at Five Model Centres of Excellence in Swaziland, 2011–2015

Indicator	2011	2015	Change
Percentage of pregnant women who knew their HIV status	95.0%	99.6%	4.6%
Percentage of antenatal care attendees tested for syphilis at first antenatal care visit	71.4%	94.8%	23.4%
Number of eligible women seeking family planning who were tested for HIV	13.8	203.6	189.8%
Percentage of women living with HIV who received ARV to prevent mother-to-child transmission (Includes azidothymidine and ART)	86.2%	98.4%	12.2%

The extent to which countries were able to reach their targets in integrating HIV and SRHR services indicates the effectiveness of the project in reaching its objectives. Botswana exceeded its HIV/SRHR

target (eight) for the number of health facilities providing integrated comprehensive HIV and SRHR services by rolling out integrated services in nine facilities. In Swaziland, the project increased the:

- number of model sites becoming Model COEs for HIV/SRHR integration (output indicator) from 0 to 5, and
- percentage of SRH/HIV integrated services provided by each of the Model COEs from 59.2% to 95% (output indicator).

Malawi exceeded its targets for increasing the number of CSOs—including PLHIV and key population groups—supported (from seven to nine) and for ensuring CSOs, PLHIV, and representatives of key populations are meaningfully engaged in consultations and processes (from four to seven).

Impact and outcome indicator data[14] in different countries points to successes in increasing the percentage of young women and men aged 15–24 who (1) both correctly identify ways of preventing the sexual transmission of HIV and (2) reject major misconceptions about HIV transmission or prevention". The data also show increases in:

- antenatal care coverage,
- contraceptive prevalence rate,
- number of women tested for HIV in family planning sites at the COEs, and
- percentage of people who know their HIV status.

These indicator data show decreases in the:

- percentage of pregnant women aged 15–24 testing HIV positive,
- HIV prevalence among pregnant women 15 to 24 years old,
- syphilis prevalence among pregnant women,
- young people['s] (15–24) HIV prevalence,
- adolescent birth rate, and
- unmet need for family planning.

Countries did not meet targets relating to social and behavioural outcomes, which may require further attention to be given to strengthening community-based systems and approaches to meet these targets. These targets include:

- percentage of young people aged 15–24 reporting the use of a condom during the last sexual intercourse with a non-marital, non-cohabiting sex partner in the last 12 months;
- percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months reporting the use of a condom during last sexual intercourse; and
- proportion of population with advanced HIV infection with access to antiretroviral drugs.

Key informants in all seven countries reported increases in uptake of services as a result of HIV/SRHR integration. Key informants suggested more:

- clients seeking HIV prevention and testing; family planning, prenatal care, and other reproductive services; and
- sex workers and other members of key populations were accessing integrated services due to perceived reduced stigma and discrimination.

They also suggested that increased uptake of services led to decreases in rates of teen pregnancy, home births, TB, and/or default on ARVs. Key informants also reported a decrease in the frequency of visits by each patient and fewer missed opportunities for services.

[14] As noted before, some Indicators represent national level data to which the project's efforts may have contributed but because other programmes were also being implemented simultaneously, any target achievement for these indicators cannot be attributed solely to the project.

Despite gains in the reduction of stigma and discrimination, several key informants in one country mentioned that men negatively affect women's uptake of services, because they did not want their wives to be seen at the clinics in case anyone thought they were accessing stigmatised services such as HIV treatment. It was highlighted that men do not access HIV and SRHR services at the clinic as much as they should as:

- they do not want to wait in long lines;
- are more likely to visit traditional healers; and
- wanted to be treated by older men like themselves, especially for ART provision, as they do not believe that women or young people understand their problems.

Reasons for Increased Uptake of Services

Client and provider satisfaction surveys conducted in 2013, 2014, and 2015 in five of the seven countries do not clearly indicate whether the project led to an increased number of clients seeking integrated services, as these were single-point-in-time surveys.

Similarly, based on the findings from the client exit surveys undertaken for this evaluation, we were unable to determine whether the provision of integrated services impacted the uptake of services, as these too are single-point-in-time surveys. Findings do show that most clients were able to receive the services they came for, and just under a third reported receiving additional services, with HTC being the most common.[15] This suggest that offering clients additional services does lead to an increase in the uptake of services by clients. However, greater efforts are required to broaden the range of additional services offered and for more efforts to be made to increase the percentage of clients receiving HTC as an additional service. Nonetheless, the fact that most report receiving HTC as the additional service is a promising start.

Key informants suggest that the increase in uptake of services was due to the following reasons:

- Increased number of services being provided at facilities
- New, client-centred approaches applied by health care providers
- Increased client privacy regarding the delivery of services (presumably because HIV clients no longer queued separately from other clients)
- Community sensitisation efforts

Other key informants suggested urbanisation, an increase in the overall disease burden, widened catchment areas, and patients from outside the catchment areas coming to seek integrated services played a role in uptake of services.

Client Awareness of Integrated Services

The extent to which clients are aware that additional services are available is another important measure of effectiveness, regardless of whether they request those services or not. The client exit interviews (Exhibit 9) show that while less than a third reported receiving more than one service, 62% of all clients, and 44% of all female clients were aware of other services they could request beyond that which they sought and received. The most commonly referenced additional services that male and female clients were aware of that they could receive was HIV testing (17.9% for males and 58.6%% for females), family planning services (11.4% for males and 62.4% for females) and ARVs/ART (11.4% for males and 36.5% for females).

Exhibit 9. Client Exit Interview—Awareness of Integrated Services

			Botswana (N=59)		Lesotho (N=21)		Malawi (N=41)		Namibia (N=40)		Swaziland (N=36)		Zambia (N=48)		Zimbabwe (N=18)	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%

[15] This question was not asked as part of the client satisfaction surveys conducted in the five countries.

Awareness of Integrated Services	Yes	M	8	13.5%	4	19.0%	9	22.0%	6	15.0%	0	0.0%	19	39.6%	1	5.3%
		F	31	52.5%	11	52.4%	31	75.6%	4	1%	23	63.9%	5	10.4%	11	57.9%
		Total	39	65.0%	15	71.4%	40	97.6%	10	25.0%	23	63.9%	24	50.0%	12	63.1%

Exhibit 9. Client Exit Interview—Awareness of Integrated Services, Continued

			Botswana (N=59)		Lesotho (N=21)		Malawi (N=41)		Namibia (N=40)		Swaziland (N=36)		Zambia (N=48)		Zimbabwe (N=18)	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Other Services of which Clients were Aware	HIV testing	M	11	18.6%	6	28.6%	8	19.5%	4	1%	2	5.6%	14	29.2%	1	5.3%
		F	38	64.4%	14	66.7%	22	53.7%	32	80%	18	50%	16	33.3%	14	77.8%
		Total	49	81.7%	20	95.2%	30	73.2%	36	90.0%	20	55.6%	30	62.5%	15	78.9%
	Family planning	M	5	8,5%%	3	14.3%	4	9.8%	4	1%	3	8.3%	10	20.8%	1	5.3%
		F	30	50.9%	14	66.7%	28	68.3%	30	75%	24	66,7%	28	58.3	10	52.6%
		Total	35	58.3%	17	90.9%	32	78.0%	34	85.0%	27	75.0%	38	79.2%	11	57.9%
	ART/ ARV	M	7	11.9%	0	0.0%	8	19.5%	4	1%	0	0.0%	2	4.2%	1	5.3%
		F	28	47.5%	2	9.5%	22	53.7%	28	70%	7	27.8%	3	6.3%	11	57.9%
		Total	35	58.3%	2	9.5%	30	73.2%	32	80.0%	7	27.8%	5	10.4%	12	63.1%
	Antenatal care	M	5	6.5%	0	0.0%	7	17.1%	3	0.8%	0	0.0%	10	20.8%	0	0.0%
		F	30	50.9%	7	33.3%	21	51.2%	24	60%	0	0.0%	3	6.3%	10	52.6%
		Total	33	55.0%	7	33.3%	28	68.3%	27	67.5%	0	0.0%	13	27.1%	10	52.6%
	STI screening	M	7	11.9%	1	4.8%	5	12.2%	2	0.5%	1	2.8%	9	18,8%	0	0.0%
		F	26	44.1%	13	61.9%	4	9.8%	17	42.5%	6	16.7%	8	16.7%	10	52.6%
		Total	33	55.0%	14	66.7%	9	22.0%	19	47.5%	7	19.4%	17	35.4%	10	52.6%
	Child welfare	M	4	6.8%	0	0.0%	3	7.3%	3	0.8%	0	0.0%	5	10.4%	1	5.3%
		F	33	55.9%	0	0.0%	3	7.3%	28	70%	0	0.0%	3	6.3%	0	0.0%
		Total	37	61.7%	0	0.0%	6	14.6%	31	77.5%	0	0.0%	8	16.7%	1	5.3%
	Other	M	2	3.4%	2	9.5%	1	2.4%	2	0.5%	0	0.0%	6	12.5%	2	11.1%
		F	14	23.7$	0	0.0%	2	4.9%	4	1%	5	13.9%	11	22.9%	13	72.2%
		Total	16	26.7%	2	9.5%	3	7.3%	6	15.0%	5	13.9%	17	35.4%	15	78.9%
	VMMC	M	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
		F	0	0.0%	6	28.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
		Total	0	0.0%	6	28.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Although the sample size is small, which limits the generalisability of the findings, the client exit interview data show that male clients are significantly less aware of the availability of integrated services than female clients. Across all countries males reported not being aware of VMMC services available to them, while only in Lesotho did female clients report awareness of VMMC services. Close to 30% of male clients in Zambia (29.2%) and 30% of male clients in Lesotho (28.6%) knew that HTC was provided, while less than 20% of male clients reported being aware of HTC services available to them in the other countries. In four countries less than 5% of men reported being aware of ART, in two countries more than 10% of male clients knew of ART and in only one country did more than 20% of men know of ART.

Sources of Information about Services

Exhibit 10. Client Exit Interview—Sources of Information About Services

		Botswana (N=59)		Lesotho (N=21)		Malawi (N=41)		Namibia (N=40)		Swaziland (N=36)		Zambia (N=48)		Zimbabwe (N=18)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Source of Information on Services	Doctor or nurse	42	70.0%	6	28.6%	33	80.5%	13	32.5%	14	48.3%	31	64.6%	10	52.6%
	Friend or family member	6	10.0%	5	23.8%	6	14.6%	8	20.0%	11	37.9%	16	33.3%	3	15.8%

Exhibit 10. Client Exit Interview—Sources of Information About Services															
		Botswana (N=59)		Lesotho (N=21)		Malawi (N=41)		Namibia (N=40)		Swaziland (N=36)		Zambia (N=48)		Zimbabwe (N=18)	
	TV or radio	9	15.0%	11	52.4%	1	2.4%	9	22.5%	1	3.4%	1	2.1%	0	0.0%
	Other	2	3.4%	1	4.8%	3	7.3%	5	12.5%	1	3.4%	3	6.3%	1	5.3%
	Pamphlet, brochure, or poster	0	0.0%	0	0.0%	0	0.0%	5	12.5%	2	6.9%	4	8.3%	1	5.3%
	NGO/CSO	1	1.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4	21.1%

Where and how clients obtain information about integrated services can provide insights into effectiveness. The client exit interviews show that health care providers are the primary source of information on services (Exhibit 10), with family members and TV and radio as the next two most often cited sources. However, in terms of primary sources at the country level, it is important to note that for Lesotho, a project-funded TV and radio campaign was most often cited as the primary source of information about services.

The findings from the client exit interviews are supported by the findings from the FGDs. Clients in FGDs typically could list most if not all of the services provided by their facility, and could speak to the benefits of those services, even if they did not access those services themselves. Clients in FGDs cited health care providers' morning health talks at each facility as a significant source of information on integrated services, but also reported hearing about integrated services via TV/radio and workshops, conversations with friends and family, and talks with traditional leaders.

Demand Generation for Services

Several countries reported achieving or exceeding targets for outcome indicators associated with the production and dissemination of awareness campaigns and materials. Malawi reported exceeding their target associated with engaging men in SRHR services as "male motivators" (target of 45 versus 100 achieved) while Zambia reported reaching 700 men "via training and awareness-raising activities, engaging men as "ambassadors of change (influencers) for integrated sexual reproductive health services, including prevention of GBV via denouncement of sexual and GBV within "Men Engagement Network" zones/districts.

Key informants reported that partnering with local NGOs was a key strategy for demand creation for integrated services. These partners used sporting events, community meetings as approaches used to sensitise youth and key populations and to promote male involvement in HIV/SRHR programmes. Key informants reported health care providers delivering in-service presentations to other health care providers on working with the Lesbian, Gay, Transgender, Bisexual, Queer, Questioning, and Intersex (LGBTQI) community and NGOs that serve them helped to reach these populations and to generate demand.

All countries developed pamphlets banners to promote the uptake of services. Five countries used radio programmes to generate demand for services. Lesotho had a TV and radio campaign that significantly increased demand for services than any other source. In other countries, efforts to increase demand for integrated services via community sensitisation meetings were viewed as successful by key informants but this did not translate to any recognition among clients.

Unintended Consequences

Participants in a FGD in one country reported that integration of services resulted in the facility being overcrowded. In some facilities where services were integrated, clients who sought HTC and ARVs services waited in the same room as clients seeking other services, which increased fears of stigma and potential breaches in confidentiality. This may impede the ability of clients' to ask for certain services such as HTC or STI screening and treatment.

While the number of community mobilisation efforts to generate demand for integrated services increased, according to female FGD participants in one country, this had the unintended consequence of a bylaw being passed that required women to bring their male partners with them for antenatal care appointments. Women who could not bring their partners, or did not wish to, had to bring a letter from the village chief verifying that they were single. Female FGD participants felt that this was discriminatory and a violation of confidentiality.

Recommendations

MOHs should build upon the project to continue to provide and scale up the delivery of integrated HIV and SRHR services to other sites in each country as integrated services are effective in improving the uptake of and access to services.

MOHs in each country should strengthen the implementation of integrated HIV and SRHR services by developing a multi-pronged approach that supports CSOs to undertake community mobilisation and demand generation activities. These include using community media, distributing IEC materials, and promoting demand generation that is linked to integrated services. These activities will complement the efforts of health care providers in referring clients for available services. The client exit interviews suggest that in most countries, health care providers played the most important role in communicating to clients about available services. In only one country, a TV and radio campaign that was undertaken played a larger role in sensitising the community about the availability of HIV/SRHR services. This is in keeping with KIIs in all countries which suggested that IEC materials, media campaigns and efforts by CSOs played the greatest role in raising awareness of integrated services. Thus, multiple methods are needed to reach clients.

UNFPA, UNAIDS and MOHs should undertake additional research to understand the barriers to the uptake of services by men, their awareness and utilisation of such services and to use these findings to develop community mobilisation and demand creation efforts that promote the uptake of HIV and SRHR services that meet the needs of men. As discussed above, despite a small sample size, men's awareness of services was not high overall.

UNFPA, UNAIDS and MOHs should examine existing data collected by clinics that can be used to more effectively monitor and evaluate the uptake of integrated services at sites to better evaluate and differentiate the impact of the project from other similar initiatives. Data from the project indicators in various countries, even when limited by incomplete reporting, suggest that scaling up the provision and marketing of integrated services, may together with complementary programmes, result in improvements in national health outcomes. These include increased knowledge of HIV, antenatal care and contraceptive coverage, HIV testing and receipt of results, as well as concomitant decreases in HIV and STI prevalence, adolescent birth rates and unmet need for family planning. On the whole, this suggests that continued expansion of integrated services to other sites in each country, and to other countries in the region and beyond, can have similar impacts in terms of increased access to services and increased uptake of services. However, it is difficult to determine the level of attribution without better site level data.

UNFPA and UNAIDS should work with MOHs to standardize models of integration across countries and document models implemented at each site. Key informants at facilities in all countries often described their integrated facilities as 'one-stop shops' despite the fact that they employed different models of integration, which hampered comparisons across countries. Thus, standardizing models of integration or at least operationalizing the definitions of each model could allow for further research into which models best suit different national contexts.

Facilities should consult with their communities that they serve about how integrated services should be provided, to ensure quality and reduce stigma and discrimination. The project achieved mixed success in reducing stigma and discrimination—while clients and key informants in several

countries reported decreases in stigma and discrimination, in one country, they described concerns that stigma towards male and female clients was limiting access to HIV services. They also expressed concerns about local legislative changes that may violate privacy and confidentiality. Consulting with clients from the surrounding communities about implementation could help facilities avoid unintended consequences of integration in terms of stigma and discrimination.

5.3 *Efficiency of the HIV/SRHR Linkages Project*

A third area of investigation for the evaluation is understanding the extent to which project resources (human, time, financial, etc.) were used to achieve results, in other words, to determine how funding, personnel, administrative arrangements, partnerships, governance arrangements, time, and other inputs, including infrastructure, commodities and supplies, contributed to or hindered the achievements of results, In this regard. Linkages between HIV and SRHR are expected to improve health outcomes, streamlining services and reducing duplication of efforts; increasing the efficient utilisation of human resources and cost effectiveness. The effectiveness achievements described in the previous section are examined below in terms of the level of resources expended to make those achievements, including human, time, and financial resources. Where possible, changes in effectiveness are also discussed in relation to funding from the EU and the Governments of Sweden and Norway for related activities to identify efficiencies. However, as noted previously, the structuring of budget reporting for EU and the Governments of Sweden and Norway funding may limit the inferences that can be made.

Service Delivery

Infrastructure, commodities and supplies

Key informants described how the project helped facility staff maximise limited resources and deliver integrated HIV and SRHR services more efficiently through the procurement of facility equipment and, in some instances, renovations to facilities. In two countries, funds were used to support CSOs to procure mobile clinics.

Key informants reported that following commodities and equipment were procured using EU and/or Governments of Sweden and Norway funding: condoms, HIV test kits, hemoglobinometers, ultrasounds, sterilisers, speculums, pelvic exam equipment, weighing scales, delivery beds, blood pressure cuffs, Pap smear specimen holders, suction devices, trolleys, Loop Electrosurgical Excision Procedure machines, cameras, acetic acid for visual inspection with acetic acid and cervicography, and computers and scanners for capturing data.

Counselling flip charts and IEC materials, such as brochures, posters, billboards and banners, were also procured to support counselling with clients and community mobilisation efforts.

Facility renovations included re-tiling, painting the interior and exterior walls, doors, and signage to display list of services, as well as additions to those facilities (e.g., PortaCabins). Furniture procured included beds, mattresses, cabinets, room dividers, and couches. These improvements helped to make services more client friendly and visible to clients. Additionally, funds were used to obtain supplies such as blankets and shawls for waiting mothers.

Six of the seven countries listed indicators specific to infrastructure to support HIV/SRHR linkages in their log frames. However, only two countries reported complete data for infrastructure-related indicators. One country achieved its target of procuring two PortaCabins and MOH-printed flowcharts. However, indicators specific to the procurement of equipment, furniture, and consumables to support HIV/SRHR linkages interventions were not enumerated and therefore could not be verified. The other country planned to renovate three facilities so these facilities could provide integrated services. However, the country did not achieve this output in even one facility of the three planned.

Key informants reported that infrastructure upgrades and renovations helped to do the following:

- Increase client access to facilities offering integrated services that were closer in proximity to where they lived.
- Expand the number of consultation rooms available to providers. This allowed providers to be assigned to a single consultation room and eliminated the need for them to move between rooms to deliver services that helped to ensure client confidentially and privacy. This is supported by the findings from one satisfaction survey, in which providers reported that stigmatisation of clients decreased.

Despite the investments in infrastructure, a number of infrastructural challenges were highlighted by KIIs including the following:

- While key informants noted an increased number of consultation rooms within facilities, only a small proportion of providers who participated in client and provider satisfaction surveys reported a similar increase. Most providers in the client and provider satisfaction survey reported that consultation space had decreased as a result of facility improvements and that this was a large constraint to ensuring privacy and reducing stigma and discrimination.
- In three countries, FGD participants reported that the newly renovated rooms were too small and more consultation rooms were needed. In one country, FGD participants reported that waiting rooms did not have a private reception area. As a result, clients could not confidentially request services, which opened them up to potential stigma and discrimination.
- Similarly, in some facilities in one country, certain HIV services were clearly marked on the doors of specific consultation room. While this had been done because those rooms were assigned to only providers trained to deliver these services, this led to concerns about privacy and confidentiality and, as a result, stigma and discrimination.
- Providers could not keep the drugs they needed to address all HIV/SRHR-related medical conditions in their consultation room as there was no temperature control that could lead to the medication expiring. This led to clients having to go to pharmacies for prescribed medication, some of which had separate queues for ARVs that may increase the potential for stigma and discrimination.
- While some facilities supported by the project in one country reportedly installed solar panels with project funding to mitigate power outages, FGD participants there were too few solar panels to provide an adequate supply of energy. FGD participants and key informants reported that there was a lack of transportation to take clients to referral facilities and to transport samples to reference laboratories. However, in one country, key informants reported leveraging the blood and tissue sample transport system created for rural facilities when the country adopted Option B+. This transport systems allows district hospitals to collect blood samples for HIV testing every fortnight, rather than requiring clients to travel to the district, which might be multiple hours away. It was noted that confirmatory HIV testing is now done at facilities, which eliminates the step of clients having to travel to another facility to complete this test.

Supply Chain

The project leveraged support from UNFPA's GPRHCS programme to ensure HIV/SRHR commodities were available in all seven countries. One country supported by the project that participated in the GPRHCS programme reported "0% of health facilities reporting HIV-SRHR commodities stock-out during last reporting cycle." In another country, key informants did not report drug stock-outs, despite the fact that many facilities had not received backup stocks of drugs.

KIIs and FGD participants in two countries reported stock-outs of supplies for family planning. In one of these two countries, facilities also experienced stock-outs of HIV test kits. Key informants reported that health care providers had overcome the issue of HIV test kit and family planning supplies stock-outs by borrowing from neighbouring facilities. However, this is not a sustainable solution, and may warrant further attention from MOH and partners to ensure that integrated facilities change their ordering

processes accordingly. In another country, key informants reported that the lack of HIV test kits in some facilities may have discouraged clients from seeking HIV testing.

This may be an un-intended consequence of integrating HIV and SRHR services. Key informants reported that providing integrated services translates to greater demand for services, which may have resulted in providers using supplies more rapidly than expected, leading to stock-outs.

Client Perspectives

Service Delivery Time and Quality

It is important to understand how clients, as the recipients of integrated services, viewed those services. Understanding client perceptions can provide insight into the extent to which integration efforts, promoted through the project, helped to increase overall efficiency of services. The client satisfaction surveys conducted in six of the seven countries suggests clients perceive that integration helps to improve service delivery quality. The Botswana client satisfaction survey showed that most clients (1) preferred receiving HIV and SRHR services at the same facility (73.6%) and (2) were satisfied with the quality of services they were receiving (82.7%). Findings from the same survey suggest that the most important benefits of integration were reduction in trips to the facility was (57.1%) and the opportunity to receive additional services (41.2%).

The 2014 Malawi clients and service providers satisfaction survey findings found that 35% clients waited less than one hour to see a service provider, and most clients (67%) preferred receiving integrated HIV and SRHR services from the same service provider. Receiving integrated services delivered by one provider:

- reduced the number of trips to the facility,
- improved efficiency of services,
- reduced waiting time,
- provided an opportunity to access additional services, and
- helped to reduce HIV-related stigma clients experienced within a facility.

The Namibia client satisfaction survey showed that clients reported similar benefits to receiving integrated services from the same provider at one time, and also showed a strong relationship between client satisfaction and the provider speaking a language that the client understood very well. Further, according to the provider component of the survey, health care providers reported that cost of services for the client did not increased.

However, data from satisfaction surveys conducted in other countries also point to key challenges resulting from integration that impacted clients' perception of quality. The 2015 Botswana client satisfaction survey revealed some disadvantages clients reported in receiving HIV and SRHR services from the same facility at one time:

- Overwhelmed service providers
- Increased in wait times
- Decreased service quality

In Swaziland, the 2013 patient and provider satisfaction survey showed that the majority of clients (85%) reported that integrating SRH and HIV services increased the time spent waiting for services due to staff shortages. Wait times exceeded three hours for the majority of clients. Survey respondents also reported long queues, lack of empathy, and a lack of customer service.

In contrast to the mixed picture that the client and provider satisfaction surveys provide, data from the client exit interviews conducted for this evaluation tell a more positive story. In terms of the relative value of receiving integrated services (Exhibit 11), those clients who were aware of integrated services typically

reported them as being better or much better (68.2%), and most attributed this to reduced wait times (52.3%). Further, most respondents reported that services were good or very good (85.8%) and that they did not have to wait for more than an hour to receive services (65.9%).

Exhibit 11. Client Exit Interviews—Perceptions of Services															
		Botswana (N=59)		Lesotho (N=21)		Malawi (N=41)		Namibia (N=40)		Swaziland (N=36)		Zambia (N=48)		Zimbabwe (N=19)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Relative Value of Receiving Integrated Services in One Visit	Much Worse	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Worse	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	9.5%	0	0.0%	0	0.0%
	Neither better nor worse	0	0.0%	1	6.7%	12	30.0 %	0	0.0%	1	4.8%	0	0.0%	3	15.8%
	Better	11	28.2%	0	0.0%	15	37.5 %	0	0.0%	2	9.6	8	34.8%	3	15.8%
	Much better	28	71.8%	14	93.3%	13	32.5 %	10	100.0 %	15	71.4 %	15	65.2%	13	68.4%
Reason for Rating	Reduced wait times	21	55.3%	10	66.7%	16	71.8 %	9	90%	28	84.8 %	11	47.8%	4	21.1%
	Reduced costs	9	23.7%	4	26.7%	6	15.4 %	0	0.0%	1	3.0%	9	39.1%	12	63.2%
	Doctor/nurse providing services	8	21.1%	1	6.7%	4	10.3 %	1	10%	4	12.1 %		34.8%	1	5.3%
	Other	0	0.0%	1	6.7%	5	12.9 %	0	0.0%	0	0.0%	1	4.3%	2	10.5%
Quality of Services Received	Poor	0	0.0%	0	0.0%	0	0.0%	2	5.1%	2	5.6%	0	0.0%	0	0.0%
	Bad	5	8.3%	0	0.0%	0	0.0%	5	12.8%	0	0.0%	0	0.0%	0	0.0%
	Just okay	5	8.3%	1	4.8%	0	0.0%	7	17.9%	4	11.1 %	1	2.1%	1	5.3%
	Good	17	28.3%	2	9.5%	15	36.5 %	6	15.4%	7	19.4 %	10	20.8%	8	42.1%
	Very good	33	55.0%	18	85.7 %	26	63.4 %	19	48.7%	21	58.3 %	37	77.1%	10	52.6%
Wait Time	Did not have to wait	15	25.4%	2	9.5%	18	43.9 %	1	2.6%	20	55.6 %	8	16.7%	2	10.5%
	Less than 1/2 hour	7	11.9%	12	57.1 %	8	19.5 %	4	10.3%	2	5.6%	33	68.8%	5	26.3%
	1/2 hour to 1 hour	21	35.6%	1	4.8%	4	9.8%	3	7.7%	1	2.8%	2	4.2%	0	0.0%
	1–2 hours	7	11.9%	2	9.5%	6	14.6 %	13	33.3%	5	13.9 %	4	8.3%	2	10.5%
	2+ hour	8	13.6%	4	19.0 %	4	9.8%	17	43.6%	8	22.2 %	1	2.1%	7	36.8%
	Don't remember	1	1.7%	0	0.0%	1	2.4%	1	2.6%	0	0.0%	0	0.0%	3	15.8%

The findings on time and quality of integrated from the client exit are, for the most part, supported by the findings from the KIIs. Key informants suggested that the quality of services delivered improved since integration, attributing these improvements to several factors:

- Decreased stigma and discrimination and increased confidentiality at integrated facilities versus at non-integrated facilities as a factor, also noted by clients. This resulted in more members of key populations accessing services.

- In one country, key informants cited the opportunity for clients to receive services in the language of their choice and consistently from one provider as factors that contributed to improved service delivery quality. Those clients who were attended to by a provider who spoke a language they understood well were more likely to be satisfied than those who could not understand the provider.
- The perceptions that facilities were "one-stop" and therefore more client-centred.
- Increased efficiency on the part of individual health care providers to improved service delivery quality.
- The availability of more services that could be delivered.

In some instances KIIs acknowledged that wait times may actually have increased because providers spend more time with each client as they offer more services. In one country KIIs suggested that a potential reason clients were initially dissatisfied with waiting times because they did not understand what was happening inside the rooms, and believed providers were wasting time. Once they were able to receive and understand how integrated services were delivered, they were more satisfied.

While the findings on time and quality from the client exit interview and KIIs are mostly positive, the findings from FGDs tell a more nuanced story. In terms of time, some FGD participants reported shorter waiting times but others reported longer wait times. A shortage of providers and increased demand for integrated services led to increased congestion at facilities resulting in longer wait times, and clients having to put aside their daily work.

FGD participants also shared concerns about the time of day when services are offered. In one country, male clients wanted services offered late in the day, or at night so women would not see them at the clinic. The lack of availability of services during non-traditional hours discouraged men from accessing available integrated services.

FGD participants described several perceived benefits of integration that improved the quality of services delivered. Clients at facilities with integrated pharmacies that were able to receive all of their drugs in one place (e.g., a dispensary) saw this as a positive benefit. FGD participants reported that stigma and discrimination decreased and confidentiality increased among providers. This allowed for clients to freely consult with their providers on HIV/AIDS and SRHR-related issues. Clients noted that since these services are integrated, no one would know the type of service they came in for, which also reduced stigma and discrimination.

FGD participants described a few challenges that influenced client perceptions about the quality of services delivered. These included:

- Drug stock-outs in some facilities, particularly for STI drugs that could be the result of increase demand for services. In these instances, clients were advised to purchase drugs from pharmacies or stores but could not afford to do so.
- In one country, participants suggested that health care providers may be overworked because they have to deliver more services and as a result the quality of services was diminished.

Cost Effectiveness

Exhibit 12 provides a summary of the findings regarding clients' reports on the cost of services.

Exhibit 12. Client Exit Interviews—Cost Effectiveness

		Botswana (N=59)		Lesotho (N=21)		Malawi (N=41)		Namibia (N=40)		Swaziland (N=36)		Zambia (N=48)		Zimbabwe (N=19)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cost of Services	Free	60	100.0%	6	28.6%	41	100.0 %	12	30.0 %	10	27.8 %	45	93.8%	19	100.0 %
	Less than $1	0	0.0%	4	19.0%	0	0.0%	28	70.0 %	19	52.8 %	0	0.0%	0	0.0%
	More	0	0.0%	11	52.4%	0	0.0%	0	0.0%	7	19.4	3	6.3%	0	0.0%

	than $1														
Cost of Transport	Free	47	78.3%	0	0.0%	26	63.3%	9	23.1 %	1	3.3%	44	91.7%	1	5.3%
	Less than $1	12	20.0%	14	67.7%	7	17.0%	21	61.5 %	26	86.7 %	3	6.3%	4	21.1%
	More than $1	1	1.7%	7	32.3%	6	14.6%	9	15.4 %	3	10.0 %	1	2.1%	15	78.9%
Other Costs	None	60	100.0%	18	85.7%	38	95.0%	22	61.5 %	25	83.3 %	48	100.0 %	13	68.4%

Most clients found services to be cost effective as they did not have to pay for services (70.7%) and those who did typically paid less than $1 USD (20.7%). In two countries, clients accessing services at NGO-run facilities indicated that they were willing to pay a small fee to access quality services. FGD participants in those countries indicated that they choose NGO-run facilities because they perceived services providers as more knowledgeable and less judgmental about HIV and SRHR-related issues. It is important to note, these fees did not increase as a result of the introduction of integrated services.

In one country, clients reported that they were required to pay for family planning medication and other prescription drugs at both government and non-government facilities. They did not have to pay for ARVs, however. The cost of prescription drugs did present economic hardships for clients, especially when clients were diagnosed with multiple health conditions that required multiple treatments.

A little over half of clients did not pay for transport services (51.6%), and those who did paid less than $1 USD (33.7%). Many clients reported walking to the clinic as the main means of transport. Participants highlighted that getting all their services in one clinic and at one time saves money because they do not have to travel from one clinic to another, or travel to the clinic on several different days during the week to access different services.

Provider Perspectives

Data from or about providers provide insight into the extent to which integrated services increased overall efficiency in terms service delivery time and capacity building.

Service Delivery Time

Key informants reported that integration improved service delivery time. A time-and-motion study conducted in one country revealed that the average consultation time following integration is one patient every 20 minutes, or three patients per hour, leading to a 115% increase in health care providers' productivity. Not only was service delivery much faster and more efficient but overall functioning improved and staff utilisation was maximised. However, findings from providers who participated in satisfaction surveys, are mixed. Some reported that time spent per client had increased and while others reported time had decreased or had not changed since integration.

Key informants reported that consultations for first-time clients may take longer. However, consultations for regular clients were shorter because they built on prior consultations and pre-existing relationships. This reduced the number of client visits, and in turn reduced the number of general consultations that providers had to do. Reducing the number client visits and consultations resulted in reduced congestion and better management of patient flow. It also resulted in more people being able to access services and health care providers being able to provide multiple services in one visit.

Capacity Building

The findings show several interrelated key staffing factors that impacted the efficiency of delivering integrated services, (1) the number of trained staff, (2) staff shortages, (3) task shifting, (4) workload, and (5) staff motivation.

Training. Firstly, it is important to note how funds were spent on training. As noted previously (Exhibit 2), 16.1% of funding from the Governments of Sweden and Norway went to health care providers' capacity building. In addition, it is plausible to presume that support from the Governments of Sweden and Norway for CSO models (34%) includes some capacity building and staff to support integration. The breakdown of EU funding does not specify any amounts spent on training.

KII reported that health care providers received training through the project to deliver integrated services with minimum referral. Training was followed up with mentorship and supportive supervision from district health offices.

Exhibit 13. Training Topics	
HIV/SRHR linkages and integration	VMMC and PMTCT
Interpreting results from Pap smears	Family planning methods and emergency contraception
ART initiation ARV interaction	Provision of services to men who have sex with men
Dried blood spot sampling	GBV awareness
Cervical and breast cancer screening	Monitoring, evaluation and reporting
Data collection and analysis	Intrauterine device insertion skills

Exhibit 13 above presents a list of training topics providers found helpful in building their capacity to deliver integrated services.

However, KII findings also describe a number of challenges:

- In-service trainings in many countries were only provided at the beginning of the project.
- In some cases, only senior nurses or one provider per facility attended these trainings. The assumption was that the provider attending the training would pass that knowledge on to other providers in their facilities. However, there does not appear to be a formal mechanism in place within facilities to ensure that this happens. Additionally, provider workloads often limits opportunities for them to do so.

As new health care providers came on board to replace staff who left or as new providers rotated into integrated facilities, there were few opportunities for them to receive formal in-service training on integration. New health care providers tended to receive ad-hoc, on-the-job training, either within their facilities or from district health officers. These training efforts were not as in-depth as the original in-service trainings. Key informants from three countries reported that government health officials are exploring ways to formerly incorporate content on service integration into existing in-service training curricula.

One capacity gap noted by key informants was the number of health care providers who could prescribe and dispense medication. In Namibia, health care providers could only prescribe the medications but not dispense them. In Botswana, there were a limited numbers of providers who are trained to prescribe ARVs; for some facilities this means infrequent visits by a physician to consult on ART.

Staffing Shortages. Key informants in all countries described staff shortages as a challenge to efficiency, which is not unique to the project, but rather an issue that impacts on the entire national health systems. Many facilities experienced high turnover rates among staff, from peer educators, to health care providers, to MOH staff, resulting in a loss of institutional knowledge and opportunities to transfer skills. The insufficient number of health care providers with the necessary skills required to deliver integrated services resulted in increased client consultation times and consequently longer waiting times for other clients. This was most apparent in rural and publicly funded facilities with limited numbers of staff, where patient flow can vary significantly from one day to the next. In one country, this meant that certain services such as ART initiation and follow-up could only be performed by a limited number of providers who were permitted to do so as part of their licensure.

Staffing shortages also occurred when one or more health care providers who received training on integrated services was unavailable because they were attending another training, on leave, or away for another reason. This meant that the remaining staff did not have the required skills to deliver integrated services as they were not trained. This resulted in clients not receiving services in a timely fashion, which led to decreased client satisfaction. This may have potentially caused clients to avoid accessing additional services at that facility or to avoid seeking those services altogether at any facility. Monthly staff rotations to different departments did help to increase the skills of health care providers, but rotating providers trained in integrated services with those who do not have the same skill set—also created strains.

Task shifting. Task shifting was used by countries to build the capacity of health care providers to deliver integrated services and to promote greater efficiency. Key informants noted that in some countries task shifting happened fairly consistently. However, in other countries task shifting only happened on an ad-hoc basis when providers were busy.

In two countries, health care assistants and lay counsellors were tasked with providing initial services to relieve the burden on higher-skilled nurses. In one country, lay counsellors in one facility would see antenatal clients for testing/consultation first so that the nurse knows their status before they arrive. In another facility, health care assistants provided child welfare care but would refer clients to higher-skilled nurses for family planning and immunisations. Nurses now can either follow up with clients themselves or have field promoters follow up on their behalf, especially those patients on medication for chronic conditions. In another country, nurses were trained not only to conduct rapid HTC and dried blood spot testing, but also trained to initiate ART Option B+ so they did not have to wait for physicians to do so. FGDs noted that most of their questions were answered during the health education session, prior to consultation with a nurse or doctor. When they met with a nurse or doctor they would discuss personal or sensitive issues confidentially.

Perceptions of Workload. Key informants reported that staff shortages resulted in increased workloads. This was especially the case when there were only a limited number of health care providers trained to provide integrated services. Providers who responded to the client and provider satisfaction surveys also reported that their workload had increased. Key informants in all countries except one noted that health care providers' workloads had temporarily increased as a result of integration, often without any additional financial compensation.

In three countries, a few key informants reported that their workloads had actually decreased. Key informants in these three countries explained that providers initially saw integration as adding to their workload. However, as they became more familiar with the concept and with delivering integrated services, their perceptions about their workload changed.

Some health care providers attributed their perceptions about increased workloads to additional responsibilities for checking the work of other providers as a means of reducing errors. Others attributed it to longer consultation time required to deliver multiple services. Increase workload was also attributed to increased reporting burdens. Providers must fill out a separate register for each type of service they provide or enter data by hand during consultations and then re-enter it into an electronic system, which is very time consuming. Given that health care providers are strapped for time, in some facilities community health workers (CHWs) were completing data entry activities. However, because CHWs have not received formal training on how to enter or clean data, data entry errors were frequent. This potentially impacted confidence in the data quality.

To address workload concerns, key informants reported that facility administration tried to leverage NGO staff supporting other projects funded by other bilateral donors. Others tried to use training on HIV/SRHR and other professional development opportunities as incentives that would motivate providers to take on additional workloads.

Staff motivation. Training, mentorship and other efforts to raise the awareness or build the capacity of service providers was one benefit that motivated staff to deliver integrated services. The impact of supervision varied, depending on the skills, experience, frequency of supervisor visits and activities conducted during those visits by the supervisor.

As a result of these efforts, key informants reported that staff shifted their mind-set, enabling them to see the importance of integrated services and consequently increased their willingness to take on more responsibility and accountability to deliver quality services. They reported that the more competent health care providers became, the more confident they were in delivering integrated services and the more satisfied they were with their jobs. This, increased clients' confidence in the services they were receiving. Key informants noted that when staff became demotivated, facility administration would try to overcome this by offering awards, focus on staff wellness, share feedback from clients, and nominate a performer of the month.

Tracking, Monitoring and Reporting of Integrated Services

It was unclear from the findings how the project created additional efficiencies regarding the tracking, monitoring and reporting of integrated services. All countries received M&E support from UNFPA and UNAIDS. UNFPA and UNAIDS helped all countries develop log frames (logical frameworks) and four countries develop harmonised tools.

However, key informants noted that the log frames were used more for donor reporting than M&E planning at the district and facility levels. Further, as noted in the evaluation design section of this report, indicator data were frequently incomplete, lacking a target, a 2015 achievement figure or data source corroborating the 2015 achievement.

During the project period, facilities in four countries developed and used harmonised data collection tools (e.g., Lesotho's Integrated Facility Reporting Form and Service Delivery and Postnatal Clinic Register that were used within an NGO supported facility) to streamline reporting processes. Facilities in the other three countries did not harmonise data collection tools, which resulted in providers having to track integrated services using multiple registers and forms. This created a huge reporting burden on providers who had to balance significant service provision tasks with administrative tasks as part of their day-to-day work. Some providers attempted to overcome this challenge by writing down additional services received in the margins of existing registers.

Key informants reported that linkage indicators included in log frames were not integrated into national M&E systems. Additionally, data from integrated facilities were collected but often not analysed due to staffing shortages and limited capacity. Key informants also reported that integration resulted in an increased number of M&E tools and indicators, creating additional reporting burdens for health care providers. Key informants noted that due to the lack of harmonised donor reporting requirements, health care providers experienced challenges reporting the linkage and other donor indicators. It is unclear from the findings as to what improvements were made to promote electronic data capturing methods.

Despite the above challenges, key informants reported the project did help to promote more robust and consistent documentation of service integration.

Recommendations

MOHs in each country expanding the implementation of integrated HIV and SRHR services should collaborate with external donors to support the renovation of facilities that will deliver these services. The findings suggest that renovated facilities improved the efficiency with which integrated services are provided, improved the quality of delivery of integrated services, especially in terms of reduction in stigma and discrimination, and decreased both cost and wait times for integrated services.

MOHs should involve local communities when planning for the renovation of facilities to deliver integrated HIV and SRHR services around space, privacy, and stigma and discrimination. Findings

around stigma and discrimination show that in some countries pharmacies still had separate ARV queues, and in one, HIV services were clearly marked on the doors of specific consultation rooms, which led to privacy and confidentiality issues thus potential stigma and discrimination. Therefore, when planning for broader implementation of integrated services in other sites in each country, planners should consider both the findings from this evaluation and also consult with community members in planning for facility upgrades, not only in terms of their space needs, but also their needs around privacy, confidentiality and prevention/reduction of stigma and discrimination.

MOHs should develop a human resources plan for health care providers to scale up the implementation of integrated HIV and SRHR services that does the following:

- **Prepare all health care providers to deliver all integrated services.**
  - **a. Offer comprehensive initial training for all providers.**
  - **b. If comprehensive initial training can only reach select providers at the district level or per facility**
    - **i. include training of trainer components in the comprehensive training so that those select health care providers can disseminate knowledge and skills to other health care providers they work with and/or**
    - **ii. provide annual, in-service, follow-up training on a rolling basis to reach all facilities.**
- **Incorporate task-shifting to reduce workload, for instance by engaging lay health workers in community follow-up, initial screenings and so forth, so that health care providers' workloads are more manageable and they can focus on delivery of services that require more technical skills.**
- **Minimise staff turn-over and rotation, and addresses staff motivation, such that trained staff are less likely to move away from facilities and thus contribute to shortages of staff trained to provide integrated services.**

Findings suggest that training and staff motivation are important factors that support providers' ability to deliver integrated services. However, staff motivation and the availability of trained staff are affected by other factors like staff rotation and shortages (which may be a feature of all national health systems in the region) and increased workloads (as a result of integration). Only in a few countries is this tension mitigated by task shifting.

MOHs in each country expanding the implementation of integrated HIV and SRHR services should collaborate with external funders to develop a robust M&E system that:

- **harmonises project indicators with national indicators, so that M&E data elements gathered by the project align with, feed into and support broader national M&E efforts;**
- **minimises reporting burden across multiple services; and**
- **maximises opportunities for using the data at different level (for programme improvement at the facility level, for commodity forecasting at facility and national levels, and for national level planning and allocation of resources) in order to encourage analysis and use of the data.**

Providers in most countries described a significant reporting burden, a lack of harmonisation of linkage indicators into national M&E systems and a lack of analysis of collected data, because of staff shortages.

Moreover, MOHs should renovate facilities and prepare providers to deliver integrated HIV and SRHR services where all services are provided by all providers in all rooms and where rooms are not marked according to services. This will ensure the provision of integrated services in the most efficient way possible and will result the greatest reduction in stigma and discrimination.

5.4 *Ownership of the HIV/SRHR Linkages Project*

This evaluation aimed to assess the ownership of the project by stakeholders at various levels in each country and the sustainability of the project beyond 2015, including assessing whether project

stakeholders in the seven project countries were likely to sustain interest and resources to continue with HIV/SRHR integration beyond the tenure of this project, taking into account the existing partnerships and the capacity required for maintaining consistent levels of delivering HIV/SRHR integration services.

This included exploring the extent to which stakeholders:

- developed a sense of ownership in terms of policy, service delivery, and documentation and dissemination of best practices; and
- at different levels reported that benefits from the project are likely to continue after completion, taking into account existing partnerships and the capacity required to maintain consistent levels of HIV/SRHR service delivery.

Policy

SADC has taken ownership and is providing leadership to the integration of HIV and SRHR at the regional level through developing the minimum standards for integrating SRH, HIV, TB, and Malaria, as well as a related strategy.

The point made earlier that at least 21 of the 29 national policy documents reviewed include language describing the alignment of HIV/SRHR linkages to national contexts, priorities and client needs is a clear indication of country ownership. At least one HIV and/or SRHR policy document for each of the seven countries address strategies or considerations for improving access to and uptake of integrated services, to reduce stigma and discrimination, which also point to country ownership.

Key informants reported high levels of passion and commitment for linking HIV/SRHR in each country. This included support from the permanent secretaries and division directors within the MOH. Countries demonstrated greater ownership through including HIV/SRHR integration within annual work plans and budgets, tied to the perception of the project's relevance to national priorities.

However, this passion and commitment did not always translate into active changes that supported integration between the highest and lowest levels. As a result, while services were integrated at specific facilities, they still tended to be siloed into different departments at the systems and even policy levels. Key informants reported delays in (1) review and revision of policies that could affect linkages; (2) funding that supported service integration; and (3) development and deployment of reporting systems that captured outcomes of linkages and integration efforts.

While political will to continue the project seems strong in all countries and at all levels within each country, key informants in most countries reported a disconnect between the high levels of political support/coordination and the actualisation of that support at the district or facility level. According to key informants, political will did not always translate into budget allocations robust enough to continue HIV/SRHR linkages/integration without external support. However, key informants may not have been aware of the resources that their governments were already committing to support integration. Thus, they suggested that external support was needed for a variety of reasons. This included—Namibia and Botswana transitioning to "middle-income" status and are anticipating lower levels of donor support; other countries reporting slow economic growth; and all countries facing multiple competing health priorities. In order to address these challenges, key informants suggested collaborating with the private-sector, for instance the mining industry to access funds to support health system changes, advocating in collaboration with the UN for additional funding from bilateral and multilateral donors, and engaging in continuous advocacy with stakeholders.

However, Botswana's successful development of a costed scale-up plan for integration within its 2015 Global Fund grant, stands as an example of how governments not only supported integration during the course of the project but have also leveraged that experience to apply for additional funding to support scale-up of integration. This grant is expected to financially support the scale-up of SRHR, HIV, TB, and maternal and child health integration in 16 health districts

A challenge noted by key informants in one country was the framing of HIV/SRHR linkages as a national programme because it was not mainstreamed into the national sectoral plans with the required budgets, accountability, and monitoring framework. Other key informants mentioned as a challenge to country ownership the role of project coordination held by a UNPFA-appointed person only funded for Phase I of the project and not a function institutionalised within the MOH beyond the project period.

Delays in appointing MOH focal persons responsible for linkages and a subsequent overreliance on the national project coordinator also created challenges to country ownership. Another challenge is the frequent changes in government and ministerial appointments, reflected in turnover of permanent secretaries, director-general's, and even mid-level programme managers, who often leave their posts to take positions with partners. Thus, even if the project is able to engage officials within MOHs and garner their support for linkages and integration, these individuals are only able to provide their support for as long as they hold office. Consequently, institutional capacity building frequently has to be repeated.

Service Delivery

Key informants across all countries reported strong support for the project at the facility level and that health care providers saw the value of delivering integrated services despite an initial increased workload. Key informants at the service-delivery level, reported there was a need to continue offering integrated services regardless of whether resources were available. However, while some MOH funding is available in several countries, it is not sufficient for continued integration or scale-up throughout each country.

Key informants in only two of the seven countries reported that the country could continue to sustain and to scale up integrated services without external funding. In one country, key informants noted the size of the country as a contributing factor in terms of the MOH's ability to continue supporting integration. In the other country, key informants reported that sufficient capacity had been built through the first phase of the project for them to be able to continue service integration without additional support.

Key informants at the national level tended to suggest that external technical and financial support is necessary for countries to continue and to scale up service integration. Specifically, they suggested that an initial stimulus of funding was necessary, focusing on training providers and equipping facilities to provide integrated services was necessary. Thereafter, MOH could be responsible for ongoing training and resupply of facilities. Other key informants suggest that the lack of resources should not be used as an excuse to not continue service integration. They see the lack of resources as a way to motivate providers to find innovative solutions.

Key informants who worked in or directly with facilities had a more optimistic view of whether it would be possible to continue service integration without additional external funding. They believed it would be possible since clients were already receiving comprehensive services before the project. They also tended to report that providers had the necessary capacity to continue integration without external support. They suggested that with a change of attitude on the part of health care providers and innovative uses of available resources and partnerships, the delivery of integrate services could continue without external support.

However, some key informants who worked in or directly with facilities reported that service integration could not continue without the physical resources that had already been provided by the project. As an example, one key informant said that it was not possible to provide integrated services without the PortaCabins, furniture, models, charts, and forms provided through the project, as clients would have to go to another clinic for services. They also noted that the scale up of service integration to other districts and sites could not occur without external technical support.

Key informants who worked in or directly with facilities reported that there was a need for more support for staff recruitment, training, and performance monitoring. Key informants said that additional training on services for the LGBTQI community was needed to reduce discrimination. Some key informants at the

national level echoed these sentiments. They suggested that pre-service training for providers would increase sustainability and that without additional training, sustainability was not possible.

Recommendations

UNFPA and UNAIDS should continue advocating for integration of HIV and SRHR services with all country stakeholders. The project was successful in encouraging country ownership of integration at multiple levels. This is evident in terms of policy at the national level in the numbers of policy documents across countries that incorporated language on integration of services and from key informant's reports of support from the permanent secretaries and from division directors within the MOHs in each country. The project also encouraged a sense of ownership even at the facility level—key informants in all seven countries saw the value of delivering integrated services despite an initial increased workload and saw a need to continue offering integrated services regardless of whether resources were available.

MOHs should advocate for allocations of the national budget to support integration of services while also collaborating with UNAIDS, UNFPA and external donors to develop sustainability plans or apply for grants that promote sustainability, and document and differentiate between government and external sources of financial support. Findings show that while the project may well have encouraged country ownership, it may still lack sustainability. Key informants reports that high-level political support did not always translate into national budget allocations that could continue to support HIV/SRHR linkages/integration without external donors for many countries also showed an inability to identify what governments had contributed versus what the project contributed. Further, at the facility level, key informants in only two of the seven countries reported that the country could continue to sustain and to scale up integrated services without external funding, due to the size of the country in one instance, and due to significant investments in initial capacity-building in the other. In all other countries, key informants reported that external technical and financial support was necessary to continue project implementation and to scale up service integration.

5.5 *Documentation and Dissemination of Best Practices*

The evaluation showed that in terms of policy, country ownership and sustainability, countries typically did not document best practices, but they did do so in terms of effectiveness and efficiency. ICF did not find specific evidence of documented and disseminated best practices for guiding changes to the national discourse and to policies specific to HIV/SRHR linkages. However, documents developed or updated with support from the project should be shared with other countries in the region. These documents can serve as examples of how language specific to HIV/SRHR linkages can be incorporated into existing policies. These include national:

- strategic frameworks and plans for HIV and AIDS, sexual and reproductive health, young people and adolescents;
- guidelines, assessment tools and implementation plans for HIV/SRHR linkages and integration; and
- guidelines for HIV treatment, PMTCT, antenatal care, ART, family planning, reproductive health.

All countries documented best practices focusing on effectiveness and efficiency of delivery of integrated services, which were shared regionally and beyond, allowing an opportunity for countries involved in the project to contribute to the regional and even global dialogue in integration of SRHR and HIV services The RPSC acted as a forum for sharing best practices and facilitated multiple opportunities to share information across the region. All countries created one-pagers on good or promising practices that were shared at the 2014 RPSC meeting, and at the 2014 UNFPA ESARO regional knowledge-sharing and capacity-building meeting. Three countries also engaged in a study on best-practice modalities and benefits of CSO involvement in supporting the scale-up of integrated HIV and SRHR programmes. Several countries collaborated to present lessons learned for the regional project at regional meetings and

international conferences, including the 2012 *Integration for Impact—Reproductive Health & HIV Services in Sub-Saharan Africa* conference, the *Fifth Africa Conference on Sexual Health and Rights* in 2012, the Models of Service Delivery Workshop in Tanzania in 2013, and ICASA in South Africa in 2013. Documentation of best practices in terms of efficiency was also captured in the SRHR indicators and shared via the INTEGRA Initiative website

Unfortunately, key informants did not discuss documentation and dissemination of best practices for ensuring country ownership and sustainability. Many of the documents created as a result of the project demonstrate country ownership but do not describe how best to ensure ownership or sustain linkages over the long term. A strong example of how to achieve sustainability that should be shared throughout the region, however, is Botswana's HIV and SRHR & AIDS Linkages Integration Strategy and Implementation Plan, which demonstrates how a country has taken ownership of national service integration efforts.

Recommendations

UNFPA and UNAIDS should host a workshop with UNFPA and UNAIDS country representatives to discuss and distil lessons learned about how to successfully advocate for adoption of integration by MOHs and to encourage country ownership in order to inform the implementation of integration in other settings.

As noted above, ICF did not find specific evidence of documented and disseminated best practices for guiding changes to the national discourse and to policies specific to HIV/SRHR linkages, nor best practices for ensuring country ownership and sustainability. Many of the documents created as a result of the project demonstrate country ownership but do not describe how best to ensure ownership or sustain linkages over the long term.

However, **countries should share policy documents and strategies** like Botswana's HIV and SRHR & AIDS Linkages Integration Strategy and Implementation Plan, **as examples of what could emerge from advocacy and engagement with MOHs.**

6 CONCLUSION

Findings from this evaluation show that integration of HIV and SRHR services was relevant to national contexts for all seven countries. Further, findings also show that integration of HIV and SRHR services was relevant to the broader regional agenda and thus may also be relevant to other regions and thus to a more global context where countries face increasingly reduced funding for HIV and siloed funding for HIV and SRHR. Similarly, findings show that for the most part the project was effective in promoting integration and efficient in doing so[16]. Further, findings show that clients in each country perceived that integrated services were relevant to their individual needs and circumstances, and were cost-effective and typically delivered in a timely fashion (via short wait times). In addition, they reported that integrated services were typically of higher quality than non-integrated services, and typically delivered in a fashion that reduced stigma and discrimination. However, these achievements were not realized without significant growing pains or challenges for health care providers, MOHs, UNFPA, and UNAIDS. Thus, to ensure the continued provision of these services and expansion of the project to other sites, there is still work to be done: to properly train health care providers, promote the project, and provide much-needed resources, and to document the project's successes and challenges with the ultimate goal of institutionalising linkages and integration of HIV and SRHR services as a national approach in each country to synergistically addressing HIV and other SRHR conditions.

[16] At least in terms of key informants' perspectives, given that these cannot be corroborated by financial data.