

A tool for

**Policy makers,
Health System Managers,
Managers of Civil Society Organisations
Managers of HIV/AIDS and SRH programmes,
& Service Providers**

**to identify opportunities and barriers when integrating SRH and
HIV/AIDS issues in Health Systems**

Background paper

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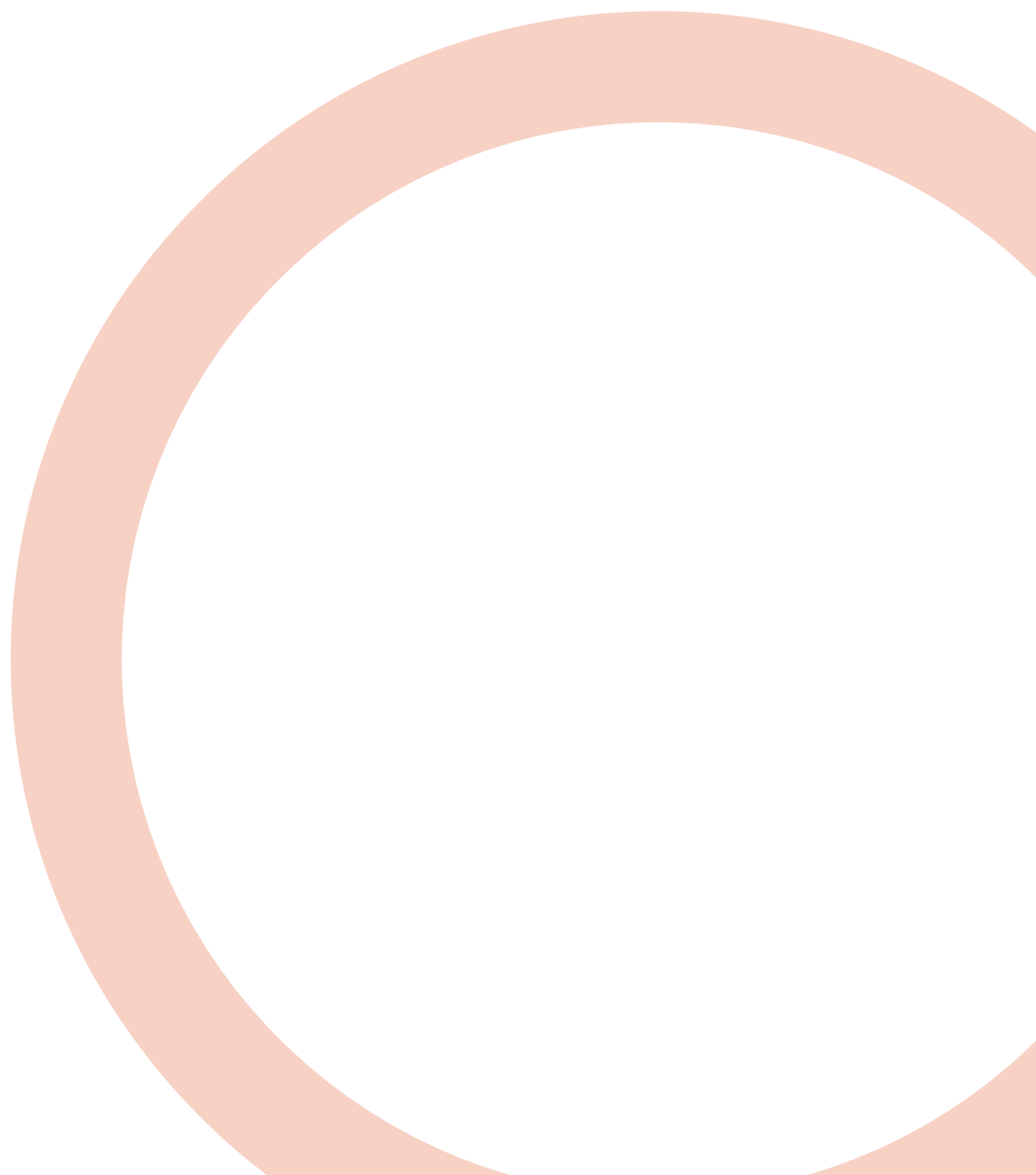
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Acronyms

AAA	Accra Agenda for Action
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral drugs
AS&RH	Adolescent Sexual & Reproductive Health
DGIS	Directorate General International Cooperation (Dutch ministry Foreign Affairs)
FP	Family Planning
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HRH	Human Resources for Health
HS	Health System
ICPD	International Conference on Population and Development
IEC	Information-Education-Communication
IMCI	Integrated Management Childhood Illness
(I)NGO	(International) Non-Governmental Organisation
KIT	Royal Tropical Institute
LIC	Low Income Country
M&E	Monitoring & Evaluation
MDG	Millennium Development Goal
MH	Maternal Health
MoH	Ministry of Health
MTCT	Mother-to-Child Transmission (of HIV)
NGO	Non-Governmental Organisation
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV/AIDS
PNC	Postnatal Care
PReP	Pre-Exposure Prophylaxis
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RTI	Reproductive Tract Infection
SRH	Sexual & Reproductive Health
SRH&R	Sexual Reproductive Health & Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAp	Sector-wide Approach
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VCT	Voluntary Counseling & Testing
WHO	World Health Organization

Executive Summary

This document is written from the perspective that integration of Sexual and Reproductive Health (SRH) and HIV/AIDS into the health system is the appropriate vehicle to make these services available for beneficiaries in Low Income Countries (LIC) in an efficient and sustainable way.

The document contains the background information needed to use a tool that helps to identify opportunities and barriers when integrating SRH and HIV/AIDS into Health Systems.

The reader will receive an overview of the definitions of a Health System and different mechanisms related to Health System Reforms. It is important to have a good understanding of these concepts because the motivation of national policy makers to work through Sector Wide Approaches (SWAs) and the influence of donors on (budgets for) national health plans and fragmented health systems all contribute to the chances of successful integration. A thorough understanding of amongst others the history of these issues, the role played by all manner of donors and advocacy groups, and the power relations between the various stake holders will enable managers in the field to analyse the factors that enable or disable the possibilities for integration.

Subsequently a chapter will be devoted to SRH and HIV/AIDS. In the brief introduction a birds eye view will cover the concepts and history of these two health issues that have a huge impact on the health of people in LIC. Both health issues already receive the attention of the (international) donor community via programmes which are not well integrated into national health systems.

The third chapter describes the concepts of integration and convergence and mentions examples of integration of priority programmes in Health Systems.

After the background information is presented, a link is made to the tool: moving from knowledge to practice. Knowledge alone does not provide the skills needed to promote integration of SRH and HIV/AIDS in the Health System. The tool to identify opportunities and barriers when integrating SRH and HIV/AIDS issues in Health Systems will assist people that want to address the issue of integration.

The tool is composed of three parts.

Part one informs about:

- a. Acronyms
- b. The use of the tool
- c. The process of integration of SRH and HIV/AIDS into Health Systems
- d. The facets of integration of SRH and HIV/AIDS into Health Systems
- e. The rating of integration of SRH and HIV/AIDS into Health Systems

Part two provides:

A description of four facets that have to be considered during this process, complemented by a set of key questions linked to these facets

Part three provides:

A spider web diagram to visualise the findings of the identification

Once the tool has been applied, information will be available to design appropriate action plans aimed at moving the process of integration forward.

The entire document is available on the website of Share-net:

HYPERLINK "http://www.share-net.nl/Download_centre"http://www.share-net.nl/Download_centre.

Introduction

The purpose of this document is to explain the thoughts and reasoning behind integration, while developing a tool that assists policy makers, health system managers, managers of priority programmes, civil society organisations, and health service providers in identifying opportunities and barriers to the integration of SRH and HIV/AIDS programmes into National Health Systems including Primary Health Care Services. The aims are to challenge people to think in depth about these issues, to use the tool and to promote discussions about its usefulness and appropriateness.

This document is not meant to be a peer-reviewed article on the state of SRH, HIV/AIDS, or Health System Development (HSD) – nor on integration of services. This paper describes a number of key concepts, issues and challenges in order to (i) facilitate a common understanding of what we are talking about; (ii) to support people that work in the area of SRH and HIV/AIDS help them to participate in the discussion and – most importantly (iii) to present a tool that identifies opportunities and barriers to the integration of SRH and HIV/AIDS programmes into National Health Systems.

The document is written on the basis of reviewing literature and discussions between the writers and members of Share-Net who consulted their partners in the South (India, Mali). These partners told us about their experiences regarding integration of SRH and HIV/AIDS in their health systems. For the definitions of integration, publications of the WHO (2005¹, 2007², 2008³) are frequently quoted, as well as the approach of M. Berer.⁴

The writing of the background paper and the development of the tool was an exercise of the Health System Working Group of Share-Net. We hope to equip Share-Net members and their partners in LIC with a concrete tool that will motivate players in SRH and HIV/AIDS programmes and services. The goal is that all of the parties involved will eventually collaborate within the health system in their aim to deliver efficient and sustainable health services that are accepted by the clients and appreciated by the health workers and their managers.

Ankie van den Broek

I The Health System and Health System Development Mechanisms

Using a tool that identifies opportunities and barriers to integrating SRH and HIV/AIDS into Health Systems requires understanding Health Systems and Health System Development Mechanisms. This chapter highlights the main concepts and discussions regarding these issues.

A Defining the Health System

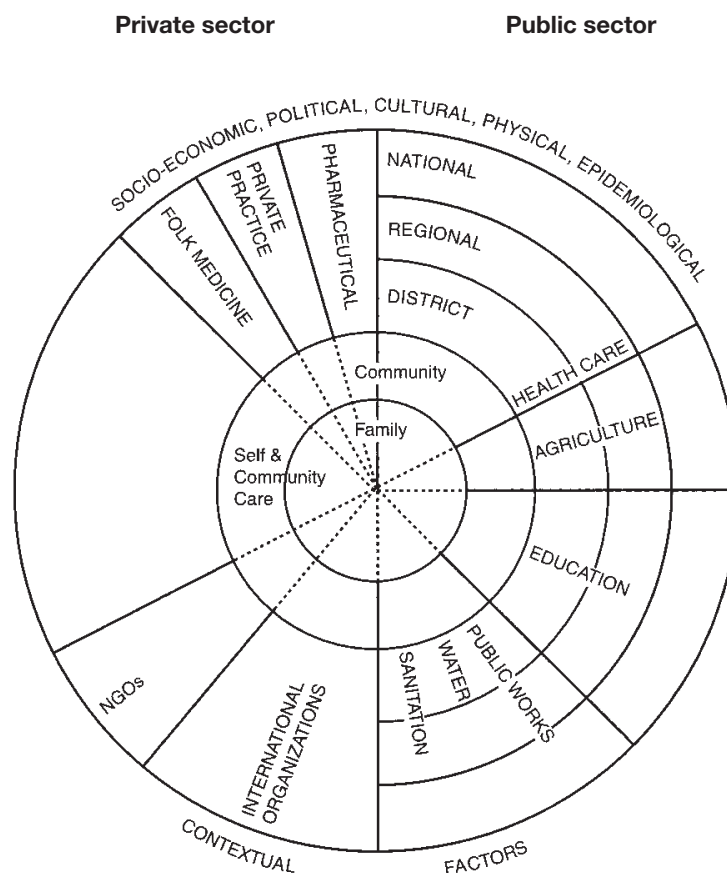
A broad and thorough description of a health system has been given by C.M. Varkevisser et.al.⁵ and is based on anthropological concepts.

A Health System contains:

- A set of cultural beliefs about health and illness that forms the basis for health-seeking and health-promoting behaviour
- The institutional arrangements of that behaviour
- The socio-economic/ political/ physical context of these beliefs and institutions.

(See figure below)

This figure shows that a health system does not function in a vacuum; it functions in a socio-cultural and political-economical environment and factors such as government structure (decentralisation for example), civil society involvement and disease patterns all have an important influence on the health system.



The health system

Taken from: C.M. Varkevisser e.a. (Designing and Conducting Health System Research Projects, 2003, KIT Publishers)

The WHO proposes the following – narrower - definition of a health system:

“Health systems are the *people, institutions and resources*, arranged together in accordance with established *policies*, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health”.

Within the Health System a distinction can be made between direct service delivery and enabling structures.

1 Direct service delivery:

- A *Services* including curative, preventive and promotional services provided by both the private and public sector:
 - Basic Health Services or Community Based Health Care
 - Hospital care in district hospitals (2nd level) and referral hospitals (3rd level)
 - Referral system between the three levels
- B *Resources*:
 - Human resources including training, remuneration and management (distribution, (re)allocation, performance, motivation, retention of staff)
 - Physical infrastructure including hospitals, laboratories, medical supplies and other equipment, training institutions and transport
- C *Supporting services* such as drug procurement and storage; equipment maintenance; blood transfusion services etc.

2 Enabling structure:

- A *Governance* of the health system, including policy setting, i.e. strategic planning, allocating of resources and monitoring performance
- B *Management & planning* as part of the planning cycle at operational level (from needs assessment to evaluation)
Instruments to enable *evidence-based* decision making, such as Monitoring & Evaluation systems, and research into health systems (operational & policy)
- C *Financing arrangements and mechanisms* such as public funding, international aid, health insurance and direct payments by patients, but also the mechanisms to ensure the equitable, efficient and effective allocation of these funds, and the financial, administrative and accounting systems supporting them
- D *Regulation and licensing* that protects the public from unsafe products, ineffective medicines or inept treatment

Health Systems in LIC are often fragile. The system can fail to properly answer the (health) needs of the communities due to many factors, such as lack of funds, lack of skilled human resources, and inadequate management structures. In past decades several strategies have been followed to strengthen health systems. In the following chapter these strategies will be discussed.

B Health System Development Mechanisms

Several strategies are followed to strengthen the Health System. The opportunities for success of integration of priority programmes such as SRH and HIV/AIDS into the system depends on how the health system has developed itself. The Health Sector Reforms and Sector Wide Approaches (SWAps) contain important processes and strategies to facilitate proper integration of programmes.

a: Health Sector Reform

In the late eighties it became clear that the high expectations of the introduction of Primary Health Care (PHC) after the Alma Ata conference (1978: Health for All by the year 2000) would not be met. In many countries the health system was in bad shape. Health services did not meet the health needs of the people, quality of care was below standard, distribution of care was inequitable and the integration of the public and private sector weak or totally absent. Several factors contributed to this situation, but negative economic development and the introduction of SAP's (Structural Adjustment Programmes) were the most influential.

In an attempt to stem these developments, several countries initiated reform processes, aimed at improving the way the health system functions. These health system reforms covered various elements of the system, affecting both the structure and the content of services and programmes.

- *System:* the roles and responsibilities of the main actors would shift, e.g. the institutional arrangements or decentralisation;
- *Financing:* searching for efficiency in purchasing services and procedures; increased income deriving from cost recovery and health insurance; installing mechanisms for an equitable distribution of resources;
- *Programmes:* changing the content of actual programmes and interventions that have proven to be cost efficient (HIV/AIDS, reproductive health, TB control, immunization) often introduced as a Minimal Package of Activities
- *Services:* increasing productivity and quality of the services by measurements linked to technical efficiency, such as making services accountable on their results, problem oriented planning, integration of vertical programmes or contracting out to NGOs;
- *Planning and monitoring:* improving the management information systems and human resources development;

“Health Sector Reform” in many countries has similar components, such as:

- Achieving universal coverage of health services
- Improving the performance of the health service
- Decentralisation (in terms of decentralisation within the MOH)
- Improving the functioning of national MOH
- Broadening health financing options
- Introducing management skills
- Working with the private sector (the “public-private mix”)
- Improving coherence between activities of all players in the sector (government, donors, civil society and clients)

The size and the impact of the reforms do not follow a blueprint. In some countries the reforms have been quite superficial while in other countries they have triggered a complex set of changes which impacted the organisation of, and the relationships between, the different stakeholders. Health systems have always been under reform and as these are not a one-off actions, the process is often called *health system development*. The reforms in the health system are often part of, or develop parallel to, reform processes such as civil service reforms.

b: Sector-wide approaches (SWAp)

Donors (including UN organisations, Bretton Woods Institutions (WB and IMF), bilateral agreements and International NGOs have, over time, supported health systems in developing countries, not only by providing funds but also by influencing the policies of the national governments. Many trends have appeared and disappeared from the international (donor) agenda. Donors have provided financial and physical support and technical assistance for capacity building.

Until the mid-nineties the support was mostly granted to specific projects: limited support was allocated to distinct geographical areas, well-defined levels of the health sector, or specific disease control programmes. This led to fragmentation, a wasting of funds, duplication and lack of ownership by the national governments. Under the leadership of the World Bank, WHO and other players it became obvious that a change was needed and that health systems should be approached in a more systematic and comprehensive way, namely one that is “sector-wide”. This approach was triggered by the fact that several countries had invited donors to support the reform of their health system. Managing reforms was difficult in the existing project mode. The link between the so-called Sector Wide Approach (SWAp) and Health System Reform (HSR) may cause confusion: positive or negative effects of HSR are easily attributed to SWAp and vice versa. It is therefore important to define SWAp. A. Cassels described (1997)⁶ SWAp for the health sector as follows:

"At the heart of SWAp is a medium-term collaborative programme of work concerning:

- *The development of sectoral policies and strategies*
- *Projections of resource availability and expenditure plans*
- *The establishment of joint management systems by governments and donors to facilitate the phased introduction of common management arrangements*
- *The establishment of structures and processes for negotiating strategic management;"*

Or, as Foster et.al.⁷ (2000) defined SWAp:

"All significant funding for the sector supports a single sector policy and expenditure programme under Government leadership, adopting common approaches across the sector, and progressing towards relying on Government procedures to disburse and account for all funds".

SWAp is an approach and a process.

The aim of SWAp is that national governments take the lead by developing a coherent National Health Plan; a plan that is able to address the major health problems within a country, defining the role of various stakeholders such as multilateral organisations, bilateral donors, private sector and civil society, and which is also able to support the development and implementation of such a plan.

SWAp is not the same as basket-funding or budget support, although the financial aspects are an important feature of a SWAp. Basket funding might be the desirable outcome of the process, but not necessarily.

SWAp can also function as a window of opportunity to integrate priority programmes into the Health System. For the success or failure of this integration, it is critical that the national government has insight into all the activities and programmes that might fit into the national plan. Only in this way are ownership and sustainability more likely to be guaranteed.

Contextual realities and constraints

The tendency towards “one programme, one M&E system and one budget” has consequences for aid structure and effects the influence of donors at a national level, but also has repercussions at service and programme level. Bilateral donors, multilateral organisations and NGOs are supposed to adapt their activities to the national health plan and are meant to contribute to the national health budget without specifically earmarking their funds. This can be a difficult process for the following reasons:

- There is less transparency and control of donor funds. This may conflict with the demands of the constituency who will want to see how funds are spent. As a result fundraising may prove difficult.
- The process of SWAp is a slow one and very time consuming. Furthermore the results of the SWAp will be reflected in the performance of the entire health sector. These results are not immediately visible during the span of a brief project. Many problems demand urgent action, such as malaria, tuberculosis, HIV/AIDS, maternal mortality, etc. Donors investing in these areas prefer to see results in a shorter time period and such results are more easily be reflected in special programmes.

- SWAp only deals with one sector, while many organisations (donors and implementing organizations) have wider mandates and missions. In order to achieve better health for people, action in various sectors is needed.

In practice we see great variety between countries who are implementing SWAps. A fair number of bilateral like-minded donors are supporting it, while others still find it difficult. At national level multilateral UN organisations are in general not yet fully on board, or do not participate at all, despite the fact that doing so is embedded in their general policy. The World Bank is fully supporting SWAp; NGOs (local and international) tend to *partially participate*, while in most countries the private for-profit sector is completely absent from the process. Within the sector resistance is increasing from managers of special/priority programmes, who believe that their programmes will suffer from this approach.

Some progress is being made towards respecting national (health) systems. The twelve principles of the Paris Declaration (2 March 2005) on Aid Effectiveness stressed the importance of nationally “owned” systems, and of respecting national priorities and donor coordination. The Accra High Level Forum (September 2008) reflected the international commitment to support the reforms needed to accelerate an effective use of development assistance, in order to achieve the Millennium Development Goals (MDG) by 2015. This meeting resulted in the Accra Agenda for Action (AAA) that aims to ensure that the technical, institutional and political changes needed to fully implement the Paris Principles are carried out.

The Millennium Development Goals themselves have a strong influence on the health sector. MDGs force governments to concentrate and report on certain elements such as child health, nutrition, safe motherhood and HIV/AIDS. This might work against an attempt to strengthen (basic) health services in general.

The *International Health Partnership* (IHP) launched in 2007 has yet to be mentioned. IHP is an agreement between donor countries, developing countries, international health agencies and foundations aimed at ensuring that all partners collaborate together more effectively in order to reach the health MDGs (MDG 4,5,6). The aim of the IHP is to aim donor support at the priorities identified in the national health plans of LIC, *Policy Environment (PRSP's and Millennium Development Goals)*.

Of course HSR and SWAps take place in an environment where policies fluctuate.

Poverty Reduction Strategies for example can have a great impact on what is happening in various sectors, including the health sector, via budget allocation (ceilings), financial and fiscal arrangements and civil service reforms. Furthermore there is increased pressure being put on the content of HSR and SWAps as policies become increasingly pro-poor.

c: Financial mechanisms

With respect to health financing and accounting, the health system can be divided into actors and functions. Four groups of actors can be distinguished in a health system or sector: financing sources, financial agents, providers and beneficiaries.

Financing sources are institutions or entities that provide funding: this can come from public, private and external sources. Public sources include the government and social security arrangements; private sources include insurances, companies, NGOs and households. External sources are in most cases international donors.

- *Out-of-pocket payments*: WHO estimates that around 50 percent of all expenditures in health are made by households. Household expenditures include direct and indirect costs. Direct or out-of-pocket payments are made at the time the health service is delivered. Out-of-pocket payments usually include fee for services, informal payments, co-payments, and costs for other expenses such as transportation and food. Indirect household payments are, for example, taxes and insurance premiums.
- *International donor assistance*: Internationally, the current trend is that more funds are being made available for HIV/AIDS (MDG 6), usually at the expense of funds for formally earmarked for Family planning/ Safe Motherhood (MDG 5). The USA in particular made commitments to finance HIV/AIDS projects through the PEPFAR initiative. These funds are in serious competition with the SRH&R agenda, as PEPFAR places emphasis the abstinence-only message for youths, instead of providing them with comprehensive sex education. This method of IEC (Information, Education and Communication) does not enable adolescents

to make choices on an informed basis, and does not take into account their own wishes, beliefs and doubts related to sexual health and rights. The shift towards STI/HIV/AIDS expenditure is probably the most dominant trend among the donor countries: "In 2005 68% of their assistance will consist of funds for STI/HIV/AIDS, which is in marked contrast to the targeted ICPD share of 8% agreed upon in Cairo in 1994" (Dalen and Reuser, 2005).⁸

The Global Fund has also greatly increased funding of HIV/AIDS, but they have in general a more positive approach to sexual and reproductive health needs and health system strengthening.

Financing agents are institutions or entities that channel, or manage, the funds provided by financing sources and use these funds to purchase health services and goods.

Providers such as hospitals, clinics, dispensaries, pharmacies, or traditional healers, receive money in exchange for, or in anticipation of producing health services and goods.

Beneficiaries are those receiving or affected by the goods and services consumed. The beneficiaries may not always be those that were initially targeted. It could be that the investments are only benefiting the rich, who most often are in good health at the expense of the poor, who may be in greatest need of quality services but are not able to access the services due to financial constraints.

Moreover, as outlined earlier, the health system involves many actors and a myriad of transactions. The monitoring of fund flows, by tracking health expenditures for example, is an essential aspect of assessing the effectiveness of health funding schemes and the proper allocation of scarce resources. It is in this way that funding gaps can be identified.

At a national level, financial resource tracking can be carried out using the *National Health Account (NHA)*. In a nutshell, a National Health Account tracks the annual flow of funds within the entire health system, from financing sources to financial agents, health managers, and health care providers; these agents then direct funds towards specific health functions. The latter are defined as the types of services or products produced - including curative care, preventive and public health programs, and also include administrative activities.

The *Reproductive Health Account (RHA)* - which may include a HIV/AIDS component - is a sub account or satellite account of a NHA. In a RHA actors, activities and transactions are limited to those involving reproductive health and HIV/AIDS. Reproductive health expenditures encompass all expenditures for activities whose primary purpose is to restore, improve or maintain reproductive health.⁹ As with any National Health Account, the RH sub account is undertaken primarily to inform the policy process. Objectives include answering the following questions:¹⁰

- How much is spent on RH and/or HIV/AIDS care? What is their share of total health expenditures?
- What is the reliance on donors for RH and HIV/AIDS services and commodities? What share of donor health funds are targeted for RH and/or HIV/AIDS?
- What share of public health funds is spent on RH and HIV/AIDS care?
- What is the financial burden on households to pay for RH or HIV/AIDS care? How does this compare to utilisation rates of services/ commodities?
- What types of services are financed by RH and HIV/AIDS funds? Such information would reveal the amount of resources actually spent on various RH activities such as family planning, maternal health, information, education, and communication campaigns (IEC) and so forth. This data can be compared to official government policies and help answer the question of whether or not (integration) policies are actually being financed and implemented.
- Who benefits from RH and HIV/AIDS spending? Despite the efforts of investing in integrated programs by governments and the international community, it is not clear if the targeted population benefits.
- Who provides what RH and/or HIV/AIDS (integrated) services and where? In many countries, there is a proliferation of RH providers and most often this is not well coordinated and/or well regulated by governments. NHA can provide data on different types of providers based upon ownership (public/ private). Such information would be useful to determine if resources are being efficiently distributed; for example, 'are government funds being used to fund services that are already well covered by NGOs?

Or the private for-profit sector?’ More in-depth analyses may provide expenditure breakdown by geographic area (region, district, rural/urban).

- How does financing of RH services compare between countries?
- What are the implications of different health-financing policy options on the mobilization and allocation of resources for RH? NHA data, particularly when conducted on a regular basis, can inform simulation exercises that produce different scenarios to illustrate the impact of changes in financing patterns. These scenarios can be useful in decision-making processes during decentralization, introduction/reduction of external resources, etc. Similarly, the effect of demographic changes can be forecast. For example, fertility changes may lead to shifts in resource use among program components, such as family planning and antenatal, delivery, and postnatal care, or the share of FP and treatment of unsafe abortion.

Financing of SRH and HIV/AIDS: synergy and competition

Financing SRH and HIV/AIDS activities involves resource mobilization and the channeling of resources through the health system in a way that results in a better reproductive health status of women and men. But how much money is needed for this? To address this question, policymakers first need to understand what is already being spent on SRH and HIV/AIDS and specifically, who is financing SRH care, how much, and for what kinds of services. To make the system more equitable, information is needed about existing inequities in the system, such as ‘what is the current distribution of RH resources between urban and rural communities?’; ‘between the rich and the poor?’ and so forth. Also, SRH stakeholders in some developing countries may be concerned that a disproportionate amount of funds may be targeted for HIV/AIDS services at the risk of under-financing other basic SRH services (as HIV/AIDS and SRH programs have many financing sources in common). Are such fears valid? To answer these queries and to diagnose the “financial health” of SRH and HIV/AIDS care in a given country, policymakers require, on a regular basis, comprehensive data on the flows of SRH and HIV/AIDS funds — and not just on the public sector but also private and donor investments.

II Sexual Health, Reproductive Health and HIV/AIDS

The tool identifying opportunities and barriers when integrating SRH and HIV/AIDS into Health Systems should be accompanied by a shared understanding of these priority programmes. This chapter describes the definitions, the history and the content of Sexual and Reproductive Health and HIV/AIDS programmes.

A Sexual and Reproductive Health

In 1994 in Cairo during the International Conference on Population and Development (ICPD) an agreement was reached on the definition of Reproductive Health.

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often they do so”.(ICPD Programme of Action paragraph 7.2)

The ICPD Programme of Action also provides an initial description of the components of reproductive health services in the context of primary health care. During the review process in 1999 (ICPD +5) this was refined further, based on the outcome of the Beijing conference in 1995, which placed more emphasis on sexual health and rights.

In 2002 the WHO came up with the following definition regarding Sexual Health:

Sexual health is a state of physical, emotional mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Since then several authors and organisations have built up a comprehensive list of sexual and reproductive health services. For the purpose of this tool we propose to use the list of SRH services used in the (draft) WHO paper 2005, which includes:¹¹

- Fertility regulation, including FP counseling and services, emergency contraception, dual protection and the role of men
- Maternal and newborn health care, including antenatal care, basic and comprehensive obstetric care, including emergency care, postpartum and postnatal care, nutrition and breastfeeding, newborn and infant care
- General gynecological services, such as for menstrual disorders and cancers
- Care for women during the menopause and attention to the sexual health care needs of older men and women
- Psychosocial support related to sexual health status
- RTI/STI/HIV services for men and women, including counseling, prevention, screening, diagnosis and management (partner notification, referral, treatment and care)
- Adolescent sexual and reproductive health
- Gender-based violence, including female genital mutilation (FGM)
- Care for women and men experiencing sexual dysfunction or infertility

Not mentioned in this WHO paper are:

- safe abortion services

We feel that these services are an essential part of SRH services. For this paper we have added these services to the list.

The Millennium Development Goals pay attention to SRH. Goal 5 is totally devoted to this issue:

<p>Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio</p>	<p>Indicators: 5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel</p>
<p>Target 5.B: Achieve universal access to reproductive health by 2015</p>	<p>5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning</p>

B HIV/AIDS

HIV/AIDS was first discovered 25 years ago and since then has had a tremendous impact on the health and well-being of millions of people. The epidemic is far from under control and the impact on development is becoming more and more visible.

The HIV/AIDS epidemic goes beyond the health system; the causes and the consequences encompass all aspects of society.

As Alan Whiteside stated in 2005:

“AIDS is the key challenge for development and the primary reason for not achieving the Millennium Development Goals. AIDS has been here for some 25 years and will stay with us for at least another such period. AIDS affects us all. AIDS touches the psyche of society”

(Alan Whiteside HEARD South Africa, 2005)

A comprehensive HIV/AIDS policy should therefore be multi-sectoral and supported at all levels. In the policy of the Dutch Ministry of Foreign Affairs this is encapsulated in the notions of Commitment, Coordination and Capacity: A comprehensive AIDS policy should include prevention, care, treatment and impact mitigation.

HIV/AIDS has had a tremendous impact on health systems in many countries, especially the LIC with a high prevalence of HIV, such as in Sub-Saharan Africa and the Caribbean. AIDS patients occupy a high number of hospital beds which can lead to a failure to properly deliver other health services.

In addition there is currently a crisis in *Human Resources for Health* in general, caused by internal and external migration and an uneven distribution of skilled health workers: There are more skilled individuals working in urban and private sectors, than in rural and non-profit organisations.

In Africa as a whole 3% of the world’s trained health workers struggle to combat 24% of the global disease burden. It is here too that 64% of the HIV positive community is located. In numbers there is a shortage of 800.000 doctors, nurses and midwives and an overall shortfall of nearly 1,5 million health workers for this continent.¹² The AIDS epidemic itself contributes to this shortfall. In Malawi for example, HIV-related illness is the leading cause of attrition of health workers.

Although aid (funding) for HIV/AIDS has increased tremendously in recent times, which is reflected by the broad attention of major financing agencies such as the Global Fund for AIDS, Malaria and Tuberculosis (GFATM), the Gates Foundation and PEPFAR, one has to be aware that such investments can trigger negative effects on other actors in the health system. For example, health workers may focus too strongly on the priority issues and pay insufficient attention to other important health problems.

For the purpose of this paper HIV/AIDS services are understood to cover the following:

Prevention:

- Community development
- Community Based Responses: Strategies to address norms and values that form a barrier to prevention
- Information and education concerning safe sex strategies, such as behavioural change interventions (i.e. condom use)
- STI diagnosis and treatment
- Voluntary Counseling and Testing (VCT)
- PMCT+
- Safe blood supply
- Developing new technologies (such as male circumcision - although still difficult to bring in practice - microbicides, PReP)
- Post-Exposure Prophylaxes (PEP)
- Harm reduction interventions

Care:

- treatment of opportunistic infections
- home-based care
- palliative care
- food supplements when needed (to support the treatment)

Treatment:

- ARV treatment including laboratory services for diagnosis and monitoring

Impact mitigation:

- Social protection strategies
- Stigma reduction (in the entire society, including health services)
- Livelihood strategies
- Workplace policies regarding HIV/AIDS
- Care for the caregivers. Often volunteers care for PLHA. This can be a difficult task and support for the care givers is essential to guarantee continuous care.

The MDGs also pay attention to HIV in goal 6:

<p>Target 6.A: To have halted and begun to reverse the spread of HIV/AIDS by 2015</p>	<p>Indicators:</p> <ul style="list-style-type: none"> 6.1 HIV prevalence among pregnant women aged 15-24 years (UNAIDS-WHO-UNICEF) 6.2 Condom use rate of the contraceptive prevalence rate (UN Population Division) Condom use at last high-risk sex (UNICEF-WHO) 6.3 Percentage of population aged 15-24 years with comprehensive and proper knowledge of HIV/AIDS (UNICEF-WHO) 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years (UNICEF-UNAIDS-WHO)
<p>Target 6.B: To achieve universal access to treatment for HIV/AIDS for all those who need it by 2010</p>	<ul style="list-style-type: none"> 6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs

III Integration of SRH and HIV/AIDS into Health Systems

In this chapter the definitions of integration are given and enabling and disabling factors for integration are identified.

A Integration and/or Convergence: what does it mean?

The idea of integrated health services is not new; it was the basis for the focus on primary health care in the 1980s. The current challenge is to be specific about what integrated services should look like in different settings and to see how integration can contribute to the intended aim of people receiving the care they need.

At different points in time, different definitions on integration were given by WHO. For instance:

- 1) *“A series of operations concerned in essence with a bringing together of otherwise independent administrative structures, functions and mental attitudes in such a way as to combine these as a whole” (WHO '62)*
- 2) *“Bringing together common functions within and between organisations to solve common problems, developing a commitment to a shared vision and goals and using common technologies and resources to achieve these goals. As such, it is a way of optimising the use of scarce resources and responding more effectively to people’s needs” (WHO '96)*
- 3) *“Integration of services can be understood as bringing together the different components of sexual and reproductive health (and HIV/AIDS) and establishing strong linkages with other health-care and related social services, with the aim of increasing effectiveness and efficiency of the health system, and of meeting people’s needs for accessible, acceptable, convenient and client-centred comprehensive care” (WHO, 2006c).*
- 4) *Convergence: provision of partially integrated services: HIV-SRH convergence entails mutual referrals and communication activities between these two services.¹³*

The technical brief of the WHO (May 2008)¹⁴ explains the multiple meanings of integration:

- A package of preventive and curative health interventions for a particular group (IMCI)
- Multi purpose delivery points
- Continuity of care over time (chronic diseases as HIV/AIDS or life cycle linked like FP, antenatal care-postnatal care, newborn and child care)
- Vertical integration of different levels of services (i.e. district hospital, health centre and health post with an overall manager for supervision)
- Integrated policy making and management

The chance of integration succeeding depends on the local context. Determinants of the content are various, including culture, prevalence of diseases and syndromes, strength of the health system, skills of health workers etc.

This paper will not elaborate on the technical aspects concerned with which services can be integrated and where. As a general guideline the following possibilities can be considered:

- Integration of sexual health services in reproductive health services and HIV/AIDS programmes
- Integration of SRH in HIV/AIDS programmes and vice-versa
- Integration of SRH and HIV/AIDS in health services separately
- Integration of SRH and HIV/AIDS together in health services

B Integration: experiences

An integrated health service is one that is working efficiently towards agreed health goals and has a vision which advocates health sector reforms, sector wide approaches and sexual and reproductive health.¹⁵

Integration is not a new concept and certainly not restricted to sexual and reproductive health and HIV/AIDS. Lessons can be learned from experiences with other priority programmes that have already identified the opportunities and barriers.

The WHO gives five main messages from the literature regarding integrated health services¹⁶

- An "always good" versus "always bad" stance on integration is not helpful. On the ground, integration is about practical questions on how to deliver services to those that need them.
- Integration is best seen as a continuum rather than as two extremes of integrated/not integrated. It involves discussions about the organization of various tasks which need to be performed in order to provide a population with good quality health services. Integrated care can look different at different service levels. In reality, there are many possible permutations.
- Supporting integrated services does not mean that everything has to be integrated into one package. The aim is to provide services which are not disjointed for the user and which the user can easily navigate. For specialist care, the issue is how their activities are linked to other services.
- Managing change in the way services are delivered may require a mix of political, technical and administrative action. It may require action at several levels, including sustained commitment from the top. It is useful to look for good 'entry points' for enhancing integration and to consider what incentives there are for health workers and their managers to change their behaviour.
- Integration is not a cure for inadequate resources. It may provide some savings, but integrating new activities into an existing system cannot be continued indefinitely without the system as a whole being better resourced.

Difficulties to integrating different health programs lie in:

- The limited *capacity* of the health system to introduce major changes
- The continued faith of health administrators in *technology* to address specific health problems, reinforced by the success of the smallpox and polio eradication programs
- Mechanisms for *funding and resource allocation* which favour specific targets
- A main commitment to *visible results* in the short term, and
- The lack of *incentives* for an integrated approach, financial or otherwise

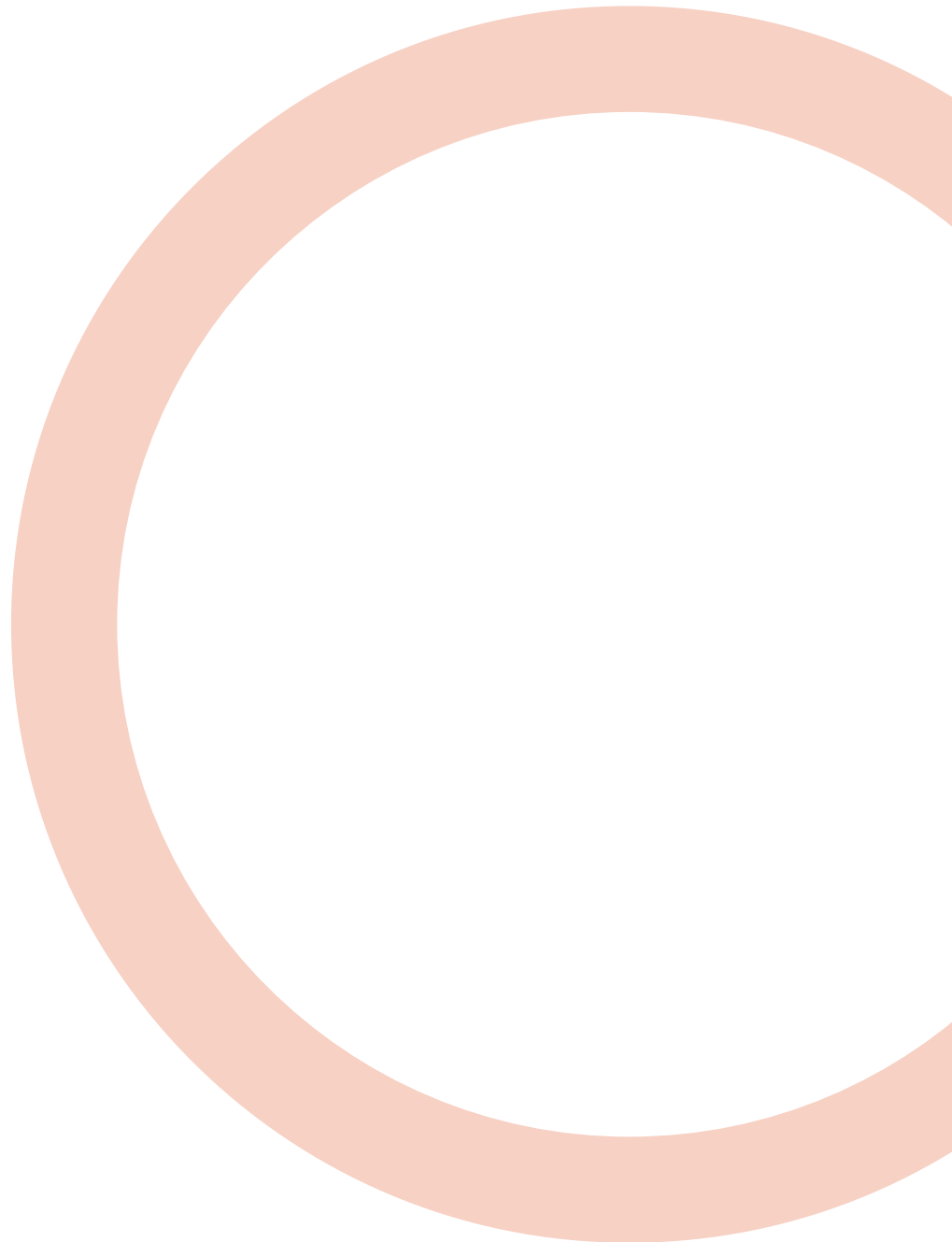
The publication in 2005 of the Millennium Project report¹⁷ and the Commission for Africa report signal a growing consensus on the case for more aid to improve the health systems in low income countries. At the time questions are raised about how such aid can be properly used, especially if the health sector is weak. In a country where the health sector is organised in such a way that first serves the middle- and higher income quintiles in the society (which is the case in most Low- and Middle Income countries), they will not reach the poverty pockets. Priority programmes (such as SRH, HIV/AIDS) have the same difficulties reaching the poor. Integration of SRH and HIV/AIDS in general health services, accessible for all segments of the population (primary health care), could contribute to reaching the poor.

In this paper the approach is taken that integration of the two priority programmes at health service level will be more efficient for patient care (less missed opportunities at service level) and that integration into the health system at all levels will result in more efficient use of human resources, funding and infrastructure.

The aim of integration of services (effectiveness and efficiency) is to:

- improve accessibility and use of the services
- improve quality of the services
- improve efficiency of service delivery
- improve client satisfaction
- address unmet need
- improve the health status of the population

SRH, HIV/AIDS and health services overlap but they also have aspects that do not interfere with one another. For example care for orphans and vulnerable children is an important part of a HIV/AIDS policy, but does not directly affect the health services.



IV From knowledge to practice

Understanding health systems, health system development, SRH and HIV/AIDS and the concepts of integration is necessary to assess the level of integration of SRH and HIV/AIDS into health systems. To facilitate this process an assessment tool has been developed.

The tool provides a methodology to guide the identification of opportunities and barriers for integrating SRH and HIV/AIDS in Health Systems. The tool can be used at national, decentralised and provider level as a guide for stakeholders (MoH, funding agencies, district health managers, providers, beneficiaries etc) that are beginning - or in the process of - integration. It can also be used to evaluate the integration process of SRH and HIV/AIDS into Health Systems.

The tool is composed of three parts.

Part one informs about:

- a. Acronyms
- b. The use of the tool
- c. The process of integration of SRH and HIV/AIDS into Health Systems
- d. The facets of integration of SRH and HIV/AIDS into Health Systems
- e. The rating of integration of SRH and HIV/AIDS into Health Systems

Part two provides:

A description of four facets that have to be considered during this process, complemented by a set of key questions linked to these facets

Part three provides:

A spider web diagram to visualise the findings of the identification

The tool can be used when stakeholders are interested in moving forward in the process of integration. The outcome of the assessment will be to start designing plans to improve integration of SRH and HIV/AIDS into Health Systems.

Notes

- 1 WHO paper "Integrating sexual health interventions into reproductive health services: programme experience from developing countries" 2005
- 2 (draft) WHO paper "Integrating sexual health interventions into reproductive health services: programme experience from developing countries" 2007
- 3 Technical Brief No. 1 May 2008: Making Health Systems Work: Integrated Health Services – What and Why
- 4 Integration of Sexual and Reproductive Health Services: A Health Sector Priority. Marge Berer, 2003 Reproductive Health Matters
- 5 Designing and Conducting Health System Research Projects, 2003, KIT Publishers
- 6 Cassels, A; A guide to sector wide approaches for health development. Concepts, issues and working arrangement, Draft .UK Department for International Development, European Commission, World Health Organisation, November 1997.
- 7 Sector-wide approaches for health development: a review of experience Foster, M; Brown, A; Conway, T [Foster, M., A. Brown, and T. Conway. 2000. Sector-wide approaches for health development: a review of experience. Geneva: World Health Organization.]
- 8 Dalen, H. van en M.Reuser (2005) Assessing size and structure of Worldwide funds for population and AIDS activities. NIDI, The Hague
- 9 Willekens, F. (2005) Towards a system of reproductive Health accounts. NIDI Reports No 68
- 10 Objectives adapted form the 'Guide to Reproductive Health Accounts', forthcoming publication by WHO, NIDI and PHRplus.
- 11 WHO paper "Integrating sexual health interventions into reproductive health services: programme experience from developing countries" 2005
- 12 Working together for Health, The World Health Report 2006
- 13 HIV-SRH Convergence, PATH, Policy and Practice Update 2 March 2007
- 14 Technical Brief No. 1 May 2008: Making Health Systems Work: Integrated Health Services – What and Why?
- 15 Integration of Sexual and Reproductive Health Services: A Health Sector Priority. Marge Berer, 2003 Reproductive Health Matters
- 16 Technical Brief No. 1 May 2008: Making Health Systems Work: Integrated Health Services – What and Why?
- 17 Investing in Development: A Practical plan to achieve the Millennium Development Goals

