2559.Share net.krt.4:2559 24-03-2009 13:29 Pagina 1

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 into Health Systems

Tool for the identification of opportunities and barriers when integrating SRH and HIV/AIDS into Health Systems

Justification of a tool on integration of SRH and HIV/AIDS

Integration of Sexual and Reproductive Health (SRH) and HIV/AIDS into a nation's health system helps make these services available in an efficient and sustainable way for beneficiaries in low income countries (LIC). However the process of integrating SRH and HIV/AIDS is a separate issue to integrating them both into existing health systems and is, in practice, a process fraught with difficulties. These difficulties are found at policy making level, management level and at providers' level and are linked to the interests of the various stakeholders, the knowledge and capacity of stakeholders in respect to SRH and HIV/AIDS, and also to the means made available to the health system and SRH and HIV/AIDS programmes.

This tool aims to facilitate the process by naming each facet that has to be considered during the integration process, providing clarity to stakeholders. The tool aims to point out where opportunities and barriers for integration may exist, so that stakeholders will know how to design actions in order to move forward in the integration process.

What the tool provides

The users of this tool are presupposed to have a basic knowledge on Health Systems, Health System Development, SRH and HIV/AIDS. For this purpose the tool is accompanied by a Document (available on the CD or http://www.share-net.nl/Download_centre in stead of website from Share-net) that provides information on these subjects.

The tool provides a methodology to guide the identification of opportunities and barriers when integrating SRH and HIV/AIDS into Health Systems. The tool can be used as a guide at national, decentralised and provider level for stakeholders such as Ministries of Health, funding agencies, District Health Managers, providers and beneficiaries; in short it is useful for anyone beginning, or in the process of, such an integration process. 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
d. 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

2559.Share net.krt.4:2559 24-03-2009 13:29 Pagina 3

Part one

a. Acronyms

ABC	Abstinence, Be Faithful, Condom	M&E	Monitoring & Evaluation
AIDS	Acquired Immune Deficiency Syndrome	MoH	Ministry of Health
CSO	Civil Society Organisation	NGO	Non-Governmental Organisation
DHMT	District Health Management Team	PCD	Professional Career Development
FP	Family Planning	PHC	Primary Health Care
HIV	Human Immunodeficiency Virus	PLHIV	People Living with HIV/AIDS
HRH	Human Resources for Health	SRH	Sexual & Reproductive Health
HS	Health System	SRH&R	Sexual & Reproductive Health & Rights
LGA	Local Government Authority	SWAp	Sector-wide Approach
LHA	Local Health Authority	VCT	Voluntary Counseling & Testing
LIC	Low Income Country		

b. How to use the tool

1. Read the document on the CD for background information in respect to Health Systems, SRH and HIV/AIDS.
2. Understand the four phases of the process of integrating SRH and HIV/AIDS programmes into each other and into the Health System (Part one, c).
3. Realise that the discussions that will take into account all the stakeholders' opinions are the core of the tool; only after the discussions take place, can a decision in respect to ranking be made (see part one, e).
4. Discuss the key questions in part two. The questions are meant to be discussed at each level of the Health System (Ministry of Health, district, provider). Complete the debates by rating the integration of SRH and HIV/AIDS for each category. The validation can be restricted to a certain level in the system (e.g. district) but can also be given to the entire system.
5. Fill in the agreed levels of integration on the axes of the spider web diagram for the four categories and draw the spider web by connecting the rating points (part three). Decide which categories and aspects need to be addressed to move forward in the process of integration.
6. Design actions to improve integration of SRH and HIV/AIDS in the Health System.

c. The process of integration

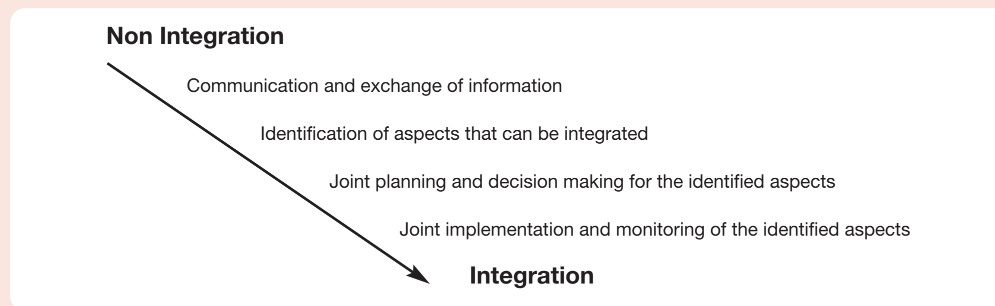
Integration of SRH and HIV/AIDS can only be reached through a process that involves all stakeholders i.e., MoH, funders and staff of SRH and HIV/AIDS programmes, Civil Society, Local Government Agencies (LGA), beneficiaries (part Two, 3). The process includes all levels in the Health System: from national policy making to health services at grass-root level.
The process of integration follows four phases that preferably should be followed in sequence, although this should not be stuck to too rigidly.

A certain amount of know-how is needed in respect to realities regarding SRH and HIV/AIDS. The availability of a sound context analysis will facilitate the integration process, providing information about SRH and HIV/AIDS services, i.e. programmes, policies and the interests and influence of various stakeholders.

The four phases in the process of integration:
1. Communication and exchange of information between stakeholders in respect to SRH and HIV/AIDS programmes.
2. Identification of aspects that can be integrated in a participatory way by all stakeholders.
3. Joint planning and decision making: During this step there must be collaboration between stakeholders in respect to the SRH and HIV/AIDS programmes. Implementation, monitoring and evaluation can still be done by the individual stakeholders.
4. Joint implementation, monitoring and evaluation of lessons learned. This is the final step towards integration.

There are four separate facets to the process of integration, i.e. service delivery, resources, governance, and technical capacity. Whether these facets act in an enabling, or disabling, way in respect to integration depends on many factors. The political, economic, social and cultural context have to be taken into account, as well as bearing in mind the attitude of individual personalities at all levels in the health system, and considering the lines of communication between different stakeholders, the availability of funds etc.

Figure 1: the process of integration



2559.Share net.krt.4:2559 24-03-2009 13:29 Pagina 5

d. Facets of integration

Integration has to be aimed at all three different levels of the health system (national, district, provider), as well targeting the direct service delivery and the enabling structures. Four facets are distinguished:

1. Service delivery
2. Resources
3. Governance
4. Technical capacity

The tool describes the facets and gives a set of key questions that are linked to them. The questions guide the discussions during each phase of the process of integration.

e. Rating for integration

Key questions can be used to assess the opportunities and barriers within the process for each component. The assessment can lead to a rating of the level of integration of a certain category in the HS. There are four distinguishable levels of integration:

1. Not integrated
2. Potential for integration
3. Partially Integrated
4. Integrated

At the end of the discussions around one category three or four key items are mentioned. These key items have to be taken into consideration before a score can be given. The score provides an idea of the overall level of integration, but it is important to realise that whether the score is high or low, the debate and the consensus in respect to integration is the most important outcome.
Most benefits will be derived not only from simply conveying the score, but from discussing this outcome with the relevant stakeholders.

Part two

Facets

1. Service delivery

The function of health systems and priority programmes is to **deliver services to fit community needs and which meet community appreciation in an efficient and sustainable way**. Needs and appreciation can differ for different community groups. There is no exact blueprint on how services should be delivered, or how SRH and HIV/AIDS services are to be integrated in primary health care services (PHC). Much depends on factors such as national prevalence, stigmatisation, urban or rural context and the capacity of basic health services etc. In order to fully integrate SRH and HIV/AIDS into PHC services, the needs of the client, the availability of services, and the way services are managed, have to be taken into consideration.

For example, certain **clients might prefer** a "supermarket approach" to health services. This one-stop-shop approach, incorporating many health services in one location, may save them time, grant them some privacy and reduce their fear of stigmatisation. On the other hand certain clients might prefer a service at a location where no other services are delivered, in search of staff with specific skills and attitudes and the opportunity to share experiences with clients looking for care for the same disease or condition.

In the day to day **management of the health services** one has to consider the efficient use of (scarce) resources and to **assure the quality** of the services provided. For example, one has to assess and monitor whether or not:

1. integration of SRH and HIV/AIDS services will lead to an overburdening of staff
2. the system can provide appropriate technical supervision for the SRH and HIV/AIDS services
3. integration of services will need specific provisions such as private rooms for counselling, laboratory equipment for tests etc.

There needs to be clear understanding in respect to whom is ultimately responsible for SRH and HIV/AIDS services delivered in PHC. Staff needs clarity as to whether it is the Local Health Authority (LHA), or the manager of the SRH or HIV/AIDS programme who will assist them in case of barriers in service delivery, or quite simply to whom they have to send reports etc.

Key questions

1. Service delivery

- Has a needs assessment been carried out amongst the (potential) users of SRH and HIV/AIDS services?
- Have all the services for SRH and HIV/AIDS in a district or country been mapped out, providing information about the number of services, their geographical location, the types of services available, and the way services are delivered?
- Who are the service providers (government, non- governmental)?
- Do the available services answer the needs of the community and create added value?
- Have providers and beneficiaries identified which services can be delivered at PHC services and which services need to be delivered separately?
- Who is responsible for the day to day management of the SRH and HIV/AIDS services delivered at PHC services?
- How are quality assurance, supervision, education, data collection and M&E, coordinated by the (district) health authority and international and national organisations that fund the SRH and HIV/AIDS programme?

As regards integration of SRH and HIV/AIDS services into the HS, consider the level of integration by looking at:

1. the way services are delivered in respect to users' needs and appreciation
2. the organisation of the day to day management of the services
3. the organisation of the health services' support systems

Not integrated	Potential for integration	Partly integrated	Integrated
1	2	3	4

Facets

2. Resources

Funds

It is not only the shortage of funds but also the question of allocation that influences the availability of funds for SRH and HIV/AIDS programmes: Choices have to be made, and these can be different for each stakeholder. Funds for SRH and HIV/AIDS can be part of the national health budget, or can be brought in through vertical programmes. Diagonal funding is a term that is used to emphasize the possibility of strengthening both the priority programs and the capacity of the HS overall, using funds earmarked for specific programmes. Collaboration between the fund holders about the availability and use of earmarked funds is vital if one is to make efficient use of available money.

Availability of funds can be discussed by looking at available funds for SRH and HIV/AIDS as a proportion of the national health budget, or by looking at the available funds for specific SRH and HIV/AIDS needs.

Human Resources

Human Resources for Health (HRH) shortages and poor performance are serious bottlenecks to the process of integrating SRH and HIV/AIDS and in the development of Health Systems in general. The integration of SRH and HIV/AIDS can be used as an opportunity for health workers to develop expertise. If SRH and HIV/AIDS programmes are managed by (international) organisations that offer more attractive working conditions for health staff than the public health services, this can lead to a "push and pull effect", resulting in staff leaving the public health services for the greener pastures of the SRH and HIV/AIDS programmes.

Integration of SRH and HIV/AIDS services into the HS will require new skills and training for a broad range of health staff, as most of them are not adequately trained to address sexuality in heterosexual adults, let alone providing services to unmarried adolescents, gay people, or intravenous drug users. Additional efforts will be needed for these staff to be able to provide high quality SRH and HIV/AIDS services.

Key questions

2. Resources

Funds

- How are funds for SRH and HIV/AIDS brought into the system? Is it through vertical or diagonal funding? Are they an integrated part of the health care budget, or are they funded via out of pocket payments?
- Is there earmarking of funds for SRH and HIV/AIDS? How is this organised and coordinated?
- Is the amount of funds for SRH and HIV/AIDS in balance with the magnitude of the problem and the demand for services in the country?
- What proportion of the national health budget funds is earmarked for SRH and HIV/AIDS?
- Do the budgets for HIV/AIDS and SRH form part of a consolidated district budget?
- Does the District Health Management Team (DHMT) have decision making power on (planning of) HIV/AIDS and SRH funds?
- Do staff allowances related to HIV/AIDS and SRH programmes conform to national rules and standards?
- Is funding for general district activities (training, supervision, transport, referral etc.) separated from funding for HIV/AIDS and/or SRH programmes?
- How can existing funds be used in different ways to achieve not only the programme's goals, but also to strengthen the HS in general?

Human Resources

- Is there a critical shortage of (skilled) health workers in the country?
- Does the SRH and HIV/AIDS programme have a negative effect on the human resources of the public, or the non-profit private health services?
- What components of SRH and HIV/AIDS services require specialized skills of PHC workers?
- Does the system encourage niches for specialization or does it favour multi-skilled health workers?
- What threats/ opportunities does integration of SRH and HIV/AIDS present in respect to job security and incentive packages for staff of SRH and HIV/AIDS (overall health) programmes?
- Do HIV/AIDS and/ or SRH programs invest in motivation, increased performance (or –assessment), career perspectives, availability, (re)location and training?
- What threats and opportunities does integrating SRH and HIV/AIDS present in respect to job security and incentive packages for staff of SRH and HIV/AIDS programmes?
- Do SRH and HIV/AIDS programmes invest in training programmes for staff, such as motivational training and assessment centres; what are the career perspectives, are there funds available for relocation etc.?

Facets

Equipment and drugs

Procurement and distribution of (medical) equipment and drugs are essential in the delivery of quality services. Stock depletion can paralyse service delivery, therefore the temptation for programme owners to develop their own drug procurement system is understandable. However, it is not efficient to have several systems in place fulfilling the same function.

Infrastructure

Health facilities are not always constructed in a way that they can host all services; for example, a quality health centre should have a private room for counselling on HIV and a proper delivery room.

Key questions

Equipment and drugs

- Do existing procurement channels provide the necessary materials for HIV/AIDS and/or SRH programmes?
- Are there separate channels for procurement, storage and distribution of commodities for SRH and HIV/AIDS?
- Would synchronization of these channels with the channel that cares for the general drugs and equipment make managing the process more efficient?

Infrastructure

- Do public and private service providers take into consideration the specific needs of SRH and HIV/AIDS programmes for their health services, i.e. are there proper delivery rooms, laboratory services and counselling rooms?
- Do HIV/AIDS and/or SRH programmes invest in general infrastructure needs (maintenance, transport & communication means etc.)?

As regards integration of resources of SRH and HIV/AIDS into the HS consider the level of integration by looking at:

1. how funds for SRH and HIV/AIDS are related and linked to national health budgets
2. the position of general HS workers in SRH and HIV/AIDS programmes
3. the synchronization of channels for the management of drugs and equipment
4. appropriateness of infrastructure of PHC services to deliver SRH and HIV/AIDS services

Not integrated	Potential for integration	Partly integrated	Integrated
1	2	3	4

Facets

3. Governance and management by different stakeholders

Five groups of stakeholders can be distinguished:

1. Ministry of Health (MoH) (various levels: district, intermediate, central)
2. Funders/owners/employees of SRH and HIV/AIDS programmes
3. Local Government Authority (LGA)
4. Civil Society
5. Beneficiaries

When scrutinizing possible links between the MoH and SRH and HIV/AIDS programmes, one has firstly to be aware of some of the pitfalls. A nation's HS can only be used for the implementation and M&E of the programmes if it functions properly. If the system is weak there will be the tendency to bypass it in order to reach “quick” results. The **unequal relationship** between those who manage the HS and those managing the SRH and HIV/AIDS programmes might be exacerbated by budgetary and/or capacity issues and could form a barrier to integration.

Such power relations are relevant in respect to all stakeholders. The influence of advocacy groups on local, national and international level on the budget allocation for SRH and HIV/AIDS should not be underestimated.

Ministry of Health

Health system reforms and SWAps are, in theory, the basis for managing HS, but in practice these processes can be quite challenging. National health plans quite often do not pay enough attention to important aspects of SRH and HIV/AIDS, let alone their integration. Sometimes strategic national health plans and the plans of SRH and HIV/AIDS programmes contradict each other.

At local (district) level the management of programmes falls under the LHA and District Health Management Team (DHMT).

The LHA can play an important role in the process of setting up communication lines and collaboration between the different programmes and services.

Key questions

3. Governance and management by different stakeholders

Ministry of Health

- Have (national and local) governments mentioned HIV/AIDS and SRH in their health plans?
- Are the programmes for HIV/AIDS and SRH governed by a separate governance and management structure?
- Is integration of SRH and HIV/AIDS programmes hampered by unequal relations between management of programmes and the MoH?
- Does the process of decentralisation within the MoH show opportunities for integration of SRH and HIV/AIDS programmes?
- How do advocacy groups and religious groups influence the MoH regarding policy making for SRH and HIV/AIDS programmes?
- How is the MoH held accountable by the different stakeholders on its results – both downstream as upstream? Is the M&E system a health information system, or a health management information system?
- Are health authorities at local level (DHMT, HS managers) autonomous in their management & planning – to what extent do central and intermediate levels of the MoH interfere? Is this different for HIV/AIDS and SRH programs?

2559.Share net.krt.4:2559 24-03-2009 13:29 Pagina 10

Facets

SRH and HIV/AIDS programmes funded by international NGOs/donors

The international donor community is an important stakeholder in the process of integration of SRH and HIV/AIDS programmes.

Although in the last decade many efforts have been undertaken to strengthen the ownership of national governments in respect to priority programmes, multilateral agencies encounter many difficulties in fully supporting SWAp. They struggle with their mandate, to which they are held accountable. At a global level most UN organisations subscribe to participation in SWAps at a national level, but it quite often depends on individual personalities as to how far the agencies will support the health sector in general and integrate these issues into their activities.

International NGOs, often funders/owners of SRH and HIV/AIDS programmes, are a very mixed group and each has their own mission and constituency. Because of the risk of losing one's own visibility, it is not always easy to effectively support SWAps and the integration of SRH and HIV/AIDS.

Local Government Authority

In many countries a process of devolution is taking place. Local governments are becoming increasingly responsible for basic health services in their area. This might provide an opportunity for better integration as local governments are usually interested in a complete package of services rather than in separate programmes. However the decentralised level does not always receive the necessary funds, or have the power to set priorities. Even when they do have this mandate, health care is not always their priority, let alone the broader aspects of SRH (often limited to maternal health alone) and HIV/AIDS. Lack of motivation to realise integration of SRH and HIV/AIDS into Health Systems is often exacerbated by the fact that incentives and equipment are generally only offered as a package deal within specific programme activities.

Key questions

SRH and HIV/AIDS programmes

- How are management and planning activities of SRH and HIV/AIDS programmes separated from those within the national health plan?
- Is there harmonization between national health plans and SRH and HIV/AIDS programmes? Do they strengthen each other?
- Is donor coordination brought in practice by supporting consolidated health programs in stead of specific programs and projects?
- Do HIV/AIDS and SRH programmes have their own line of command, their own hierarchical system and their own regulations regarding conditions of work, quality assurance etc?

Local Government Authority

- Is there an interest of local governments in the integration of HIV/AIDS and SRH in the district health system?

2559.Share net.krt.4:2559 24-03-2009 13:29 Pagina 11

Facets

Civil Society

Special attention has to be given to **NGOs and and private non-profit organisations**. NGOs can contribute to integrated services and many deliver a comprehensive package of services because they own hospitals and health centres. Another group of international and local NGOs play a crucial role in reaching specific risk groups and providing the appropriate services for them, such as safe abortion services, HIV/AIDS prevention services for adolescents, or basic health services for intravenous drug users. Integration of their programmes into the national HS has to be safeguarded by mechanisms in the enabling structures (M&E, HMIS, budgeting, licensing etc.).

Private for-profit services are an important part of the health sector, but seldom provide a full package of PHC services that include SRH and HIV/AIDS.

Consumer/patient organisations:
These groups are becoming increasingly important in LIC. Associations of People Living with HIV (PLHIV) play a considerable role in service delivery. They lobby for better services and the development of local and national programmes for HIV/AIDS. The primary concern of these groups is, however, not automatically the integration of HIV/AIDS services into the HS.

Advocacy groups focus strongly on one issue; this can be HIV/AIDS or SRH. When the relationships between both issues are not fully understood, simultaneous integration of HIV/AIDS and SRH may be jeopardized; one issue may be favoured above the other.

Religious groups sometimes have strong attitudes towards SRH and HIV/AIDS related issues. They may influence national and local policies (for example, Family Planning services at health service level), or are advocates of ABC (Abstinence, Be Faithful, Condom), sometimes without the C.

Consumer and advocacy groups play a role in respect to the rights and needs of PLHIV, and influence the Sexual Reproductive Health & Rights of men and women, but they do not always support a responsive HS as an entity on its own. The power of international, national and local advocacy groups can influence the availability of resources and the way services are organised in respect to SRH and HIV/AIDS.

Key questions

Civil Society

- What kind of services regarding SRH and HIV/AIDS are provided by the civil society (NGOs)? (funds, technical assistance, service delivery, etc)
- Is there a need for specialised SRH and HIV/AIDS services for specific groups or conditions that are provided by NGOs?
- How do these services link to the health system?
- How are private for profit services integrated in the health system?
- Are consumers/ patient organisations recognised by the system? Do they have a space to express their wishes regarding (integration of) SRH and HIV/AIDS services and PHC services?
- Do CSO (incl. advocacy groups) have an influence on the planning and implementation of SRH and HIV/AIDS programmes in the country/ district? How do these advocacy groups look towards integration?
- How do religious groups relate to national policies?
- Have CSO instruments, information and capacity to M&E the results of health services incl. HIV/AIDS and SRH programmes?

2559.Share net.krt.4:2559 24-03-2009 13:29 Pagina 12

Facets

Community

Community is a part of civil society and in that role they have already been mentioned under consumer/patient groups and advocacy groups. However communities have to also be mentioned as a separate stakeholder in the integration process, namely as beneficiaries of the programmes and services.

Integration of SRH and HIV/AIDS services must also answer the needs of its beneficiaries. Involving communities in the designing of the service delivery is essential to the development of responsive services. Communities have an opinion on which services they would like to have delivered together, for example, and which ones they would like to see separated.

Key questions

Community

- What are the perspectives of the community in respect to what services have to be delivered by whom and where?
- How is the community involved in management (objective setting/ co-funding, M&E, management & planning) of health services – is this different for HIV/AIDS and SRH programs?

As regards to integration of the governance of SRH and HIV/AIDS programmes, consider the level of integration by looking at:

1. the influence and interests of stakeholders in respect to SRH and HIV/AIDS
2. the level of coordination between stakeholders
3. the efforts to work jointly towards a responsive health system

Not integrated	Potential for integration	Partly integrated	Integrated
1	2	3	4

2559.Share net.krt.4:2559 24-03-2009 13:29 Pagina 13

Facets

4. Technical Capacity

To guarantee quality of care technical capacity (which includes technical knowledge) for policy making, planning, implementing and M&E of SRH and HIV/AIDS should be sufficient at all levels of the HS in order for it to be able to react effectively to needs and demands regarding SRH and HIV/AIDS.
In order to maintain a certain level of expertise and competence non-integration might be preferred in certain contexts, or by certain stakeholders.
Technical capacity at service delivery level will strongly depend on the availability of skilled staff for SRH and HIV/AIDS programmes, availability of the necessary supplies, and appropriate monitoring of the services delivered.

Important aspects for integrating the technical capacity of SRH and HIV/AIDS in the health system are:

1. The incorporation of SRH and HIV/AIDS in training curricula (pre-service and advanced education) of general health service workers.
2. The sharing of lessons learned in respect to SRH and HIV/AIDS with all five groups of primary stakeholders.

Key questions

4. Technical Capacity

- Is there sufficient technical knowledge of SRH and HIV/AIDS issues within the different levels in the system?
- for policy making
- for planning
- for resource management
- for implementation
- for monitoring and evaluation

- Is this technical knowledge made available through special officers for SRH and HIV/AIDS and/or is the know-how shared with general HS workers?
- Are SRH and HIV/AIDS integrated in pre-service training curricula of HS workers? Is the content of this training based on feed back of up to date national health plans?
- Are SRH and HIV/AIDS incorporated in curricula for advanced education or professional career development (PCD) plans of general HS workers?
- Are knowledge and experiences from SRH and HIV/AIDS programmes and health systems shared with all stakeholders?

As regards the integration of technical capacity within the health system, consider the level of integration by looking at:

1. the spread of knowledge on SRH and HIV/AIDS among general health workers
2. the integration of SRH and HIV/AIDS in curricula of pre-service training and continuous education and in PCD plans
3. the sharing of experiences between stakeholders of SRH and HIV/AIDS programmes and stakeholders in the health system

Not integrated	Potential for integration	Partly integrated	Integrated
1	2	3	4

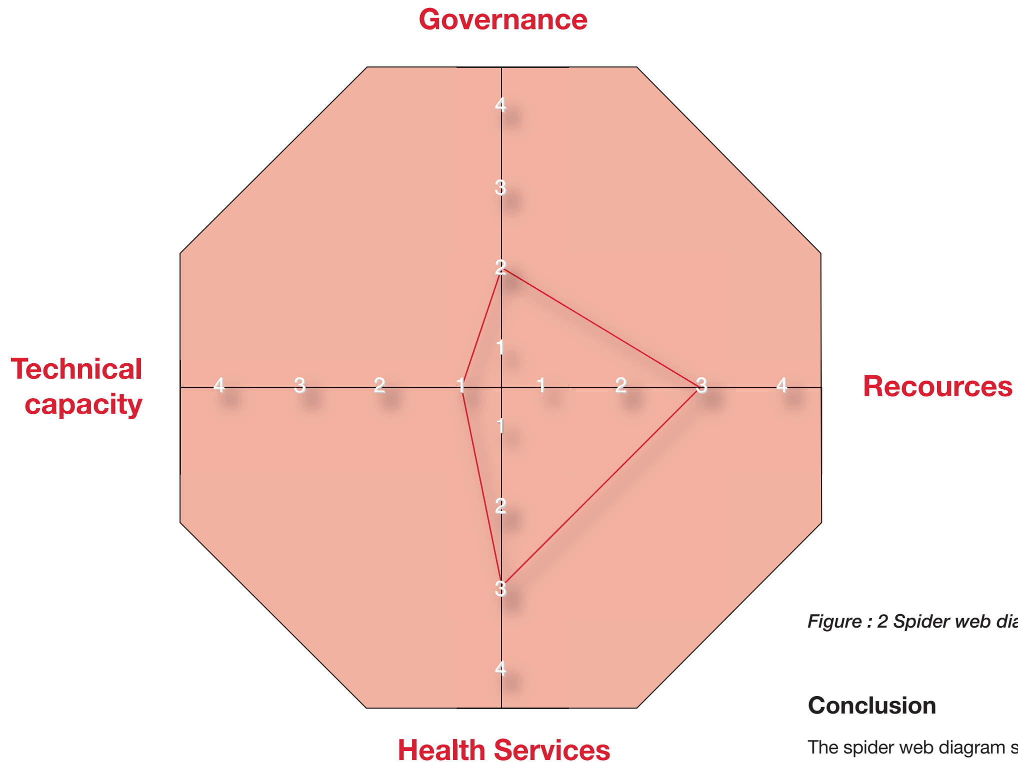


Figure : 2 Spider web diagram on integration

Conclusion

The spider web diagram shows which facets need to be addressed in order to move forward in the process of integration. The outcome of the exercise can be used to:

1. Formulate an overview on where opportunities and barriers to integration can be found.
2. Design an action plan to move forward in the integration process.

Take care: The methodology to develop this spider web diagram does not validate using this spider web diagram as a comparison between the level of integration between different districts or countries. It limits itself to assisting the measure of integration of SRH and HIV/AIDS in health systems.

The spider web diagram can be used to compare the process of integration in a district or country on the condition that the methodology and participants in the assessment process have not changed drastically during time.