SRH and HIV integration has the potential to increase the efficiency of both services by saving money, resources (human and institutional) and lives. There is little conclusive evidence on whether integration leads to gains in health system efficiency and/or reduced costs for clients, and the ongoing Integra research will contribute to filling this gap.

Integra
The Integra project, a five-year research project to gather evidence for delivering integrated SRH and HIV services, has been implementing the evidence base about the cost effectiveness of integration and its impact on HIV prevention, stigma reduction and unintended pregnancies. The International Planned Parenthood Federation (IPPF), in collaboration with LSHTM and Population Council, is implementing this Special Initiative on HIV prevention, stigma reduction and unintended pregnancies. The evidence base about the cost effectiveness of integration and its impact on both services by saving money, resources (human and institutional) and lives is little conclusive evidence on whether integration leads to gains in health system efficiency and/or reduced costs for clients, and the ongoing Integra research will contribute to filling this gap.

What are the costs and possible benefits from integrating HIV and sexual and reproductive health (SRH) services?

Integra

COST, EFFECTIVENESS AND SAVINGS

INTEGRATION CAN ACHIEVE EFFICIENCY GAINS, BUT THERE IS NO BLUEPRINT FOR INTEGRATION

Observations
- Inefficiencies were noted in both HIV and SRH services and there is clear potential for integration to expand service provision simply by enabling better use of existing resources.
- Opportunities for integration vary considerably by setting, and for integration to be a success programme managers need to be much more astute about resource limitations and costs in different facilities.
- Specifically for HIV counselling and testing, clear cost differences were observed between those integrated with sexual health services and those that were not. HIV stand-alone clinics should be only considered when there is a clear demand in that community (i.e. because of stigma) or a large group is not accessing other forms of health care.

Overall recommendations
Integration can achieve efficiency gains, but there is no blueprint for integration. The Integra study demonstrates that the integration of SRH and HIV services is clearly feasible at a variety of service levels. However, any efficiency gains from integration are likely to be highly context specific, as much will depend on the current levels of resource use within health facilities (or other service levels). This presents a challenge to programme managers, as a blueprint integration approach may not be the best way forward.
- Policy makers need to work together, from different divisions within the Ministry of Health and other Ministries (such as those from the reproductive health, HIV and/or gender units), to arrive at an approach to SRH and HIV integration that supports managers at all programme levels to work together to identify any resource inefficiency and/or duplication and find joint solutions.
- Collaborative resource planning processes – at the national and also lower levels (regional and local) – should be established to facilitate SRH and HIV integration.
- Service managers should develop better approaches for assessing costs and efficiency, as well as for monitoring duplication across multiple programmes.

Further research
The Integra project will disseminate the research results to help inform policy makers and enable managers to rapidly assess these factors and develop the best model for their facility. A gap in the evidence base remains regarding client and systems costs. The final results from Integra will examine the former; however the latter is probably where the biggest gains are to be made.

Further research could explore a ‘tipping point’ in regard to resource use. Where research indicates that HIV and SRH integration is the most efficient way to encourage new clients to access cost-effective services, such as HIV counselling and testing, this ‘tipping point’ would indicate where integrated services may require additional resourcing. Finally, more research is required to capture gains made at both the client and systems levels.

Findings
Findings emerging from Integra are beginning to show some of the potential for economic gains, but also of the challenges in achieving these, for example:
- Integrated HIV and SRH services for specific clients – such as young people – in Malawi: The costs of integrated services for different clients can vary. The uptake of integrated services by adolescents was observed to vary widely over time. This was in part related to variations in supplies. Ensuring stable supplies is an important component of ensuring that efficiency gains are achieved. When supplies are low, so is patient load and hence the average cost of seeing clients increases, with staff being under utilised, as a consequence of the poor supplies.
- Integrated family planning and HIV services in Kenya: There is a wide variation in the current costs of providing both SRH and HIV services. Various factors drive these costs, such as the availability of supplies, physical space of the facility and capacity of staff, and key is the use of human resources. While most providers are concerned about the potential increased workload that integration brings – in fact there is a wide difference across facilities in the number of clients being seen. Programme managers need to carefully assess which facilities can adapt to the increased workload and which may become over-burdened.
- Integrated HIV counselling and testing services in Swaziland: Early signs show that integrated HIV counselling and testing within SRH services are much lower cost than some HIV stand-alone facilities, but the picture is not uniform. Some stand-alone facilities are extremely efficient, but where demand for counselling and testing services is low, then services are often of a high cost.

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