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Integra

Strengthening the evidence base for integrating HIV and sexual and reproductive health (SRH) services



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Making the most of scarce resources:

Cost, saving, and efficiency gains from SRH and HIV integration

The results from the Integra initiative provide evidence that can help guide planners, managers and policymakers towards the greatest value for money – in terms of human rights, health outcomes and cost savings. Policymakers, programmers, managers, and clinicians can listen to and learn from evaluations of different models of integrating sexual and reproductive health and HIV services. New thinking and new types of investment are needed to transform national responses to HIV around the world.

In the most resource constrained settings, integration often happens out of necessity. Where there is only one practitioner, by default they end up providing all of the services at that facility, or referring clients where other options are available. Even where the luxury to be more mindful of different approaches to integration exists, there is no blueprint for the most cost-efficient way of integrating services and context needs to be taken into consideration.

In some settings integration may mean looking for creative solutions to enhance planning, budgeting and management; in others, integration may be achieved through strategies aimed at strengthening the capacity or skills of health care providers to provide multiple services and to overcome fear of increased workload. Finding solutions to commodity stock-outs or supply chain blockages may also be critical facilitators of integration.

By evaluating the effectiveness and efficiency gains from different models of integrating SRH and HIV services, due focus can be put back on achieving health and human rights outcomes in ways that address people's needs while also providing good value for money.

Speaking on the new investment framework in a plenary session at the recent International AIDS Conference in Washington DC, the Director of Evidence, Strategy and Results Department at UNAIDS, Dr Bernhard Schwartländer, suggested that with a slight increase of investment now, the 'bill' will be dramatically reduced in the future. He concluded with this Chinese proverb: "***Those that say it can't be done should get out of the way of those doing it***".

Integration is happening. Policymakers, programmers, managers and clinicians can learn more from and be better guided by the lessons learned from research.

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Visit our upgraded website – an online resource showcasing the latest research findings, project reports and innovations, and interactive discussions about current questions, debates and good practice in linking SRH and HIV.

RESEARCH HIGHLIGHTS: PRELIMINARY RESEARCH FINDINGS

KENYA: PROVIDERS' WORKLOAD

Examining the link between workload and unit cost estimates in the context of SRH and HIV service integration: a case study of selected government facilities in Kenya

S. SWEENEY, C. MICHAELS, A. VASSALL, C.D. OBURE, F. TERRIS-PRESTHOLT

Background: There is a great deal of interest in integrating health services in low-income countries. Integration often requires reorganization of existing service delivery models. As a result, health workers may be concerned about increases in workload. This work aims to examine variation in staffing and workload across the facilities and explores how this may be linked to variation in unit costs.

Methods: As part of the Integra Initiative in Kenya, cost and output data were collected in 24 government health facilities integrating HIV and SRH services. Cost data were collected from July 2008 to June 2009 using a combination of approaches. Staff time was allocated as a percentage of their full-time equivalent according to service mix and time use. Unit costs were estimated per visit for each service provided.

Results: The workload and degree of task orientation varied considerably between facilities. The average number of services provided per day per clinical staff member varied from 6.9 to 28.5. Staff at busier facilities (more visits per day) tended to provide a smaller range of services. This is consistent with traditional arguments that task-orientation enables health workers to cope with a heavy client load by keeping clients moving and enabling task shifting. We found an inverse relationship between the range of services provided by one staff member and the unit cost per visit. Salary costs accounted for 64–91% of unit cost estimates across services.

CONCLUSIONS: Task specialization still plays a major role in the organization of Kenyan health facilities. Human resources make up the majority of unit costs for SRH services, and more efficient utilization of staff time may improve the cost-effectiveness of service provision. Integration could lead to reductions in cost of service provision, though further research is needed to determine the effects of integration on workload and client flow.

KENYA AND SWAZILAND: COST AND EFFICIENCY

Does integration impact the costs and efficiency of delivering HIV and SRH services?

C. OBURE, A. VASSALL, F. TERRIS PRESTHOLT, C. MICHAELS, C. WATTS AND THE INTEGRA RESEARCH TEAM

Background: Economic theory suggests potential efficiency gains resulting from Integration of HIV and SRH services. However, reviews on the impact of integrating SRH and HIV services have consistently identified scarcity of evidence around efficiency gains associated with such integration. To generate evidence on the efficiency of delivering integrated HIV and SRH services, a costing study was conducted in two low resource settings (Kenya and Swaziland).

Methods: We collected cost and output data from 41 health facilities in Kenya and Swaziland using standard costing methods for the 2008/2009 financial year. The analysis was conducted from the health provider perspective. We estimated the unit cost of SRH and HIV services and assessed the relationship between unit costs and human and capital resource use. All costs are adjusted to 2011 US dollars.

Results: We found variations in resource use and unit costs of SRH and HIV services across facility types in both settings. Average unit costs per visit for integrated HIV counselling and testing services ranged from US$ 5.04 to US$6.40 in Kenya and US$7.24 to US$14.14 in Swaziland. We specifically compared the costs of integrated and stand-alone HIV counselling and testing (HCT), and found in most cases, the costs of integrated HCT to be lower. A substantial element of cost variation between and within integrated services is accounted for by differences in personnel costs across settings.

CONCLUSIONS: In the context of significant policy interest in optimizing scarce resources, the results of this study demonstrate that there may be potential for substantial gains in efficiency resulting from the integration of services particularly through better utilisation of existing human resources.

MALAWI: YOUTH-FRIENDLY SERVICES

Using a discrete choice experiment to examine youth preferences for characteristics of SRH services in Malawi

CHRISTINE MICHAELS

Background: Effective design and delivery of youth-friendly health services is a critical concern for policymakers in Malawi. Global efforts to improve utilization of SRH services by young people have been adapted for use in Malawi and are outlined in *The Malawi Youth-Friendly Health Services Training Manual*.[1] To date there has been no rigorous evaluation of youth-friendly health service delivery in Malawi and the extent to which availability of youth-friendly services will result in an uptake of these services by young people remains unclear.

Methods: As part of the Integra initiative, the Family Planning Association of Malawi (FPAM) has committed to addressing the SRH needs of young people and is aiming to improve access to SRH services for young people in rural Malawi through the expansion of outreach services in Ntcheu District. The economics team at the LSHTM has partnered with FPAM to design and implement a discrete choice experiment (DCE) among youth in Ntcheu to try and broaden our understanding of what constitutes a youth-friendly service and to begin to look at how young people value the different components of a youth-friendly service.

Results: Preliminary analysis of the qualitative work that was done in conjunction with the DCE suggests that young people have experience in making trade-offs and looking for service characteristics that suit their needs. Differences in decisions making processes suggest that young people's preferences may change over time as they gain experience in using SRH services and become more familiar with their own needs. For many young people a perceived lack of confidentiality is a key concern when thinking about accessing family planning (FP) services. Exploring issues around what 'confidentiality' means to young people could be critical for understanding the extent to which this is linked to concerns about stigma and whether integration of SRH and HIV services can provide a safe and comfortable space for young people to receive services.

CONCLUSIONS: Results may help policymakers identify which components of a package of youth-friendly SRH services are most important to young people, how young people value specific elements and what factors motivate young people in deciding where to access FP services. In a resource constrained setting, understanding these trade-offs may be particularly important in helping policymakers to prioritize certain components of youth-friendly service development.

1. The Malawi Youth Friendly Health Services Training Manual: Participants Handbook. 2009. MOH, Government of Malawi: Lilongwe.

THERE'S NO BLUEPRINT TO INTEGRATION

PAYING ATTENTION TO ABOVE SERVICE-LEVEL COSTS AND SAVINGS

DR ANNA VASSALL

While 'disease specific' approaches to health service can be an effective way of mobilizing and expanding new HIV and sexual reproductive health services, they can result in duplication at all levels of the health system. These essential services therefore eventually need to be embedded and integrated in broader health services and the systems supporting them.

Integrating health services can reduce costs for the client, saving scarce time and money, by providing multiple services during one visit. For the providers, integration can increase their flexibility to determine the use of resources in response to the needs of the clients they serve, which can enhance the quality and frequency of services provided.

In addition, and as yet under researched, integration can potentially have an equally important impact on the efficient use of resources used to support services. Recent studies estimate that up to 50 percent of health service expenditure is spent in management support and governance of health services. Ensuring that health services are well planned; that key resources such as drugs are efficiently supplied; and that health service staff are properly trained to the appropriate level all require substantial investment. Where these elements of health systems are weak, arriving at cohesive health system development plans, that make the best use of all the available resources in an integrated way is essential – and ultimately will bring the best outcome for all clients and those who serve them.

In Integra, the economics research has focused on costing and efficiency gains at the service level. Future research could also investigate how gains can be made at the systems level.





Dr Anna Vassall is an economist Co-Principal Investigator for the Integra initiative and a Lecturer at the Department of Global Health and Development, at London School of Hygiene and Tropical Medicine (LSHTM)

"I joined the Integra initiative in 2010, and since then I have been responsible for guiding the economic component of the project. In my previous work, I had been intensively involved in supporting the Ministries of Health to plan comprehensive health services that meet the needs of their entire population. The potential of integration is not only to provide quality services, but also to reduce the duplication and wastage of resource-use in places that unfortunately have very limited resources available to provide the most basic health services. Integrating SRH and HIV services is a key element of this effort."

> "Integra has been a wonderful experience, to research how integration can bring both public health and economics benefits in practice, right at the health service level."

MESSAGE FROM PARTNERS AND PROGRAMME MANAGERS

"In the current economic climate, many countries are seeking to rationalise their health-related expenditure. Integrating HIV and sexual and reproductive health and rights (SRHR) services contributes to, but also requires, strengthening health systems, but the wider agenda linking policies and programmes on HIV and SRHR also requires a multi-sectoral and community-based approach, reaching beyond the health sector.

All too often the verticalization of HIV and SRH programmes (both at the national level and in donor funding priorities) does not support this logical alignment. At best this leads to disjointed planning, and at worst to mismanagement, and often results in missed opportunities for health, duplication of effort and increased stigma.

Despite the existing and growing evidence that supports HIV integration from a public health and clinical perspective. Investment in implementation science and wide variety of costing studies is vital to support future development of policy and programming in this area.

ASA ANDERSSON, REGIONAL PROJECT COORDINATOR, UNAIDS/UNFPA PROJECT ON LINKING HIV AND SRH IN SOUTHERN AFRICA AND ANDISWA HANI, M&E CONSULTANT FOR JOINT UNFPA/UNAIDS SRHR AND HIV LINKAGES PROJECT



"Integration is a reality and a practical course towards reducing missed opportunities for services."

ESTHER MUKETO



"Working on Integra has helped me to understand the complexity and diversity of integration at the health facility level, and the great need for further research to understand the effects of all of these various approaches."

SEDONA SWEENEY

MEET THE TEAM

Esther Muketo is a Programme Manager (Service Delivery) at Family Health Options Kenya (FHOK)

I have been working with the Integra team to oversee quality of care at FHOK service delivery points. I am involved in providing technical oversight to service providers on provision of integrated services to ensure delivery of quality services. Through partnership with the Ministries of Health I ensure quality assurance for integrated service delivery. I also interact with clients who assess integrated services and receive their feedback on our service delivery. It has been exciting to note that the Integra Initiative is meeting needs of the actual service users through minimizing missed opportunities for service access.

Charity Ndwiga is a Programme Officer in the Reproductive Health Programme at the Population Council, Nairobi

My work in the Integra initiative focuses on coordinating and monitoring the implementation activities in all sites in Kenya. This involves close collaboration with the Ministry of Health in Kenya at all levels of health care. I have overseen the development of the mentorship program for SRH and HIV integration that has successfully improved access to HIV and SRH services particularly for the long-term method of family planning in three districts in both Kenya and Swaziland. In addition I was part of the team that pre-tested and revised the Balanced Counselling Strategy Plus (BCS+) toolkit to include additional components to address counselling requirements for an integrated HIV and post-natal services package in line with the latest WHO Medical Eligibility Criteria (MEC), 2010.



Dr Lawrence Oteba is the HIV Officer and Integra liaison at Africa Regional Office (ARO), IPPF

The Integra team at IPPF ARO have played a crucial role in liaising between different Member Associations (MAs), and partners, throughout the preparation and implementation of the project to make sure that the process moves smoothly. With a range of technical skills, programme and financial management, the team have helped to prepare the ground for implementation in the three countries as well as to share the emerging lessons with other MAs throughout the region.



"SRH and HIV integration is at the core of much of our service provision in the region. Research is important for us to provide the best quality, accessible and well managed services for all of our clients. It has been terrific to have been part of the Integra team for many years."

DR LAWRENCE OTEBA

"Working with Integra has just been exciting! From seeing the facilities re-organize service delivery to accommodate integrated SRH and HIV services to having national products such as the mentoring guide is a great learning experience for me. The health system has to work in synchrony for successful integrated SRH and HIV service."

CHARITY NDWIGA

Sedona Sweeney is a Research Fellow at the London School of Hygiene and Tropical Medicine (LSHTM)

I joined the Integra team in early 2011. As part of the team, I was involved with the economic analysis side of the study; my responsibilities cover collection and analysis of resource utilization for each of the services. I have been based in Kenya for the last year and a half, and have spent a great deal of that time in the field collecting cost data. As I visit each site, I am struck by the very different approaches to integrating service delivery at the health facility level. At this point, I think the question is really not whether to integrate, but how and when to do so, and which model is most effective in which setting. These are the questions Integra is looking to answer.

EVENTS

PAST EVENTS

AIDS 2012: XIX International AIDS Conference, Washington DC, USA; 22–27 July 2012

IAEN: International AIDS Economic Network (7th AIDS and Economics Pre-Conference) Washington DC, USA; 20–21 July 2012

UPCOMING EVENTS

Integration for Impact Conference, Nairobi, Kenya; 12–14, September 2012

American Public Health Association (APHA) Annual Meeting and Exposition, San Francisco, USA; 27–31 October 2012

Global Symposium on Health Systems Research (HSR), Beijing, China; 31 October to 3 November 2012

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