

# Assessment of the Policy Environment for the Integration of Reproductive Health and HIV&AIDS Services in Ghana



**USAID**  
FROM THE AMERICAN PEOPLE

HEALTH POLICY  
INITIATIVE

# Assessment of the Policy Environment for the Integration of Reproductive Health and HIV&AIDS Services in Ghana



**USAID**  
FROM THE AMERICAN PEOPLE

**HEALTH POLICY INITIATIVE**

---

Suggested citation: Jeffers, J.B., M.-B. Dohlie, and P. Antwi. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

The USAID | Health Policy Initiative, Task Order 1, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. Task Order 1 is implemented by Futures Group, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and Futures Institute.

The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government, or the Ghana AIDS Commission or other Ghanaian partners.

# Table of Contents

		Pages
■	Acknowledgments	4
■	Foreword	5
■	Executive Summary	6 - 8
■	Abbreviation	9
<b>Chapter One</b>	Introduction	10 - 11
<b>Chapter Two</b>	Assessment	12 - 13
<b>Chapter Three</b>	Stakeholders' Perceptions Of Integration	14
<b>Chapter Four</b>	Stakeholders' Views On Client's Needs	15 - 16
<b>Chapter Five</b>	Efforts To Integrate Services	17
<b>Chapter Six</b>	Stakeholders' Views On Level Of Integration Of Services	18 - 19
<b>Chapter Seven</b>	Perceived Contribution Of Policies To Integration Of Services	20 - 23
<b>Chapter Eight</b>	Perceived Challenges To Service Integration	24 - 27
<b>Chapter Nine</b>	Perceived Benefits Of Integrated RH And HIV Prevention And Aids Care And Treatment Services	28
<b>Chapter Ten</b>	Conclusions	29
<b>Chapter Eleven</b>	Recommendations	30 - 32
■	References	33
<b>Annex A</b>	Key Organisations Interviewed	36

## Acknowledgments

The authors are grateful to all the respondents in different organisations who graciously took time from their busy schedules to share their insights. They also wish to express their sincerest thanks to the Ghana AIDS Commission for all its support and active involvement in the assessment and to PEPFAR and USAID/Ghana for funding the assessment.

The authors would like to thank the following for their different contributions and support:

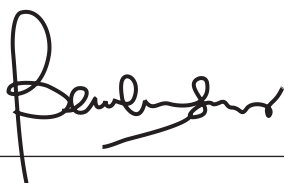
- Dr. Angela El-Adas, Director-General, GAC
- Dr. Nii Addo, Programme Manager, NACP
- Dr. Richard Amenyah, Director of Technical Services, GAC
- Dr. Silvia Anie, Director, GAC
- Mr. Kyeremeh Atuahene, Ag. Director of Research Monitoring & Evaluation, GAC
- Mr. Clive Ashby, Research Coordinator, GAC
- Ms. Gertrude Akpalu, NSP Coordinator, GAC
- Ms. Amma Ofosuah Dankyi, Secretary to the Director-General, GAC
- Ms. Anna Hoffman, Health Officer, USAID/Ghana
- Mr. Peter Wondergem, HIV/AIDS Advisor, USAID/Ghana
- Mr. Kenneth Essuman, IHS
- Ms. Salomey Sey, IHS

## Foreword

The Government of Ghana has progressively responded to the HIV epidemic using locally generated evidence and gradually scaling up effective HIV interventions. Integration of family planning/reproductive health (FP/RH) and HIV prevention and AIDS care and treatment services is an effective intervention to ensure that Ghanaians receive needed services. Helping sero-positive as well as sero-negative women and couples space or limit births as they desire is a cost-effective intervention that contributes to good health and well-being; prevents unwanted pregnancy, abortion, and unwanted births; and ultimately lowers maternal and infant mortality. Conversely, ensuring that sexually active Ghanaians seeking FP and other RH services receive HIV prevention services or AIDS care and treatment as needed will enable them to more effectively protect themselves and others against HIV transmission.

Gathering the views of health-related institutions, civil society, and health care personnel, among others, as we have in this qualitative assessment, will contribute to our understanding of their views on current integration efforts and the extent to which current policies support integration.

The Ministry of Health and the Ghana AIDS Commission are grateful to all the researchers and most importantly to the participating institutions for contributing this body of knowledge to help streamline the policy and legal environment in which we deliver the national response. The recommendations made will help shape the development of the National Strategic Plan for HIV/AIDS 2011–2015 and also inform Health Sector programmes so as to contribute towards the Millennium Development Goals especially MDG 4, 5 and 6.



---

**Dr. Benjamin Kunbuor,**  
Minister of Health  
Ministry of Health



---

**Dr. Angela El-Adas,**  
Director-General  
Ghana AIDS Commission

## Executive Summary

The Government of Ghana (GOG) recognizes that maintaining the health of the population is essential to development and has committed to reaching the Millennium Development Goals (MDGs) by 2015. Integration of the delivery of family planning and reproductive health (FP/RH) and human immunodeficiency virus (HIV) prevention and acquired immune deficiency syndrome (AIDS) care and treatment services is expected to advance progress towards these goals. Integration can contribute to more efficient use of scarce healthcare resources as well as improve continuity of care for clients. Ensuring that policies and guidelines support service delivery integration is an essential step towards expanding integrated service delivery in Ghana.

The Ghana AIDS Commission (GAC) identified integration of FP/RH and HIV&AIDS services as one of the priority areas for policy reform. Ghana's impressive national response to the HIV epidemic has greatly increased access to and use of HIV prevention and AIDS care and treatment services and has thus contributed to continued low levels of HIV in the general population. The primary mode of HIV transmission in Ghana is heterosexual intercourse. The National AIDS/STI Control Programme (NACP) estimates that national prevalence among all adults was 1.85 percent in 2009 and projects that it will rise gradually to 1.92 percent by 2015 (NACP, 2010a). This success in slowing the spread of HIV has not been matched by success in improving maternal mortality or meeting RH needs. In the last few years, FP use has stagnated. Renewed commitment to FP is important, as is continued vigilance to slow the spread of HIV.

The GAC recognizes the importance of a supportive policy environment for integration of FP/RH and HIV&AIDS services and has requested that the USAID-supported Health Policy Initiative (USAID/HPI) conduct a qualitative assessment of the policy environment for such integration. The assessment is funded by the President's Emergency Plan for AIDS (PEPFAR) and is the first step in endorsing an integrated FP/RH and HIV&AIDS service delivery policy by 2012. The assessment includes a review of existing policies, regulations, and guidelines, and a survey of key informants. The information collected aims to identify current policies on FP/RH and HIV&AIDS services and 1) determine their effectiveness in promoting integration of services, 2) assess key stakeholders' current understanding of integration of FP/RH and HIV&AIDS services, 3) identify challenges to providing integrated services, and 4) recommend strategies to integrate these services. The assessment is expected to provide a foundation for the open dialogue needed to reform policies so that they support and promote integration.

The key informants interviewed have a clear understanding of the synergies between FP/RH and HIV prevention and AIDS care and treatment. They recognize that these services target all Ghanaians who are sexually active and that integration presents an opportunity to talk with clients about multiple preventive healthcare services. For the respondents, integration means that the services must be available in the same facility (although they may be provided by the same or different providers). Respondents state that in a large facility clients should be able to move from unit to unit with minimum difficulty and without encountering barriers. They also think that the success of integration hinges on collaboration, coordination, and communication between health workers to ensure that they are meeting all of a client's RH needs.

Respondents unanimously observed that FP clients need voluntary counselling and testing (VCT) because they are sexually active and that FP visits represent a good opportunity to discuss HIV prevention. Two respondents raised concerns about the cost-effectiveness of making an investment to introduce VCT in all FP clinics. Respondents observed that persons living with HIV (PLHIV), especially those on antiretroviral therapy (ART), often feel healthy and resume sexual activity and are therefore at risk of pregnancy; dual-method use enables them to 1) be sexually active yet be protected from pregnancy until they want to become pregnant or feel healthy enough to become pregnant, and 2) protect their partners from HIV transmission.

Respondents stated that efforts to integrate services have been limited by funding. They also voiced concerns about health workers' biases and poor counselling skills. One summarized the situation as follows: "There is a need for a paradigm shift. There is a need to have service providers make conscious efforts to offer FP to AIDS patients, and counselling and testing to FP clients." When asked about the level of integration of FP/RH and HIV prevention and AIDS care and treatment services in Ghana; two respondents answered, "On a scale of 1–10 [10 being fully integrated], I would rate them a 3." According to the respondents, the following factors contribute to the level of integration within a facility: layout, level of collaboration among staff, competence and experience among staff, and quality of information and counselling. Only some respondents emphasized that offering all services in one place is not necessarily the best; they can be convenient even if different facilities are near each other. However, all consider staff coordination of information, services, resources, training, and supervision essential. Separate and parallel information systems currently used for reporting, monitoring, and management of FP services and HIV prevention, as well as AIDS care and treatment services, make it difficult for service delivery personnel to share information, improve efficiency, and coordinate patient care. Level of integration depends on availability of staff and good management and planning at the individual facility.

The respondents were asked if existing policies, guidelines, and regulations for the delivery of FP/RH, HIV prevention, and AIDS care and treatment services support or hinder integration of service delivery. All respondents perceive the policies to be adequate and do not think that the policies hinder service integration. However, the majority stated that existing policies, protocols, and guidelines do not promote integration and that dissemination about integration is often inadequate. In addition, integration is not routinely discussed, nor is it incorporated into daily activities.

The challenges to integration most frequently identified by the respondents were human resources (HR) issues, including attrition, funding, training, and infrastructure. In addition, weaknesses in the health system appear to create operational barriers that influence performance and quality of care. According to respondents, a decrease in the number of private sector providers and lack of providers in rural areas, particularly midwives, have exacerbated staff shortages and greatly affected FP and prevention of mother-to-child transmission (PMTCT) service delivery. In addition, all respondents expressed concerns about the effects of heavy workloads on performance and quality of care, and cited antenatal care (ANC), FP, and ART service providers as those who have particularly heavy client loads. In addition, they observed that FP, VCT, and AIDS care and treatment are all complex services



that require knowledge of many types of medications, contraceptives, protocols, and health conditions, as well as extensive counselling and willingness on the part of providers to take the time to ensure that they understand a client's needs and are providing the most appropriate care.

Respondents identified many challenges related to quality of care and alluded to the fact that when people initiate ART or a FP method, they should receive lengthy counselling in order to understand how to comply with their drug regimen or use their contraceptive method. They emphasized that skilled providers and good client/provider interactions are extremely important, and identified the challenge involved in encouraging clients to 1) initiate use of FP and/or ART, 2) return for referral and resupply, and 3) use the method correctly or adhere to treatment regimens. Respondents stressed the importance of easy access to resupplies of drugs and FP methods, as well as follow-up care, to address side effects or complications. Several stakeholders identified the need to streamline standards and protocols, train health workers in the basic information they need to know, provide them with job aids, and encourage them to provide client-oriented services.

Many different challenges identified by respondents combine to create operational barriers in the work environment and are detrimental to quality of care (for example, inadequate pre-service and in-service **training** for technical and counselling knowledge and skills). Other challenges include inadequate **infrastructure and supplies** (such as lack of space with privacy for consultations, and insufficient **transportation** for supervision and other needs). Respondents also mentioned weak **commodity procurement and distributions systems** for FP and ARV.

Many respondents suggested that programme managers need to revise existing standards and protocols to include **minimum standards** for integrated FP/RH, VCT, and ART services appropriate for the Ghanaian context. They suggested focusing on the basic information to be provided during counselling sessions, as well as identification of personnel authorized for different functions. The respondents further suggested that these materials be the basis **for updated training curricula, job aids, and behaviour change communication (BCC) materials**. Several respondents mentioned record keeping as a constraint that affects tracking of patient information, monitoring of activities and programme performance, as well as planning for future programmatic needs.

The respondents suggested various **organisational issues** need to be addressed, including unclear and changing priorities, overlapping responsibilities, and competition for funding between FP/RH and HIV& AIDS programmes. In addition, all respondents identified the level, coordination, and timeliness of **funding** as major challenges to integration. Funding sources include the GOG, the National Health Insurance Scheme (NHIS), and donors and patients. According to the respondents, the implementing ministries, departments, and agencies (MDA) must plan, budget, and advocate the Ministry of Finance to ensure GOG funds are available and released when needed for programme implementation. They also pointed out that planning, budgeting, coordinating, and ensuring availability of funds among various programme components, including materials for behaviour change communication (BCC), training, and staffing, are critical to effective integration of services.

# Abbreviations

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANC</b>	Antenatal Care
<b>ART</b>	Antiretroviral Therapy
<b>BCC</b>	Behaviour Change Communication
<b>CHPS</b>	Community-based Health Planning and Services
<b>CSW</b>	Commercial Sex Worker
<b>CT</b>	Counselling and Testing
<b>FHD/GHS</b>	Family Health Division, Ghana Health Service
<b>FP</b>	Family Planning
<b>GAC</b>	Ghana AIDS Commission
<b>GHS</b>	Ghana Health Service
<b>GOG</b>	Government of Ghana
<b>HIV</b>	Human Immunodeficiency Virus
<b>HPI</b>	Health Policy Initiative
<b>HR</b>	Human Resources
<b>IDUs</b>	Injecting Drug Users
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MARP</b>	Most-at-risk Population
<b>MDA</b>	Ministries, Departments, and Agencies
<b>MDG</b>	Millennium Development Goal
<b>MOH</b>	Ministry of Health
<b>MSM</b>	Men who have sex with men
<b>MWRA</b>	Married Women of Reproductive Age
<b>NACP</b>	National AIDS/STI Control Programme
<b>NHIS</b>	National Health Insurance Scheme
<b>NPC</b>	National Population Council
<b>NSF II</b>	National Strategic Framework II
<b>NSP</b>	National Strategic Plan for HIV&AIDS 2011-2015
<b>PEPFAR</b>	President's Emergency Plan for AIDS
<b>PF</b>	Partnership Framework
<b>PLHIV</b>	Person Living with HIV
<b>PMTCT</b>	Prevention of Mother-to-child Transmission
<b>PPAG</b>	Planned Parenthood Association of Ghana
<b>RH</b>	Reproductive Health
<b>RHSP</b>	Reproductive Health Strategic Plan (2007–2011)
<b>RTI</b>	Reproductive Tract Infection
<b>S&amp;D</b>	Stigma and Discrimination
<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>USAID</b>	United States Agency for International Development
<b>USG</b>	United States government
<b>VCT</b>	Voluntary Counselling and Testing

## Introduction

The Government of Ghana (GOG) recognizes that maintaining the health of the population is essential to development and has committed to reaching the Millennium Development Goals (MDGs) by 2015. Integration of the delivery of family planning and reproductive health (FP/RH) and human immunodeficiency virus (HIV) prevention and acquired immune deficiency syndrome (AIDS) care and treatment services is expected to advance progress towards these goals. Integration of service delivery can contribute to more efficient use of scarce healthcare resources as well as improved continuity of care for clients. For example, when clients seek FP services, healthcare providers in a well integrated facility may use the opportunity to also offer voluntary counselling and testing (VCT), and HIV&AIDS service providers can ensure that FP and other RH needs are met. Integrated services provide the additional advantage of reducing feelings of stigma and discrimination (S&D) that often stop patients from seeking separate HIV&AIDS services. FP and VCT have natural synergies and meet the needs of the same client populations. Ensuring that policies and guidelines support integration is an essential step towards expanding integrated service delivery in Ghana.

The Ghana AIDS Commission (GAC) identified integration of RH and HIV&AIDS services as one of the priority areas for policy reform in the Partnership Framework signed by the GOG and the United States Government (USG) in December 2009. This framework supports implementation of the National Strategic Framework II (NSF II) (GOG, 2006). The goals of the NSF II are to 1) reduce new HIV infections among vulnerable groups and the general population, 2) mitigate the impact of the epidemic on the health and socioeconomic systems, as well as on persons living with HIV (PLHIV) and others affected by the epidemic, and 3) promote healthy lifestyles, especially in the area of sexual and reproductive health. In the partnership framework, the GOG and the USG established the goal of endorsing an integrated RH and HIV&AIDS service delivery policy by 2012 and rolling out integrated services in five regions by 2013. The GAC requested that the National Population Council (NPC) constitute a Task Force to advise it on the best way to integrate RH and HIV&AIDS activities (NPC, 2009).

The GOG has also committed itself to the Reproductive Health Strategic Plan (RHSP) 2007–2011 (RCHD/GHS, 2007). The RHSP objectives include: 1) reducing maternal morbidity and mortality; 2) reducing neonatal morbidity and mortality; 3) enhancing and promoting RH; 4) increasing contraceptive prevalence through promotion of, access to, and quality of FP services; 5) developing and implementing cross-cutting measures to ensure access and quality of RH services; and 6) enhancing and promoting community and family activities, practices, and values that improve RH. Both the RHSP and NSF II seek to improve the health of Ghanaians of reproductive age.

Ghana has greatly increased access to and use of HIV prevention and AIDS care and treatment services. This impressive national response has contributed to continued relatively low levels of HIV in the general population. As of 2008, the National AIDS/STI Control Programme (NACP) reported that the number VCT centres had reached a total of 102, an increase of 26 percent (NACP, 2008a). A

<sup>4</sup>Ghana is currently in the process of developing the National Strategic Plan for HIV & AIDS 2011–2015.

total of 808 facilities provided VCT in 2009 and 845 PMTCT (Acquah and Emmart, 2010). The number of facilities providing antiretroviral therapy (ART) has increased rapidly from two pilot sites in 2003 to almost 140 facilities, including teaching and regional hospitals and most district hospitals, in December 2009 (Rosen and Asante, 2010). In 2009, 28 percent of sero-positive pregnant women and 40 percent of adults and children meeting criteria received ART (NACP, 2008a; GAC, 2010).

The HIV epidemic in Ghana is a mature, generalized epidemic with pockets of high concentration. The National AIDS/STI Control Programme (NACP) estimates national prevalence among all adults was 1.85 percent in 2009 and projects that it will rise gradually to 1.92 percent by 2015 (NACP, 2010a). The primary mode of HIV transmission in Ghana is heterosexual intercourse. Prevalence is significantly higher among most-at-risk populations (MARPs), including commercial sex workers (CSWs), men who have sex with men (MSM), and sero-negative partners of PLHIV; little is known about injecting drug users (IDUs). The Ghana Health Service (GHS) plans to continue expanding the number of VCT centres and ART facilities throughout the country in order to increase access to and use of HIV prevention and AIDS care and treatment services. In addition, continued monitoring of HIV incidence and prevalence contributes to prevention of HIV bridging from MARPs into the general population.

FP use in Ghana has stagnated in the last few years. After increasing from 13 percent among married women of reproductive age (MWRA) in 1988 to 25 percent in 2003, the use of any FP method decreased to 24 percent in 2008 (GSS, 2009b). Over 70 percent of women either want no more children or want to wait at least two years before their next birth (ICF Macro, 2010). Despite universal knowledge of FP and strong desire to delay or limit childbirth, use of modern methods actually decreased from 19 percent among MWRA in 2003 to 17 percent in 2008 (GSS, 2009b). Hence renewed commitment to FP is important to enable Ghanaians to act on their knowledge and desire to control their fertility.

In recognition of the importance of a supportive policy environment for integration of FP/RH and HIV&AIDS services, the GAC requested that the USAID-supported Health Policy Initiative (USAID/HPI) conduct a qualitative assessment of the policy environment for such integration. The assessment is funded by the President's Emergency Plan for AIDS (PEPFAR). The assessment is the first step towards the goal of endorsing an integrated RH and HIV&AIDS service delivery policy by 2012.

## Assessment

The objectives of this assessment are to:

- Identify and assess current policies on RH and HIV&AIDS services that support integration;
- Assess key stakeholders' current understanding of "integration of RH and HIV&AIDS services." This includes their understanding of who is (are) the target population(s) in need of services, the kinds of services needed, and service delivery strategies for best meeting those needs;
- Identify operational challenges to providing integrated RH and HIV&AIDS services;
- Identify examples of integrated RH and HIV&AIDS services, if possible, and assess their strengths and weaknesses;
- Make recommendations for strategies to integrate RH and HIV&AIDS services.

The respondents' insights are expected to contribute to a common understanding and lay the foundation for the open and effective dialogue required to initiate and complete the process of policy reform to support service integration in Ghana.

### Assessment Methodology and Confidentiality

In close collaboration with Ghanaian stakeholders, including the GAC and GHS, HPI staff, a Ghanaian public health expert specializing in RH and an international consultant conducted the assessment by reviewing existing policies, regulations, and guidelines; developing a questionnaire; and interviewing key informants. The consultants provided informed consent prior to the interviews and collected data through one-on-one, confidential interviews. This report shows all stakeholder quotes in quotations and italics; they are not attributed to individuals in order to maintain confidentiality.

### Key Stakeholders

The GAC and GHS selected a purposive sample of 27 key organisations (Appendix A), and HPI interviewed one or more informants from each. Informants include:

- Officials at the MOH, GHS, GAC, NACP, Family Health Department of the GHS (FHD/GHS), and other government agencies that play a role in the management, planning, and delivery of RH, HIV prevention, and AIDS care and treatment services;
- Development partners in the areas of RH and HIV&AIDS service delivery;
- Service providers responsible for provision of RH and/or HIV&AIDS services in the government, private, and nongovernment sectors.

---

## Assessment Limitations

Survey questions are open-ended, which allows the assessment team to collect a wide range of information from the stakeholders. However, the open-ended nature of the responses and the different backgrounds of the stakeholders limit the analyses and comparisons that can be made between responses of individual stakeholders or different categories of stakeholders. The relatively small sample of respondents, limited timeframe, and use of purposive sampling represent additional limitations.

## Stakeholders' Perceptions of Integration

The assessment sought to explore the respondents' views on integration of RH and HIV&AIDS services. The respondents have a very clear understanding of the synergies between RH and HIV prevention and AIDS care and treatment. They recognize that these services target all Ghanaians who are sexually active and that integration presents an opportunity to talk with clients about multiple preventive healthcare services.

The responses show considerable consistency and indicate that, for the respondents, integration means that the services must be available in the same facility, although they may be provided by different health workers. The respondents observed that in a large facility clients should be able to move from unit to unit with minimum difficulty and without encountering barriers. They also said the success of integration hinges on collaboration and coordination among health workers, which helps ensure that they are informed of a client's FP/RH needs and able to provide the most appropriate service to meet those needs. The statements below summarize stakeholders' perceptions.

- “Health service delivery must be comprehensive, so patients don't need to go to different places for services.”
- “Integrated services are like grocery shopping ... the patients like to make one stop to get all they need.”
- “If it were a one-stop shop, you wouldn't lose people ... within Korle Bu itself, you lose people going room to room.”
- “Reproductive health services should include pregnancy prevention, antenatal care, safe abortion, post-abortion care, treatment of sexually transmitted diseases, tuberculosis, family FP, and Life Saving Skills for midwives.”
- “When doing FP, you need to identify who is HIV positive and catch them early. For FP clients, if you think your partner is going around, then you should use condoms. Postnatal is a time to talk of FP. [For] HIV-positive women who do not want any more children, one should provide abstinence and condoms so that the woman can protect herself. She also may want children, so she needs to use dual methods. A HIV-positive woman who wants a baby may want to space. There is a need for a one-stop shop. Reproductive and Child Health nurses have time constraints. It's difficult to cover all of this when there are lots of clients waiting for care.”

## Stakeholders' Views on Clients' Needs

### Family Planning Clients' Need For Hiv Counselling

Respondents unanimously observed that FP clients need HIV counselling and testing (CT) because they are sexually active, and that FP visits are a good opportunity to discuss HIV prevention. Two stakeholders raised concerns about the cost-effectiveness of making an investment to introduce VCT in all FP clinics. These respondents suggested FP patients are unlikely to be from MARPs such as CSWs, MSM, discordant partners of PLHIV, or IDUs.

- “Yes, you presuppose FP clients are having unprotected sex.”
- “Every woman should be offered comprehensive services because Ghana has a generalized HIV epidemic with pockets of concentration.”
- “The challenge is that FP services typically reach only women.”
- “There is a need to develop a conscious effort on the part of providers so that all FP clients receive HIV counselling and testing if they want and all HIV & AIDS patients are counselled in FP.”
- “Yes, FP clients need provider-initiated VCT.”
- “STI clients also need counselling ... not by force—they need to opt-in to the service.”
- “If FP clients come for STI treatment, then there is a reason to talk with them about HIV.”
- “Average age of first sexual encounter is 18. The use of condoms will have little impact on HIV transmission. Providing HIV VCT at all FP service sites may not be the most effective way to keep HIV transmission low.”

### HIV & AIDS Patients' Need For Family Planning

Respondents observed that PLHIV, especially those on ART, often feel healthy and resume sexual activity and are therefore at risk of pregnancy. They also observed that dual-method use enables PLHIV to be sexually active, be protected from pregnancy until they want to become pregnant or feel healthy enough to become pregnant, and protect their partners from HIV infection.

Research confirms respondents' views. A 2006 survey in Ghana of female ART patients participating in a pilot project to integrate FP into ART services showed that over 56 percent wanted children in the future; however, only 36 percent were using a FP method at the time of the survey (Adamchak et al., 2006). Little is known about how ART affects a woman's fertility desires over her reproductive life, but sero-positive women need to know how to control the number and timing of their births as well as protect their partners and babies from HIV infection. The majority of the stakeholders suggest that ART providers need FP skills, as clients have already formed a relationship with them based on trust and confidence and may feel more comfortable and free to discuss RH issues with these providers. Several respondents mentioned the example of Mildmay Clinic in Uganda, where clients receive all needed services, including ART and FP/RH.



- “Yes, [there is a need for FP], because some PLHIV are coming in pregnant. They are having unprotected sex. They are having unprotected sex and have a need for the male and female condoms.”
- “Yes—as soon as they feel healthy they return to normal, active life. They have a need for dual methods.”
- “PLHIV are very healthy-looking; you cannot stop them from having sex. They have a need to protect themselves. They need dual protection—the male and female condom.”
- “Yes, they have RH needs, and the challenge of negotiating use of the condom.”
- “There are two aspects for PLHIV who want another baby: 1) prevention of infection of partner, and 2) prevention of passing HIV on to the baby. And, for those who do not want another child, they need a dual method. For a woman living with HIV who wants a baby and who is on ARV, she needs to space her baby until she feels healthy.”

## Efforts to Integrate Services

Respondents asserted that efforts to integrate services have been limited by funding. Consequently, they were not able to provide many examples of integration. A few respondents observed that more information about both FP and HIV prevention is being provided to clients than in the past. One respondent described collaboration between the Planned Parenthood Association of Ghana (PPAG) and the GHS in which PPAG provides adolescent-friendly services and manages “youth corners” for the GHS. The youth corners provide information about FP as well as HIV prevention. However, respondents voiced concerns about health workers' biases and poor counselling skills. One summarized the situation as follows: “There is a need for a paradigm shift. There is a need to have service providers make conscious efforts to offer FP to AIDS patients and HIV CT to FP clients.”

In 2006, GHS and the ACQUIRE Project collaborated to implement a pilot project for the integration of FP into ART. The pilot took place in two hospitals and consisted of training staff in FP units to provide VCT and staff in ART units to provide FP counselling and methods (Arglah, 2006). Lessons learned from the pilot highlighted that FP providers tend to think that their clients are not at risk of HIV, and ART providers tend to feel that sero-positive women should not be sexually active. They feel that heavy client load leaves busy health workers little time to provide services they do not deem “urgent”. An assessment conducted after the ART training indicated that during [ART] visits only 20 percent of patients were asked if they want more children, and only 10 percent reported discussing FP (Adamchak et al., 2007).

According to respondents, the NACP has conducted training to reduce stigma among health workers towards sero-positive patients and to sensitize them of the need for provider-initiated counselling that encourages HIV testing. They also reported that GHS regional trainers and health workers in selected districts have received FP updates. UN organisations are currently supporting the Millennium Village Project, an effort to implement a comprehensive programme that will achieve zero mother-to-child-transmission of HIV in a single village.

## Stakeholders' Views on Level of Integration of Services

Respondents were asked if they consider public sector FP/RH and HIV prevention and AIDS care and treatment services to be integrated in Ghana.

- *“On a scale of 1–10, 10 being fully integrated, I would rate them a 3.”*
- *“Most FP clinics do not have VCT. When talking about spacing births, it's important to talk about HIV prevention.”*
- *“The majority of FP providers are not trained in HIV counselling. Those manning FP clinics should be trained in counselling.”*
- *“In the spirit of integration, the packaging of MOH condoms has been changed to include the slogan “be safe,” plus both the MOH FP programme symbol, the red triangle, and the AIDS ribbon ... dual protection.”*

At the level of the community clinic, the community-based health planning and services (CHPS) compound, and health centres, patients receive basic services including antenatal care (ANC), delivery, postnatal care, FP, growth monitoring and immunisation, treatment of minor ailments, syndromic STI management, and treatment for tuberculosis (TB) (NPC, 2009). Patients are referred to the district hospital, and in some locations to the regional hospital, for provision of ART and long-acting FP methods. At the district level, if a health centre staff member has received training, basic RH and VCT services are essentially integrated because, as one respondent observed, “there is only one public health nurse who provides all of the services.” That being said, not all facilities are equipped or fully stocked with FP commodities and HIV test kits. Moreover, staffing shortages are often severe at the district level. A facility baseline assessment conducted in 2005 showed that only 50 percent of health centres normally headed by a medical assistant actually had one assigned; 10 percent had a community health/enrolled nurse as the highest level of staff providing services (Quality Health Project, 2005). Availability of integrated services is further limited because, according to one respondent, “the majority of FP nurses are not trained in HIV CT,” nor are providers of ART trained to provide FP methods.

At district and regional hospitals, patients receive all basic care as well as medical and surgical services, ART, abortion care, laboratory services, and counselling (NPC, 2009). At this level patients usually have to go to different rooms within the hospital to receive services, and they have to see different providers. The 2005 facility baseline assessment mentioned above showed that all regional and district hospitals had at least one doctor, one medical assistant, one nurse, one midwife, and one community health/enrolled nurse per facility—the minimum required. Some respondents raised the issue about whether a facility needs to offer VCT in the FP clinic if it offers the service in another unit (e.g., a PMTCT unit). According to respondents in the hospitals visited, patients can receive same-day services. At times, however, a staff person may be away from the facility to conduct outreach activities or perform other tasks, and if there are no other staff members trained and present to perform the tasks of those absent, clients will have to make a return visit. Respondents also stated that some facilities always leave one trained person in place.

At all regional hospitals, midwives and health workers work as a team in the ANC unit to provide focused ANC, PMTCT, and VCT. According to respondents, the ANC patient load tends to be very high. For example, the team at Ridge Hospital estimated that on some days they see 70–100 ANC clients. Hospitals such as Ridge conduct group counselling sessions on FP and HIV while clients wait. During the consultation, the midwife assesses if the patient needs further one-on-one counselling. According to the respondents, one-on-one counselling takes place when clients want VCT or FP services. However, the patient load is often so heavy that midwives do not take time to counsel patients individually; nurse respondents reported that clients often agree to be tested when they do receive counselling. One informant commented that “women opt-in for HIV testing during ANC visits; their baby is precious to them.” According to the respondents, ANC clients with sexually transmitted infections (STIs) are often referred to separate STI clinics. Patients are also referred to the hospital lab for required lab tests and to the hospital pharmacy for necessary medications.

ART providers interviewed by HPI refer their patients to FP clinics for contraceptive information and methods. Because of the complexity of ART provision, it has proven to be a challenge to ask these providers to shoulder the additional burden of FP counselling and method provision. As one respondent observed “there is a need to really think through all the issues of integrating FP and ART. Client-provider interaction time is often less than 10 minutes. How much time will it take to counsel a sero-positive woman on FP?” Another respondent stated that “currently, with ARV, there is no deliberate effort to refer patients for FP. Dual protection is not highlighted.” Ghana recently developed ART patient records that, according to respondents, are very detailed and require substantial record keeping due to the complex drug regimens. Maintaining confidentiality of the information is paramount, but often presents additional challenges. One respondent said that “shared confidentiality”—maintaining the privacy of the patient while at the same time informing colleagues of information needed to provide appropriate care—is a real challenge. For example, when a sero-positive patient is referred to the FP unit for services and the patient does not disclose her status to the FP nurse, the nurse will not be aware of the patient's status, nor her ART regimen. Respondents in some of the facilities visited pointed out that the NACP has provided more cubicles to enhance privacy.

According to the respondents, many factors contribute to the level of integration within a facility. These factors include but are not limited to the layout of the facility, level of collaboration and competence and experience among staff, and quality of information and counselling. A few respondents emphasized that offering all services in one place is not necessarily the best choice. Sometimes services can be near each other and still convenient; however, staff coordination of information, services, resources, training, and supervision is essential. FP was introduced as a vertical programme and maintains its own systems for training, logistics, monitoring and evaluation (M&E), and supervision. Similarly, VCT, PMTCT, and ART have their own system for administration and management. At the district and lower level, however, the District Health Management Team is responsible for administration and management of all services. The FP unit in each facility stores/maintains FP patient records whereas the ART unit handles those for ART. These parallel information systems make it very difficult for service delivery personnel to share information, improve efficiency of reporting and logistics, and coordinate patient care. Not surprisingly, the level of integration appears to depend on availability of trained staff, good management and planning, and coordination of service delivery at the individual facility.

## Perceived Contribution of Policies to Integration of Services

The respondents were asked if existing policies, guidelines, and regulations for the delivery of RH, HIV prevention, and AIDS care and treatment services support or hinder integration of service delivery. Many spoke very generally about policies. One service provider said, *“I do things this way because in the training they told me I should do things this way. I am not familiar with the policies.”* Another said, *“I cannot cite specific policies, but I know they go through the process of reviewing guidelines and protocols.”*

Policies and guidelines specifically mentioned by name by respondents included the *Adolescent Reproductive Health Policy* (NPC, 2000), *National Guidelines for Prevention of Mother-to-Child Transmission of HIV* (MOH, 2008b), the *National Reproductive Health Service Policy and Standards* (GHS, 2003), and the *National HIV/STI Policy* (GAC, 2004).

All respondents perceive the policies to be adequate and do not think that they hinder integration of services. However, the majority stated that existing policies, protocols, and guidelines do not **promote** integration of services and that dissemination about integration is often inadequate. In addition, integration is not routinely discussed or incorporated into daily activities. Comments included the following:

*“Current policies touch on it, but you need to make more noise about it.”*

*“There is a need to streamline—adopt/develop basic service standards appropriate for the local context.”*

*“There is a need for guidelines with standard operating procedures.”*

The following section presents excerpts from the relevant policies, standards, and guidelines that pertain to integration or “linkages” between services. It should be noted that these policies, standards, and guidelines were not developed to promote integrated service delivery. Therefore, while they frequently identify common programme objectives and linkages, they do not go into extensive detail about how to integrate service delivery.

### Family Planning

*The National Reproductive Health Service Policy and Standards* (GHS, 2003) states the following: “Family planning services serve as a link to other reproductive health services such as the prevention and management of RTI including STI/HIV/AIDS” (p. 9). The document then lists the following as some of the objectives of FP: “to prevent and manage RTIs including STI/HIV/AIDS” and “to promote dual protection.” It also defines dual purpose/protection as “the use of male or female condom on their own to prevent both unintended pregnancies and STI/HIV/AIDS (dual purpose) or the use of male or female condom in addition to other family planning methods to prevent STI/HIV/AIDS (dual method).”

## HIV Counselling and Testing

*The National Guidelines for the Development and Implementation of HIV Counselling and Testing in Ghana* (MOH, 2008a) discuss FP as follows (p. 17):

*“Basic family planning information shall be incorporated into all HIV counselling sessions, both for HIV positive and HIV negative clients. Especially for HIV positive clients the risks of mother-to-child transmission and the benefits of family planning shall be explained. When possible, FP services shall be provided at the VCT site. If this is not possible, HIV positive VCT clients shall be referred for FP services. Both men and women shall be encouraged to access FP services to make informed decisions about contraceptive measures appropriate to their HIV status. Staff of the FP programmes shall be trained in maintaining confidentiality of HIV test results and the importance of maintaining a respectful attitude to all FP/HIV clients.”*

## STI Management

*The National Reproductive Health Service Policy and Standards* (GHS, 2003) discusses STI management as follows (p. 14):

*“Prevention and ensuring early management of reproductive tract infections including HIV has been shown to control the spread of HIV among the population. It also reduces the consequences of such infections on the mother and foetus or baby. In Ghana STI and HIV infection are common among women reporting at our health facilities. The policy therefore supports every effort at prevention and managing individuals, pregnant women, couples and adolescents who are infected with STI or HIV/AIDS.”*

The document lists the following among the objectives of reproductive tract infection (RTI) services:

- “To prevent and control sexually transmitted infections (STIs).”
- “To prevent transmission of HIV.”
- “To manage and support people living with HIV/AIDS.”

Among the target groups of the services are “individuals in the sex industry/commercial sex workers.” The policy does not specifically mention MSM. The protocol for tasks/activities to be done during RTI service provision includes “Management of HIV&AIDS patients including provision of antiretroviral drugs and prevention of mother-to-child transmission.” While prevention of mother-to-child transmission (PMTCT) of HIV&AIDS and promotion of condom use (male and female) are included in service delivery strategies, dual protection is not specifically mentioned.

*The National Guidelines for Management of Sexually Transmitted Infections* (NACP, 2008b) do not specifically mention FP but refer to “safer sex”: “Stay cured with safer sex practices, including the use of condoms (risk reduction).”

## Antenatal Care and PMTCT

The National Reproductive Health Service Policy and Standards (GHS, 2003) includes the following among the objectives of antenatal care:

- “To promote and maintain the physical, mental and social health of mother and baby by providing education to the pregnant mother and her family on nutrition, rest, personal hygiene, family planning, immunisation, danger sign, RTI including STI/HIV/AIDS, the birth preparedness and complication readiness.”
- “To prevent mother-to-child transmission of HIV&AIDS.”

The policy specifies that the activities of antenatal care shall include

- “Monitoring of normal pregnancy”
- “Identification of complications of pregnancy”
- “Management of complications of pregnancy and referral”
- “Provision of supplementary micronutrients
- “Prevention of malaria including provision of malaria prophylaxis”
- “Immunisation”
- “Health education including malaria prevention”
- “STI prevention/condom use/safer sex”
- “Voluntary counselling and testing” and
- “Birth preparedness/complication readiness.”

At the same time, the document presents the objective of PMTCT as a component of Safe Motherhood: “The prevention of mother-to-child transmission of HIV programme is to reduce the transmission of HIV from the mother to the baby. The programme is also to improve health service provision and psychological support for mothers and children.”

Included among the objectives of PMTCT services are the following:

- “Introduce HIV voluntary counselling and testing (VCT) for pregnant women.”
- “Administer Nevirapine to mothers and babies during and after delivery respectively.”
- “Specifically advise HIV infected mothers on appropriate alternatives to breastfeeding.”
- “To facilitate the integration of PMTCT of HIV into the formal delivery services.”

## Safe Delivery, Postpartum Family Planning and PMTCT

*The National Reproductive Health Service Policy and Standards* (GHS, 2003) presents the definition and objective for the above services (p. 5) as follows:

“The main objective of labour and delivery care is to ensure safe delivery.”

“The postnatal period begins at the end of delivery and ends six weeks after delivery.”

The objectives of postnatal care include among others

- "To provide health education on nutrition, danger signs, family planning, infant feeding/breastfeeding and immunisation of the baby" and
- "To counsel and provide family planning services."

Specific activities to be included in all these services are

- "STI prevention (condom use/safer sex)"
- "Family planning motivation, counselling and services" and
- "Voluntary counselling and testing."

On its list of "Other opportunities for HIV counselling and testing," *The National Guidelines for Prevention of Mother to Child Transmission of HIV* (MOH, 2008b) includes "**HIV Testing during Labour** (p. 12): Any woman with undocumented HIV status at the time of labour shall be offered HIV counselling and testing. Testing shall not however be done when delivery is imminent or in the second stage of labour. Immediate initiation of appropriate antiretroviral prophylaxis shall be recommended to women in labour in the event of a positive test."

**"Post Partum and Newborn Testing:** Any woman whose HIV status is unknown postpartum shall be offered HIV counselling and testing. In the situation where the mother's HIV status is unknown postpartum and she is unavailable to be counselled and tested, rapid testing of the newborn as soon as possible after birth (within 48 hours postpartum) is recommended."

### **Tuberculosis**

*Implementation of TB/HIV Collaborative Activities in Ghana: The Technical Policy and Guidelines* (GHS, 2007) identifies FP as one of the basic components of integrated TB/HIV services. In section 4.1.3.4 the document describes a "one stop shop" approach that includes "family planning and support."



## Perceived Challenges to Service Integration

The challenges to integration most frequently identified by respondents in the survey were various HR issues, including attrition, funding, training, and infrastructure. In addition, weaknesses in the health service support systems appear to create operational barriers and influence performance and quality.

### Human Resources

*“How to ensure that services are available at referral points and you are not “referring a patient to an empty room.”* This and similar statements describe the situation from the provider's point of view. According to respondents, a decrease in the number of private sector providers and lack of providers in rural areas, particularly midwives, have exacerbated staff shortages and greatly affected FP and PMTCT service delivery<sup>5</sup>. The respondents perceive that the National Health Insurance Scheme's (NHIS) policies that exclude coverage for FP benefits and provide coverage for maternity care for accredited providers have been a disincentive for private providers, especially those who are not accredited by the NHIS, because the number of clients using private providers declined as many turned to public hospitals for maternity care. The NHIS is currently reviewing its policies and considering adding FP as a covered benefit. Another problem is the fact that, as one respondent observed, *“Young people are moving away from midwifery.”*

Other respondents suggested that the GHS should review allocation of job responsibilities among cadres and identify opportunities for streamlining duties and shifting tasks to lower-level workers who frequently are capable and experienced. Another respondent described ongoing GHS efforts to use financial incentives to encourage physicians to take positions in rural regions. Finally, respondents recommended improving teamwork.

### Workload: Performance And Quality Of Care

All respondents expressed concerns about the effects of heavy workload on the performance and quality of FP, HIV prevention, and AIDS care and treatment services. Respondents specifically cited ANC, FP, and ART service providers as those who have particularly heavy client loads. In addition, they observed that FP, VCT, and AIDS care and treatment are all complex services that require knowledge of many types of medicines, contraceptives, protocols, and health conditions. These services also require extensive counselling and willingness on the part of providers to take the time to ensure that they understand a client's needs and provide the most appropriate care. The following were typical statements: *“The challenge is the workload. They need another ART clinic. It is a lot of work”* and *“You need to really think about the services you want to combine and be careful not to overload the system.”*

<sup>5</sup>This issue is addressed in *An Estimate of Potential Costs and Benefits of Adding Family Planning Service to the National Health Insurance Scheme(NHIS) in Ghana and the Impact on the Private Sector, PPME, 2008.*

During the interviews several issues came up related to quality of care. The respondents alluded to the fact that when people initiate ART or a contraceptive method they must receive lengthy counselling to understand how to comply with their drug regimen and/or use the FP method. Skilled providers and good client/provider interaction are extremely important for uptake as well as adherence; several midwives and nurses interviewed expressed pride in the relationship of trust and confidence they have developed with their patients. They mentioned that, on their days off, their patients prefer to make a return visit rather than obtain services from another health worker. Other interviewees who are programme managers felt that health workers sometimes avoid providing either FP and/or HIV counselling because they do not view them as being necessary services for their patients and they feel they do not have the time to provide them. Several stakeholders identified the need to streamline standards and protocols; train staff in the basic information they need to know; provide them with job aids; and encourage them to provide client-oriented services.

The respondents' statements reflect the challenges involved in encouraging clients to initiate use of FP and/or ART, return for referrals and resupply, and adhere to their treatment regimens. As one respondent observed, *“there is the challenge of getting clients to take up services.”* Another interviewee observed *“the complexity of providing ART to a sero-positive woman [during pregnancy, which] requires that she delay [the treatment] until she is in the 14th week ... . There is the risk of losing her during this period.”* Similarly, there is the challenge of ensuring that a woman who has been referred to another facility for FP actually goes there to obtain the service. Getting sero-positive clients to initiate use of both services is even more complex. As some respondents explained, *“when integrating FP into ART, there is the challenge of tracking patient-client interactions and the need for tracking adherence with ARV,”* and *“there continues to be confusion about possible interactions between AIDS drugs and FP methods.”* Finally, respondents emphasized the importance of providing easy access to follow-up care to address side effects or complications and obtain resupplies of drugs and FP methods.

## Health System Challenges And Operational Barriers

Many factors combine to create operational barriers in the work environment for staff and insufficient quality of care for clients. The respondents identified pre-service and in-service **training** as an area of concern. They frequently expressed the *“need to ensure that service providers have the skills and the resources to offer full services at some set minimum standard.”*

In addition to training on technical issues, they mentioned training in counselling skills and good client-provider interaction as essential. As several respondents noted, the effectiveness of VCT as well as FP counselling often depends on the rapport between a health worker and her patient. Finally, all respondents suggested that training to reduce stigma and eliminate health providers' biases has helped but needs to be continued. Respondents reported that while *“in the past there was a view that if you were HIV positive you should not have sex, ART has changed that,”* and that efforts to sensitize health workers need to continue.

According to the respondents, **infrastructure and supplies** are other areas of concern. This includes lack of space with adequate privacy for consultations. They emphasized the need to improve **commodity procurement** for FP and ARV, including the system for distributing commodities, and **transportation** needed for a variety of uses. The respondents specifically mentioned the “*challenge of getting blood samples transported from the sub-district to district levels to perform CD4 counts,*” as well as transportation for supervision.

The respondents emphasized the need for **effective monitoring, good support, and supervision** to promote integration of services: “*There is a need for lots of monitoring and supervision to ensure integration*” but [according to the respondents] these areas are inadequate or lacking. Some respondents recommended exploring opportunities for team-based provision of services that would improve communication between staff and improve coordination of care to better meet clients' needs. Other respondents recommended motivation and incentives to staff that would be linked to performance and encourage them to provide better counselling and better-quality services.

Many respondents suggested that programme managers need to revise existing protocols to include minimum **standards, protocols, and guidelines** for provision of integrated FP and ART services and that these be evidence-based and appropriate for the Ghanaian context. They also suggested that the minimum standards and protocols should not only define the basic information on both FP and HIV prevention that should be provided during counselling sessions but also identify which levels of personnel should be authorized to provide which kinds of functions. The respondents further suggested that these materials should be the basis for updated **training curricula, job aids, and behaviour change communication materials** to help ensure that health workers are well-informed and provide quality information and services to their clients.

Several respondents mentioned that keeping records for tracking needed patient information, reporting for performance monitoring, and planning future programme needs was a challenge. **Reporting** takes place in ART clinics for ART patients and in the FP clinics for those seeking FP. **Patient records** are especially challenging because, as one respondent explained, “*HIV documentation is already cumbersome. There is a need to simplify it in order to add the patient's RH history.*”

The respondents suggested that **organisational issues** related to unclear priorities, overlapping responsibilities, and competition for funding create challenges between FP/RH and HIV & AIDS programmes. They also raised the issue of **decentralisation**. According to some, increasing fragmentation makes planning, as well as supervision and monitoring, more difficult. They suggested that decentralisation requires additional sensitisation about integration of services at the local level.

The majority of stakeholders felt that funding limitations result from shifting priorities and that both donors and the GOG have prioritized funding of HIV-related services over that of other services. For example, the NHIS provides benefits for ART, ANC, and maternity services for its members, but does not provide benefits for FP (PPME, 2008). As one stakeholder observed, “*one service suffers at the hand of another.*” In addition there is the “*challenge of getting the GOG to see this [integration] as a priority and ensure funding.*”

In addition, all respondents identified the level, coordination, and timeliness of **funding**, both for specific health services as well as specific service components, as major challenges to integration. Funding sources include the GOG, the NHIS, donors, and patients. One stakeholder mentioned the *“need for the government to put its money where its mouth is. It doesn't matter how good your plan is if it is not funded.”* Respondents mentioned the challenge of effective coordination of GOG and donor funds. One said *“the goal is to make the programme not too dependent on donors, yet ensure timely flow of funds.”* Some respondents emphasised different donor requirements for how and when funds may be used, and the challenge of coordinating these requirements with programme needs. As one respondent noted, there is a *“need to make a deliberate effort and advocate for multi-donor budget support for both RH and HIV prevention commodities.”* According to the respondents, the implementing ministry must plan, budget, and advocate the Ministry of Finance to ensure GOG funds are available and released when needed for programme implementation.

The respondents suggested that government resources should be forthcoming in a timely fashion so that national, regional, and district level plans can be implemented at the appropriate time. Finally, they pointed out that planning, budgeting, coordinating, and ensuring availability of funds among various programme components—including BCC materials; training; and staffing—are critical to ensure effective service integration.

## Perceived Benefits of Integrated RH and HIV Prevention and AIDS Care and Treatment Services

In addition to asking about challenges of integration, the interviewers asked the respondents whether or not integration is cost-effective, and to identify its additional benefits, if any. All agreed that integration is cost-effective, although several qualified their view with comments such as “in the long run,” and “*one midwife offering both services is more cost-effective than two, although some might argue that it is not that efficient doing more talk if there are too many clients and it is compromising quality.*”

The respondents observed that integration helps ensure confidentiality because it allows clients to deal with just one health worker, which reduces dropouts. Their comments also suggested that integration helps reduce “missed opportunities.” For example, one respondent said the following: “*ANC attendance is high, [so] we can get women when they come in for ANC service.*” Respondents also mentioned the benefit of better meeting clients needs. As one stakeholder summarized the situation, “*integration has the potential impact of responding to many health needs.*”

## Conclusion

Research has shown that integrated services can better meet clients' RH needs, reduce stigma related to HIV&AIDS-related services, increase efficiency of resource use, and advance progress towards achieving national goals (Hardee, 1995). Survey respondents observed that most patients who seek preventive care in public health facilities come for either FP, ANC, and/or outpatient care and that it is important to take advantage of their visit to counsel them and provide them with multiple preventive care services as appropriate, especially VCT. Moreover, increasing FP use contributes to better spacing of births, which reduces infant and child mortality as well as maternal mortality. Similarly, improving access to FP for sero-positive women who want to space and/or limit births is a cost-effective intervention to prevent mother-to-child transmission and reduce unwanted pregnancy and abortion. The following recommendations reflect many of the suggestions made by the respondents.

## Recommendations

Although the GAC should initiate many of the recommendations because of its coordinating and management role in the area of HIV&AIDS, the MOH and GHS are important partners that will need to “drive” the policy and other activities to support implementation of integration.

1. **Engage important stakeholders in policy dialogue related to integration of FP/RH services with HIV prevention and AIDS care and treatment.** Suggested activities:
  - **Do final review of NSP 2011–2015 to ensure integration is addressed.** This plan will guide the national response for the next five years, so it is important for the GAC to ensure that integration is adequately addressed in this important guiding document.
  - **Identify and involve relevant stakeholders.** Important stakeholders such as MOH/GHS and the NPC Task Force on Integration need to be actively involved to ensure that the efforts build on past experiences and insights. The private nonprofit and for-profit sectors have important roles to play, as do professional organisations. Finally, it is important to incorporate integration of services as a quality-of-care issue in ongoing quality assurance/ improvement efforts.
  - **Develop an integration action plan and strategy,** using the NSP 2011–2015 as an overall guide. For the different types of services (FP, HIV prevention, and AIDS care and treatment), develop a detailed action plan to address integration. The strategy guiding implementation must be flexible, taking into consideration the diversity among sites. (The assessment responses indicate that implementation requires flexibility, depending on the level of the facility, staffing, and other issues.) In addition, it is important to consider how to meet needs among different target groups (men, women, youth, MARPs, etc.).
  - **Disseminate strategy and continuously follow up and provide adequate support to those implementing the action plan.** Relevant GHS departments and agencies as well as private nonprofit and for-profit management must support programmatic interventions, including pilots, to ensure implementation. The activities will flow from the action plan and will include a number of different interventions. Each facility needs to include integration into its facility action plan/workplan. Integration of services is important for quality of care, so it is important to consider involving regional, district, and facility quality assurance teams in the efforts. It might be useful to apply appreciative inquiry to explore how some services such as tuberculosis (TB) and integrated management of childhood illness (IMCI) have been successful.
  
2. **Use the policy dialogue to clarify roles and responsibilities among stakeholders.** Several department/agencies/organisations are responsible for implementation. Unclear roles and responsibilities hamper efforts while clarity contributes to improved collaboration and coordination. Suggested activities:
  - Charge stakeholders with clarification and agreement on roles and responsibilities.
  - Ensure assistance with organisational development and analysis of important processes as needed.

*This recommendation expands on a suggestion made during the dissemination of the assessment results in Accra, Ghana, on 6 September 2010. Appreciative inquiry is the art and practice of asking questions that strengthen a system's capacity to apprehend, anticipate, and heighten positive potential. Benchmarking or other quality improvement approaches already in use can also be applied.*

3. **Review and revise policies, standards, protocols, and guidelines for integration of FP/RH, HIV prevention, and AIDS care and treatment services as needed; strengthen dissemination.** Suggested activities:
  - **Establish teams of technical experts.** Standards, protocols, and guidelines must be evidence-based, user-friendly for different levels, and appropriate for the Ghanaian context. Therefore, the users of the documents—that is, different types of healthcare staff and managers—need to be actively involved in the review and development process to ensure buy-in.
  - **Identify policies in need of review; revise as needed.** Some suggested policies are *National Reproductive Health Service Policy and Standards (2003)*, *National HIV&AIDS and STI Policy (2004)*, *Adolescent Reproductive Health Policy (2000)*, *National Guidelines for Mother-to-Child Transmission of HIV (2008)*, and *Quality Assurance Strategic Plan for Ghana Health Service 2007–2011*.
  - **Ensure effective dissemination**, including use of the different documents during training and supervision. Healthcare managers play an important role in ensuring that regular meetings and other opportunities are used to disseminate and reinforce messages about service integration to staff.
  
4. **Use evidence to advocate for prioritisation of and funding for service delivery integration, including adequate funding for FP/RH and HIV&AIDS services.** This includes advocating for political commitment and adequate funding from the Ministry of Finance and relevant MDAs, as well as donors. Advocacy should be planned and coordinated to ensure funds are available and released when needed for implementation. Suggested activities:
  - Select and train effective champions.
  - Adapt or develop advocacy materials. The Goals and the RAPID models contribute to evidence-based advocacy (Sanders, 2010).
  
5. **Strengthen efforts to adequately meet HR staffing needs in the health sector.** Ghana has established ambitious targets for health as part of the commitments made, for example, to the MDGs and Universal Access. Task shifting to lower levels of staff, continued expansion of training of health workers, strengthening of training, and the development and use of strategies to improve staff performance are all important issues. The recently conducted HR/Task Shifting Assessment, as well as other initiatives/ongoing efforts, will need to inform this important area (Acquah and Emmart, 2010). Suggested activities include:
  - Support and strengthen efforts to alleviate the HR crisis through accelerated task shifting and continued efforts to expand the healthcare workforce. (The HR/task shifting report will contain more specific recommendations.)
  
6. **Strengthen pre-service and in-service training for healthcare personnel, and ensure that training reflects service integration.** Availability of adequately prepared healthworkers is a major impediment to future expansion of HIV&AIDS services (Acquah and Emmart, 2010). Suggested activities to strengthen training for service integration include:

<sup>7</sup>HPI recently worked with Ghanaian partners to apply the Goals model and to conduct a RAPID training. Both models are part of the Spectrum Suite and can be used for advocacy purposes. The Goals model helps efforts to respond to the HIV&AIDS epidemic by showing how the amount and allocation of funding is related to the achievement of national goals, such as the reduction of HIV prevalence and expansion of care and support. The RAPID model helps project the socioeconomic impacts of high fertility and rapid population growth. Both models can be downloaded at: <http://www.futuresgroup.com/resources/software/>



- **Encourage and support review and update/revision of training curricula to ensure they address service components of integrated FP/RH and HIV prevention and AIDS care and treatment services.** It is important to build on current efforts to reevaluate curricula and teaching methods to better prepare future health workers to provide HIV&AIDS-related services. Pre-service training must graduate healthcare providers who have adequate skills and knowledge to provide integrated services.
  - **Encourage use of policies, standards, guidelines, and protocols during training.** It is also important that healthcare personnel have access to these documents in the workplace, and that supervision and monitoring continuously emphasise them.
  - **Ensure that cross-cutting issues are an integral part of training.** This includes S&D reduction and gender issues, but should also include quality assurance and improvement, teamwork, and workplace innovation, as well as MARP issues.
7. **Streamline/improve patient files, record keeping, and reporting systems.** Respondents stated that patient files are cumbersome and that having access to sufficient client information while at the same ensuring confidentiality can be a challenge. Suggested activities:
- **Establish expert group or work with existing group** to streamline systems.
  - **Review and modify existing systems.** In this process it is important to involve the users. Patient monitoring and management systems and data reporting tools that provide key components for adaptive patient management, healthcare quality, and clinical sustainability, such as IQ Solutions, could be adapted to the Ghanaian context.
  - **Implement new or revised systems.**
8. **Continue to streamline and strengthen systems to ensure that logistics, monitoring, evaluation, and supervision promote and support service integration.** There are many ongoing efforts in these areas. It is important to ensure that all of them address integration. Suggested activities:
- **Ensure that all stakeholders recognize the important goal of integration and understand how their activities can contribute** to it (for example, the effective use of communication to clarify job descriptions and produce job aids to increase familiarity with policies, standards and guidelines; strengthen performance systems; and increase supportive supervision).
  - **Strengthen and support managers** to improve systems and use quality improvement approaches to promote innovation and change through teamwork.
9. **Ensure that BCC campaigns and materials deliver integrated messages and reinforce each other.**
- Establish expert group(s) or work with existing groups
  - Ensure that stakeholders understand the goal of integration
  - Review current BCC efforts
  - Brainstorm on innovative ways to deliver messages
  - Incorporate integrated messages in existing and new campaigns and materials.

<sup>8</sup><http://www.futuresgroup.com/software/iq-solutions/>

## References

- Adamchak, S., T. Grey, C. Otterness, K. Katz, and B. Janowitz. 2007. *Introducing Family Planning into Antiretroviral Programs in Ghana: An Evaluation of a Pilot Intervention*. Durham, N.C.: Family Health International.
- Adamchak, S., B. Janowitz, R. Amehyah, and H. Nagai. 2006. *Family Planning Use and Unmet Need among Female ART Clients in Ghana*. Accra: Family Health International, Ghana Health Service, EngenderHealth.
- Akanlu, G., A. Gyekye, K. Hanson, K. Essah, J. Dupree, R. Loganathan, and K. Foreit. 2006. "Service Provider's Perspectives on Update of Antiretroviral Therapy: Lessons to Guide Program Expansion." Third draft. SHARP Project.
- Arglah, O. 2006. *FP/ART Integration in Ghana: Early Impressions & Interventions*. Accra: Engenderhealth/The ACQUIRE Project.
- Arglah, O., E. Bonku, and D. Wohlfarht. 2005. *Integrating Family Planning Counselling and Services into HIV Care and Treatment Services in Ghana: A Performance Needs Assessment*. Accra: ACQUIRE Project, Family Health International, Ghana Health Service and Ghana Health Partners.
- Farrell, B. 2009. *Family Planning-Integrated HIV Services: A Framework for Integrating Family Planning and Antiretroviral Therapy Services*. New York: EngenderHealth/The ACQUIRE Project
- Ghana AIDS Commission. 2010. "Ghana's Progress Report on the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS." *Reporting Period January 2008–December 2009*. Accra: Ghana AIDS Commission.
- Ghana AIDS Commission. 2009. *Partnership Framework in Support of Ghana's HIV/AIDS National Response in Collaboration with All Development Partners Between the Government of the United States of America and the Government of the Republic of Ghana*. Ghana AIDS Commission.
- Ghana AIDS Commission. 2006. *National HIV and AIDS Strategic Framework 2006–2010*. Accra: Ghana AIDS Commission.
- Ghana AIDS Commission. 2004. *National HIV/AIDS and STI Policy*. Accra: Ghana AIDS Commission.
- Ghana Health Service, Health Promotion Department, Family Health Division. 2008. *Final Report on Collation and Review of Reproductive Health Educational Materials to Integrate HIV/AIDS Messages*. Accra: Ghana Health Service.
- Ghana Health Service. 2007. *Implementation of TB/HIV Collaborative Activities in Ghana. Technical Policy and Guidelines*. Accra: Ghana Health Service.
- Ghana Health Service, Reproductive and Child Health Department. 2007. *Reproductive Health Strategic Plan 2007–2011*: Accra: Ghana Health Service.
- Ghana Health Service. 2003. *National Reproductive Health Service Policy and Standards. 2nd edition*. Accra: National RH Service and Standards, Ghana Health Service.

- Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. 2009a. *Ghana Demographic and Health Survey 2008*. Accra, Ghana: GSS, GHS, and ICF Macro.
- Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. 2009b. "Ghana Demographic and Health Survey 2008." *Preliminary Report*. Accra: GSS, GHS, and ICF Macro.
- Grogan, C., R. Killian, K. Bruce, and A. Bannerman. 2009. *Do Free Condoms Increase Self-Reported Rates of Condom Use in HIV+ Clients? A Pilot Study*. Accra: Quality Health Project, NACP, GHS.
- Hardee, K. and N. Yount. 1995. *From Rhetoric to Reality: Delivering Reproductive Health Promises through Integrated Services*. Durham, N.C.: Family Health International.
- ICF Macro. 2010. *Fertility and Family Planning in Ghana: A new look at data from the 2008 Ghana Demographic and Health Survey*. Calverton, Md. (USA): IDF Macro.
- Mayhew, S. 2004. *Sexual and Reproductive Health in Ghana and the Role of Donor Assistance. A Case Study*. Washington, D.C.: Population Action International.
- Ministry of Health. 2008a. *National Guidelines for the Development and Implementation of HIV Counselling and Testing in Ghana*. Accra: Ministry of Health.
- Ministry of Health. 2008b. *National Guidelines for Prevention of Mother to Child Transmission of HIV*. Accra: Ministry of Health.
- Ministry of Health, Policy, Planning, Monitoring and Evaluation Division. 2008. *An Estimate of Potential Costs and Benefits of Adding Family Planning Services to the National Health Insurance Scheme in Ghana, and Impact on the Private Sector*. Accra: Ministry of Health.
- National AIDS/STI Control Programme. 2010a. *National HIV Prevalence & AIDS Estimates Report 2009–2015*. Accra: National AIDS/STI Control Programme, Ghana Health Service, Ministry of Health.
- National AIDS/STI Control Programme. 2010b. *2009 HIV Sentinel Survey Report*. Accra: National AIDS/STI Control Programme, Ghana Health Service, Ministry of Health.
- National AIDS/STI Control Programme. 2008a. *Annual Report 2008*. Accra: National AIDS/STI Control Programme, Ghana Health Service, Ministry of Health.
- National AIDS/STI Control Programme. 2008b. *National Guidelines for Management of Sexually Transmitted Infections*. Accra: National AIDS/STI Control Programme, Ghana Health Service, Ministry of Health.
- National Population Council. 2009. *Report on Health Facility and Community Assessment to Determine the Level of Integration of Sexual Reproductive Health (SRH) and HIV/AIDS Programmes and Activities in Fanteakwa and Akwapim South Districts of the Eastern Region*. Accra: National Population Council.
- National Population Council. 2008. *Final Report on Collation and Review of Reproductive Health Educational Materials to Integrate HIV/AIDS Messages*. Accra: National Population Council.

- National Population Council. 2000. *Adolescent Reproductive Health Policy*. Accra: National Population Council.
- Planned Parenthood Association of Ghana. 2009. *The Case for Adding Family Planning on the National Insurance Scheme Position Paper*. Accra: PPAG.
- Population Reference Bureau. 2009. *Supporting the Integration of Family Planning and HIV Services*. Washington, D.C.: Population Reference Bureau.
- Quality Health Partners and Ghana Health Service. 2009a. *Assessing the Impact of Family Planning Promotional Campaigns in Selected Districts in Ghana*. Accra: Quality Health Partners.
- Quality Health Partners and Ghana Health Service. 2009b. *Improved Quality of Reproductive and Child Health Services in 37 Districts in Ghana. Endline Assessment. Results*. Accra: Quality Health Partners.
- Quality Health Partners and Ghana Health Service. 2005. *Facility Baseline Assessment of Regional Hospitals and Facilities in 28 Target Districts in Seven Regions of Ghana*. Accra: Quality Health Partners.
- Quality Health Partners and the National AIDS/STI Control Programme – Ghana Health Service. 2009. *Do Free Condoms Increase Self-Reported Rates of Condom Use in HIV Positive Clients? A Pilot Study*. Accra: Quality Health Partners.
- Rosen, J, and F. Asante. 2010. “Cost of HIV/AIDS Adult and Pediatric Clinical Care and Treatment in Ghana.” Forthcoming report.
- Sanders R. 2010. “Cost and Impact Scenarios to Inform Development of the Ghana National Strategic Plan for HIV&AIDS 2011–2015.” Forthcoming report.
- SHARP Project. 2006. *Formative Research on Uptake of PMTCT: Report on Interviews with PMTCT Service Providers. Sharp Research Briefs No. 1*. Draft. Accra: SHARP Project.

## Key Organisations Interviewed

1. Human Resources Directorate, Ministry of Health
2. Policy Planning Monitoring and Evaluation Unit, Ministry of Health
3. Family Health Division, Ghana Health Service
4. Health Promotion Unit, Ghana Health Service
5. National AIDS/STI Control Programme, Ghana Health Service
6. Policy Planning Monitoring and Evaluation, Ghana Health Service
7. Public Health and Reference Laboratory, Ghana Health Service
8. Ghana AIDS Commission
9. Joint United Nations Programme on HIV/AIDS
10. Royal Danish Embassy
11. United States Agency for International Development
12. United Nations Population Fund
13. United Nations Children Fund
14. World Health Organization
15. University of Ghana Medical School
16. University of Ghana School of Public Health
17. University of Ghana Nursing School
18. University of Ghana College of Hospitals and Surgeons
19. Ghana Registered Nurse Midwives Association
20. Ghana Medical Association
21. Biomedical and Laboratory Science at Korle Bu Teaching Hospital
22. Ridge Hospital
23. Police Hospital
24. La General Hospital
25. Dodowa District Hospital
26. Narh Bitra Hospital
27. Christian Health Association of Ghana



**USAID**  
FROM THE AMERICAN PEOPLE

HEALTH POLICY  
INITIATIVE