Guide for rapid assessment of interactions between HIV programmes and health systems

World Health Organization
Regional Office for the Eastern Mediterranean

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Introduction

The Eastern Mediterranean Region of the World Health Organization and the Middle East and North Africa Region of the Joint United Nations Programme on HIV/AIDS (EMR/MENA) are characterized by low levels of HIV prevalence in the general population and increasing evidence of concentration of risk in specific populations including injecting drug users, sex workers and men who have sex with men. Stigma associated with HIV and risk behaviours is high. The income levels of countries in the Region and the maturity and capacity of health systems vary a lot and there are many different ways in which HIV programmes interact with national health systems.

In order to gain better insight into the relationships between HIV programmes and health systems, in particular in terms of integration of HIV programmes into general health systems, in different country contexts in the Region, the WHO Regional Office of the Eastern Mediterranean launched in 2009 a project entitled "Achieving coverage, quality and sustainability in the context of existing health systems". The subject of the project is the interaction between, and integration of, HIV programmes and interventions into health systems. While national HIV responses engage a wide range of sectors this project focuses on the health sector. A similar approach could be applied to other disease programmes in the health sector and to HIV programs of other sectors. The approach is also applicable beyond the EMR/MENA Region, in particular in countries with low-level/concentrated epidemics.

As a first step, the project undertook four country case studies to explore the degree to which existing health systems integrate HIV/AIDS programmes and interventions. This has involved the development of a conceptual framework for the assessment of the current status of integration and the analysis of determinants and effects of integration. An initial assessment instrument consisting mainly of semi-structured interview questions was applied in four countries: Islamic Republic of Iran, Morocco, Sudan[1] and Yemen. The results of these studies provided a snapshot of the current status of integration in these four countries. However, the case studies had limitations in terms of providing insight into stakeholders' views on the determinants of integration and its effects. Based on the experience of the four country case studies and recommendations made by national AIDS programme managers in the Eastern Mediterranean Region at the 19th regional meeting in 2010, a further evolution of the assessment methodology and tool took place to include more explicitly two themes:

1) stakeholder perception with regard to enabling and constraining factors of the health system for HIV programme delivery; and

2) the awareness and comprehension of effects of the HIV programme on the performance of the health system.

Besides elucidating stakeholders' viewpoints, the methodology is designed to trigger relevant reflection and discussion among decision-makers and their advisers in ministries of health, WHO and other partners. The methodology was piloted in Egypt between April and June 2011. A number of adaptations were subsequently made which are incorporated in this document.

[1] The objectives of these country case studies were: to assess and describe the situation regarding integration of HIV programmes and services into the existing health system; to explore and describe by whom and based on what considerations the decisions are made regarding the way how health sector HIV programmes are implemented including decisions on integration versus non-integration; and to explore and describe views of key stakeholders regarding the positive and negative effects of integration or non-integration in terms of facilitating increased access to quality interventions/services and their sustainability.

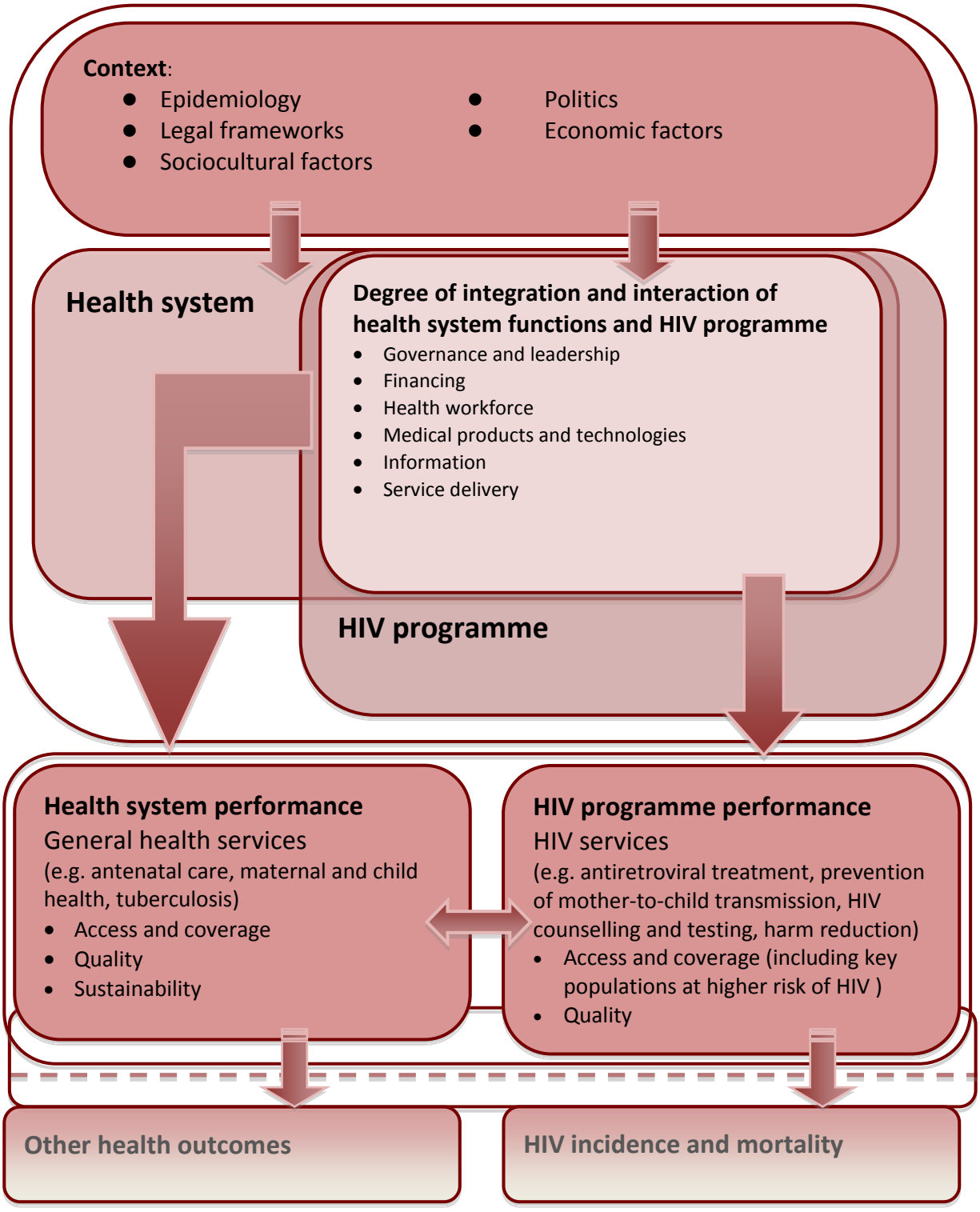


Figure 1. Conceptual framework for rapid assessment

Conceptual framework

This assessment tool is based on a conceptual framework for the analysis of the interactions between HIV programmes and the general health system. The emphasis throughout is on the determinants and effects of integration of HIV programme functions in general health system functions.

The framework is designed around the six health system functions (governance and leadership; financing; health workforce; medical products and technologies; information; service delivery) that determine, together with broader contextual factors, the coverage, quality and sustainability of health interventions and ultimately the achievement of improved health outcomes. HIV programme functions are integrated to varying degrees into general health system functions and sometimes develop separate so-called "parallel" systems with potential positive and negative repercussions on the general health system's and their own functionality (see Figure 1).

Purpose of the assessment

This assessment is designed to explore how the HIV programmes interact with the national health system and, in particular, how HIV programme functions are integrated into national health systems. Furthermore, it examines the factors that have influenced the degree of integration, including the ability of health systems to accommodate HIV programme needs. In this respect the assessment may also reveal health system strengthening needs. Lastly, the positive and negative aspects of the interactions between the HIV programme and the health system are studied in view of HIV programme and health system performance.

The assessment aims to promote thinking and discussion on the above issues among a specific group of stakeholders, namely government, private sector and civil society leaders involved in public health, and representatives of beneficiaries. The results should inform the preparation of grant proposals for HIV/AIDS and health systems strengthening, national planning for HIV/AIDS and overall national health planning. Consideration should thus be given to conducting the assessment as part of the situation analysis in those processes.

While health is a public good that is the concern of many sectors, the assessment focuses on the health sector[2], in order to limit it to a manageable scope.

Accordingly, the objectives of the assessment are:

- to assess and describe the current situation regarding integration of HIV programmes and services into a country's health system;
- to explore the views of stakeholders on:
    - the ability of the existing health system to fulfil the requirements for effective HIV programme performance;
    - how the existing capacity of the system influences decision-making on integration of HIV programme functions;
    - the positive and negative effects of the current level of integration of HIV programmes/interventions on the performance of the health system and of the HIV programme;
    - positive and negative effects of the current level of integration on the achievement of coverage, quality and sustainability of HIV interventions.
- to initiate discussion on positive and negative aspects of the current interactions between the HIV programme and the health system and explore ways for improvement.
- to formulate strategies and plans to improve the efficiency of HIV/AIDS interventions implemented through the health system.

This assessment is designed to trigger discussion in countries on the optimal ways to implement HIV programmes in the context of an existing health system, with the aim of benefiting the performance of both

[2] It should be noted here that other sectors, such as for example the education sector, are also important contributors to public health and might face similar issues regarding integration of HIV programmes.

the HIV programme and the health system. This should reflect on *how* to achieve the optimal degree of integration of HIV programmes in a country's health system context and on how to leverage these interactions to achieve strengthening of the system. These discussions should, in turn, inform the design and implementation of ongoing and planned HIV service delivery in order to achieve improved overall results.

Overview of rapid assessment methodology

The aim of the rapid assessment is not to gain a complete picture of the interactions between the health system and the HIV programme, but rather to develop an understanding of the most relevant aspects that impede or enhance HIV programme and/or overall health system performance, to promote discussion around these, and to formulate strategies to improve both. The assessment thus focuses on a few chosen thematic areas. The methodology includes a review of documents, key informant interviews, and a workshop for validation of the findings.

Key informants

It is suggested that the methodology be targeted primarily at a limited number of leaders from government, private sector, civil society and international development partners involved in the planning, design, implementation and funding of HIV-related policies and programmes and representatives of beneficiaries. In addition, the opinion of service providers will be sought by interviews with health care workers at the facility level. For reasons of patient confidentiality and the need for ethical clearance, it is not possible within the scope of this assessment to conduct interviews directly with the recipients of services. Instead, their views will be sought through interviews with representatives of consumer organizations (e.g. associations of people living with HIV).

Assessment instrument

The assessment instrument focuses on several key areas of interest, each of which is dealt with in detail**.** It consists of a guide for key informant interviews that includes questions and prompts, arranged into thematic modules according to health systems functions. Each module is preceded by the requirement to draw an organizational diagram in order to gain an overview of the relation between the health system and the HIV programme, without adding to the length of the interviews. It is envisaged that these diagrams are drawn by the lead expert beforehand and will be validated and elaborated on by the interviewees.

Assessment process

The following eight steps are proposed for a national level exercise facilitated by WHO Regional Office for the Eastern Mediterranean. This process can, however, be adapted for use at lower levels in the health system (provincial, district), or within a health service organization, in which case the roles of experts and contributing organizations would require adaptation.

Establishment of a steering committee

A steering committee, comprising senior managers from within the government (Ministry of Health) and leaders representing nongovernmental organizations and development partners, is assembled by the relevant authority (e.g. Minister of Health, Chair of National AIDS Committee). Committee members should be involved in HIV and reproductive health programmes and/or in activities cutting across the health system and should be interested in guiding the assessment within the country context. This broad representation will help ensure that linkages between the various systems are considered in sufficient depth.

Appointment of a lead expert and assessment working group

A lead international expert should be appointed to manage and implement the assessment. This lead expert will work in close collaboration with a consultant from the assessment country who is more closely familiar with the local context. Both the lead expert and the national consultant must have a good understanding of

HIV programmes and their interactions with and integration into health systems. Two staff members from the Ministry of Health will be assisting them in this work; one representing the National AIDS Programme (or equivalent) and one representing a department of the Ministry of Health whose activities cut across the health system. Together, the consultants and Ministry of Health staff will form the Assessment Working Group (AWG). This group will take responsibility for adapting and implementing the rapid assessment instrument. Moreover, this group will be involved in selection of key informants, developing draft versions of organizational charts, and in planning the analysis of findings and in report writing.

Selection of key informants

A number of selected health leaders with sufficient understanding of the health system and the HIV programme need to be interviewed. These should be drawn from the Ministry of Health, the National AIDS Programme/Committee, other relevant government bodies (e.g. regulatory authority, Ministry of Finance etc.), the Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordination Mechanism (if present), United Nations agencies (e.g. United Nations Joint Programme on HIV/AIDS, World Health Organization, World Bank, United Nations Children's Fund) and other organizations such as influential large donors (Global Fund, President's Emergency Plan for AIDS Relief (PEPFAR), bilaterals), associations of medical professionals, nongovernmental organizations providing HIV and health services and civil society organizations that represent and/or are advocates of people living with HIV. In addition, a limited number of health facility managers and health care providers will be interviewed on the issues within their area of expertise and responsibilities. The total number of informants will likely be in the range of 35–45 persons. A suggested list of informants for each of the thematic areas of the assessment is provided in Annex 1.

Desk review

The national consultant, with guidance from the lead expert and assistance from the other members of the assessment working group, will conduct a desk review for Phase 1 of the assessment. This involves the review of relevant documents, such as recent official policy documents, strategic plans, grant applications, and evaluation reports. A list of documents that are recommended for inclusion on the desk review, and a general outline, are provided in Annex 2. The review will aid in drawing up the six organizational diagrams prior to the interview process.

Interviews

Interviews with key informants are guided by the semi-structured interview questions presented in this assessment instrument (in English and Arabic). They will be conducted jointly by the lead expert and the national consultant. Simultaneous translation might be needed depending on whether the lead consultant speaks the local language.

Preliminary data analysis, presentation and discussion

The lead expert, with support from the national consultant, carries out a preliminary analysis of the primary data. The findings from this preliminary analysis will then be presented to the steering committee for initial validation and for identification of issues that require more clarification and in-depth analysis. The lead expert and national consultant will then conduct additional analysis and prepare a draft report. The findings and the draft report will be shared with a group of stakeholders consisting of HIV and health systems leaders and, as appropriate, client representatives during a synthesis and validation workshop. During the workshop further discussion of the issues can take place to validate the findings and to stimulate the development of more ideas and inspire motivation for improvement. The objectives of this workshop thus are: 1) to validate the findings; 2) to gather more opinions around the interactions between the HIV programme and the health system and, in particular, the integration of the HIV programme; and 3) to discuss recommendations to address obstacles to beneficial integration and to strengthen synergies between the HIV programme and health system.

Final data analysis and reporting

The lead expert, with support from the national consultant, finalizes the analysis and collates the findings and recommendations into a draft of the final report. The draft report is presented to the steering committee and WHO. Their feedback is subsequently incorporated into the final report. The steering committee may agree at that point on key recommendations to be implemented, a follow-up mechanism and concrete next steps to be taken.

Dissemination of findings and next steps

The steering committee will decide on how the findings may be presented to a larger group, perhaps as part of a regular HIV programme review meeting, and the written report distributed to interested/relevant individuals/organizations. Also, the WHO Regional Office will compile the final reports from participating countries for analysis of the wider situation in the Region and to facilitate higher-level discussion of the issues.

Summary of assessment process

- A lead expert is contracted.
- The Ministry of Health of the assessment country nominates national members of the steering committee.
- The steering committee nominates members of the assessment working group.
- The national consultant arranges a first meeting of the steering committee and assessment working group to orient the steering committee on the conceptual framework and the assessment methodology; WHO and/or the lead expert present the conceptual framework and methodology at this meeting.
- The steering committee reviews the objectives and processes of the assessment and provides input on the selection of key informant.
- The assessment working group reviews the assessment instrument to ensure it is comprehensive and appropriate to the country context.
- The national consultant collects relevant background documents and literature and collates the information into a desk review report.
- The assessment working group sends letters of request for cooperation to the initial group of key informants and schedules interview appointments; it is crucial that key informants are well informed before the interview about the process and objectives of the assessment.
- The lead expert and national consultant conduct the interviews.
- The lead expert, with assistance from the national consultant, conducts preliminary analysis of the data collected.
- The assessment working group and lead expert present the preliminary findings to the Steering Committee for discussion, validation and identification of issues that require clarification and more in depth analysis.
- The assessment working group organizes a synthesis and validation workshop with a selected group of key stakeholders during which findings, implications and recommendations are discussed.
- The lead expert, with support from the national consultant, prepares a draft of the final report.
- The assessment working group and lead expert present the draft of the final report to the steering committee. Key recommendations are identified and the steering committee may agree on a follow-up mechanism for their implementation and determine concrete next steps, including the wider dissemination of the final report.
- The lead expert finalizes the report.

Definitions

For the purposes of this rapid assessment instrument, the following terms are defined:

Health sector: The health sector consists of organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health-related nongovernmental organizations and community groups, and professional associations.[3]

Health system: A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health.[4]

Health service delivery: Delivery of services, be they health promotion, prevention, treatment or rehabilitation, delivered in the home, the community, the workplace, or in health facilities.

Stakeholder: Any party to a transaction that has particular interests in its outcome.

Policy: Officially recognized plans or strategy or regulations that explain an organization's intention to influence and determine decisions, actions, and other matters.

(HIV) Programme integration: The reliance on routine health system structures, mechanisms and/or processes to execute a particular function of the (HIV) programme. Programmes may vary both in their *level* and *nature* of integration. The *level* of integration can be viewed as varying from complete separation ('no integration'), to basic coordination ('limited integration'), to active collaboration ('moderate integration'), to complete sharing of structures, mechanisms or processes ('high integration'). The *nature* of integration is associated with the individual structures, mechanisms and/or processes under consideration.

Coverage (of HIV services): Number of people reached by (HIV) health prevention, care and treatment services, usually expressed as a percentage of the estimated number of people in need of services.

Quality (of HIV services): The achievement of optimal physical and mental health through accessible, cost-effective care that is based on best evidence, is responsive to the needs and preferences of patients and populations, and is respectful of patients' personal values and beliefs.

Sustainability (of HIV programmes/interventions): Programme sustainability includes, but is not limited to, the continued commitment of funding and resources. The definition also involves the extent to which the programme continues to be operational, cohesive and developing.

Rapid assessment instrument

Phase 1: Preparation prior to interviews

In order to limit the number of questions asked of each informant and to ensure that the interviewer has a sufficient understanding of existing structures and processes to inform the interview, draft diagrams of organizational structures are to be drawn prior to the interview stage of the assessment (Table 1). This is to be done by the Assessment Working Group using available organizational charts and descriptions, as well as personal knowledge.

The diagrams are not intended to show every single detail, but rather to provide an overview of the situation that will give understanding of the functioning and extent of any linkages/integration without the need for further detailed questioning of informants. Each diagram should clearly highlight linkages between the HIV programme structures/mechanisms and the general health system structures/mechanisms. Examples of each type of chart for guidance purposes are given in Annex 3, but their format is only for demonstration purposes and other formats may be used, as appropriate.

[3] Adapted from: *Glossary of terms used in the "Health for All" Series No. 1–8*. Geneva, World Health Organization, 1984 (Health for All Series, No 9). http://whqlibdoc.who.int/hq/1998/WHO_HPR_HEP_98.1.pdf

[4] *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva, World Health Organization, 2007.

The prepared diagrams should be brought to the interviews so that they can be used at the start of each interview to establish a common understanding between the informant and the interviewer of the relevant structures and/or processes. Informants can then be asked to review and, if necessary, revise the diagrams. These discussions should focus on key aspects of the diagrams only and not take up more than a limited part of the allocated interview time (max. 5-10 minutes).Based on the informants' input, as well as on more detailed analysis of the collected data, the diagrams can be further adjusted. The resulting diagrams should then be discussed with participants in the synthesis and validation workshop. Once finalized, the diagrams can be added as an annex to the report.

Table 1. Diagrams to be prepared before interviewing informants

No.	Theme	Description	Information sources
1	**Leadership and governance**	Diagram of the **organizational structure** of the national HIV programme and its placement in relation to other relevant organizational structures (i.e. Ministry of Health, National AIDS Commission, Country Coordinating Mechanism, private sector, civil society, etc), clearly outlining any (formal and informal) linkages between them.	a) Documents e.g. strategic plans, grant applications, programme reports, publications. b) Interviews with leaders from e.g. National AIDS Control Programme, National AIDS Commission, Ministry of Health, UNAIDS, country coordinating mechanism, WHO
2	**Leadership and governance**	Diagram of the HIV programme **decision-making bodies/positions** in relation to the decision-making bodies in the general health structures (e.g. Ministry of Health; Ministries of Finance, Education and the Interior; donor coordination mechanisms), indicating how they relate to each other hierarchically and functionally.	a) Documents e.g. strategic plans, grant applications, programme reports, publications. b) Interviews with leaders from e.g. National AIDS Control Programme, National AIDS Commission, Ministry of Health, UNAIDS, country coordinating mechanism, WHO
3	**Health financing**	Flow chart showing main **funding sources and financial management systems** for HIV programmes in relation to the general health system financing sources and systems (include private sector and household expenditures).	a) Documents e.g. strategic plans, grant applications, programme reports, publications. b) Interviews with leaders from e.g. National AIDS Control Programme, National AIDS Commission, Ministry of Health, UNAIDS, country coordinating mechanism, WHO, PEPFAR, World Bank Multi-country HIV/AIDS Program. Also service providers.
4	**Medicines and technology**	Flow chart showing the **systems for the procurement and supply** of HIV-related drugs and commodities (i.e. ARVs, drugs for treatment of opportunistic infections, HIV test kits) in relation to the general Ministry of Health procurement and supply systems.	a) Documents e.g. strategic plans, grant applications, programme reports, publications. b) Interviews with leaders from e.g. National AIDS Control Programme, National AIDS Commission, Ministry of Health, UNAIDS, country coordinating mechanism, WHO, PEPFAR, World Bank Multi-country HIV/AIDS Program. Also service providers. c) Available information from WHO Regional Office for the Eastern Mediterranean showing organization of procurement of medical supplies for HIV services
5	**Information**	Chart showing the **systems for data collection, analysis and reporting** for the HIV programme in relation to the general health management information systems. The chart should also include mention of the structures responsible for data analysis and reporting (both upwards and downwards).	a) Documents e.g. strategic plans, grant applications, programme reports, publications. b) Interviews with leaders from e.g. National AIDS Control Programme, National AIDS Commission, Ministry of Health, UNAIDS, country coordinating mechanism, WHO
6	**Service delivery**	Organizational chart showing **how HIV services** (prevention, care, treatment) **are delivered in relation to the health care delivery system**, i.e. what services are delivered; where (e.g. type of facility); when (e.g. dedicated clinic hours); and by whom? The chart should indicate systems for referral across services and collaboration between programmes.	a) Documents, e.g. strategic plans, grant applications, programme reports, publications. b) Interviews with leaders from e.g. National AIDS Control Programme, National AIDS Commission, Ministry of Health, UNAIDS, country coordinating mechanism, WHO

Phase 2: Data collection through semi-structured interviews

Scheduling interviews

- The assessment working group, with input from the Steering Committee, will draw up an initial list of key informants. It is preferable that these interviews are scheduled in advance of the field visit from the lead expert, even though in practice interviews tend to be prone to last minute scheduling changes. Before scheduling interview appointments, it is important to consider the following:
- Is a letter of introduction needed? Some informants may be unwilling or unable to participate in an interview unless a formal letter of introduction has been presented in which the objectives and methodology of the assessment have been elaborated. It is often helpful if this letter of introduction is (co-)signed by a key official within the Ministry of Health or another government department to demonstrate high-level support for the assessment.
- Is formal approval from higher management needed? In some organizations approval from headquarters needs to be obtained before the informant is allowed to participate in any interview. The invitation for participating in the assessment should therefore be issued sufficiently in advance so that the informant will have time to obtain the required approval.
- Does the informant need to sign a consent form? Sometimes local or institutional regulations may require that informants sign a consent form before the interview. A sample consent form is provided in Annex 5.
- Is an interpreter necessary? It is important that informants are able to express themselves freely and, as such, they should be offered the possibility of conducting the interview in their own language. If the interviewer does not speak this language, a professional interpreter is strongly recommended. This interpreter should be sufficiently familiar with the relevant jargon and terminology. To this end the interpreter should be provided beforehand with a copy of the interview guide in both languages, as well as a list of key terms and abbreviations.
- The location and time for the interview should be chosen so as to best accommodate the informant, and should be such that the interview can take place in an undisturbed, quiet and confidential surrounding. Offices that are shared by several people are thus not recommended as interview locations. Private offices or meeting rooms are preferred.

Before initiating the interview

Before undertaking any interviews, the interviewer(s) needs to have full understanding of the major definitions (described previously) that are being used and should understand the underlying rationale for each of the questions provided in the interview guide. The interviewer(s) have to be sufficiently familiar with the information summarized in the diagrams prepared in Phase 1. It is recommended that before commencing the interview phase, interviewers test their understanding of the methodology, their background knowledge, and interview skills in a small number (1—3) of practice interviews. Ideally, these practice interviews are conducted during a 1 day training under the guidance of someone experienced in the methodology and interview techniques. Video or audio recording of these interviews and subsequent play back can be particularly helpful during the training. It should be kept in mind that the focus of these practice interviews should be on the interview process itself (e.g. did the interviewer probe sufficiently? Did he or she ask questions in an open and non-leading way? Did the interviewer give sufficient time to respond?) and on the interviewer's understanding of the assessment objectives and methodology (e.g. if the informant did not understand the question, was the interviewer able to explain or rephrase it?). They should, however, not focus on the content of the responses. The informant should thus ideally be someone who is directly involved in the assessment and who either would not be on the list of assessment informants or who would not object to be interviewed again.

At the start of each interview, the interviewer should introduce all the members of the assessment team present and explain what the objectives of the assessment are, what the structure of the interview (including expectations of time needed) will be, and how the information obtained will be used. Some possible guidance for this is given below:

> "We are conducting an assessment entitled 'Rapid Assessment on Interactions between HIV Programmes and Health Systems'. The assessment seeks to find out what the linkages are between HIV programmes and the health system in general and, in turn, how these linkages affect the HIV programme and health system performance. This

> information may help to improve policies, programmes and services, both in this country and across the region. We are interested in hearing your ideas and opinions on this subject. For this purpose we have developed a series of questions to guide our discussion.
>
> In general, we are looking for as clear as possible a description of the situation and for your estimations and opinions on certain aspects of it. Wherever possible, though, we would like to know the motivation for your ideas and opinions. The information you provide us will not be made attributable to you. The interview will take approximately one hour. We thank you kindly for your cooperation and we hope that you will find participating in this assessment useful."

Furthermore, it should be made clear that the informant's participation is strictly voluntary and that (s)he can withdraw his/her permission for use of the data at any time, during or after the interview. Expectations about confidentiality and anonymity should be clarified. The interviewer(s) should, furthermore, ask the informant for permission to record the interview. The interviewer should not exert any pressure on the informant to give such permission and, if permission is not granted, the recording device should be left switched off and stowed away. Lastly, the interviewer(s) should make sure to give the informant the opportunity to pose any questions (s)he may have before commencing with the interview.

Conducting the interview

Provided permission is granted by the informant, interviews should be recorded whenever possible. Furthermore, it is advisable that the interviewer(s) or a separate note taker create sufficiently detailed field notes to provide a summary of the interview, to enable regular reflection on the data thus far collected and to provide contextual detail to the interviews during the data analysis stage (e.g. observations regarding interview setting, presence of third parties during the interview). In order to maintain confidentiality and to reduce the risk of an interviewee feeling uncomfortable about discussing certain topics, we strongly recommend that during an interview no other people are present in the room than the informant(s), the interviewer(s), the note taker and, if relevant, a translator. The total number of people present in the room should be kept to a minimum. In particular other stakeholders in the assessment should not be present during the interview, even if they are members of the assessment working group, as this could lead to response bias wherein the interviewee may answer questions in a way that he or she considers agreeable to the other stakeholder present, or may avoid raising certain sensitive issues for fear of offending or reprisal.

The purpose of the interviews is to obtain information on the interactions between the HIV programme and the general health system by describing the level of integration of HIV programme functions with the general health system functions and eliciting the informant's opinions on what determines the current status of interactions and how these interactions influence the performance of the HIV programme and of the health system. The type of information sought thus requires significant critical reflection on the part of the informant. It is therefore important that the interviewer provides sufficient space for the informant to consider and formulate his/her answers, i.e. allows the informant enough time to elaborate his/her answers and, if necessary, clarifies the questions with the aid of the prompts provided. (Remember: a good interview is typically one in which fewer questions are asked but more detailed answers are given.) It is important that the interviewer keeps the focus clearly on issues of HIV programme and health system *interaction* rather than on a detailed description of the functioning of the health system or HIV programme itself. If the informant deviates too far from the topic of interest, the interviewer will need to steer the conversation carefully back on track. Also, if the answers are not sufficiently clear or specific the interviewer should probe further for clarification or ask for examples.

The interview guide has been designed in such a way that not all questions need be asked to all informants. Rather, questions have been grouped into a series of thematic 'modules'. It is recommended that per informant the interview focuses on only the 2 to 3 modules that are best aligned with the informant's interests and areas of expertise. The order in which questions within a thematic module are posed may be altered compared to the interview guide, although it should be noted that questions have been arranged in the order that is most likely to follow the natural flow of a conversation. It is possible that answers to particular questions are already given in preceding questions. In that case, it is not necessary to repeat the question, although additional probing may serve to enrich the previously given answer.

At the close of each interview, the informant should be asked whether (s)he has any remaining questions regarding the assessment process and/or her/his contribution to it. It can also be helpful to ask the informant whether (s)he can recommend any other informants for the assessment (i.e. 'snowball sampling').

Interviewer checklist

- Interview guide, including interview summary sheet
- Latest, updated versions of Diagrams 1-6
- Recording device with spare batteries[5]
- Notebook and pens/pencils
- If applicable: consent form

Phase 3: Data processing after the interview

At the end of every interview day or, when possible, after each interview the international lead expert and national consultant should discuss each interview and prepare a brief summary note (or elaborate the notes taken during the interview. See Annex 4). These discussions and notes will help identify areas that need further clarification in subsequent interviews with other key informants and provide an 'organic' overview of the main findings as they emerge.

If interviews have been recorded, recordings should be transcribed as soon as possible after the interview. This is preferably done verbatim. As transcription can be a very time-consuming process, a professional transcription agency, preferably one familiar with medical and health systems terminology, can be used to do this. If, however, due to time and/or budget constraints verbatim transcription is not feasible, then the audio recordings should be used to create a set of reasonably detailed interview notes (or to elaborate the notes taken during the interview), whereby care should be taken not to impose any undue bias on what data is or is not captured in these notes. To preserve anonymity identifiers such as names or job titles should be removed from audio recordings and transcripts if these are shared with external parties. In that case, a separate record should be maintained to link back the files to individual respondents and this record should be kept confidential. Alternatively, the contract with the transcription agency should explicitly state the need to maintain informant anonymity. If interviews were conducted in a language other than English, transcripts and interview notes should be translated into English.

Phase 4: Data analysis

If possible, analysis should be done using the full, verbatim interview transcripts. However, if such transcripts are not available, the analysis should be based on the detailed interview notes. Due to the rapid nature of the assessment, a so-called 'framework approach' is best suited to the analysis. This approach uses an analytical framework that is derived from the *a priori* determined assessment objectives and data collection tools, while allowing for the emergence of new themes from the data.[6] Individual sections from the interview transcripts and notes are indexed using predetermined, as well as emerging, themes and sub-themes. A preliminary version of the analytical framework is presented in Figure 2. However, this framework should be further refined throughout the data analysis.

The indexing of data against the framework is preferably done using a Qualitative Analysis Software (QAS) package, such as Atlas, Ti or NVivo, as this allows for rapid, easy retrieval of data according to theme or sub-theme. These indexed sections of the transcripts are then used to compare and contrast findings across the different interviews. Through an iterative process, hypotheses on effects and potential causal pathways are generated, tested against the data, and subsequently refined or rejected.[7] Secondary data sources (e.g. policy documents, programme evaluations) can be used to triangulate findings.

[5] The interviewer should have familiarized himself/herself with operating the recording device beforehand, i.e. know how to turn it on/off, know how to pause recording if the interview is interrupted, check that volume settings are correct, etc.

[6] Pope C, Mays N. *Qualitative research in health care,* 3rd edition. Oxford, Blackwell Publishing, 2006.

[7] Note: The process of "hypothesis testing" in qualitative research is distinct from statistical hypothesis testing as no numerical values are assigned to this type of data. Instead, it refers to the development of a theory to explain a certain 'qualitative' observation and using the personal judgement of the researcher to assess whether the theory is sufficiently supported by the interview data.

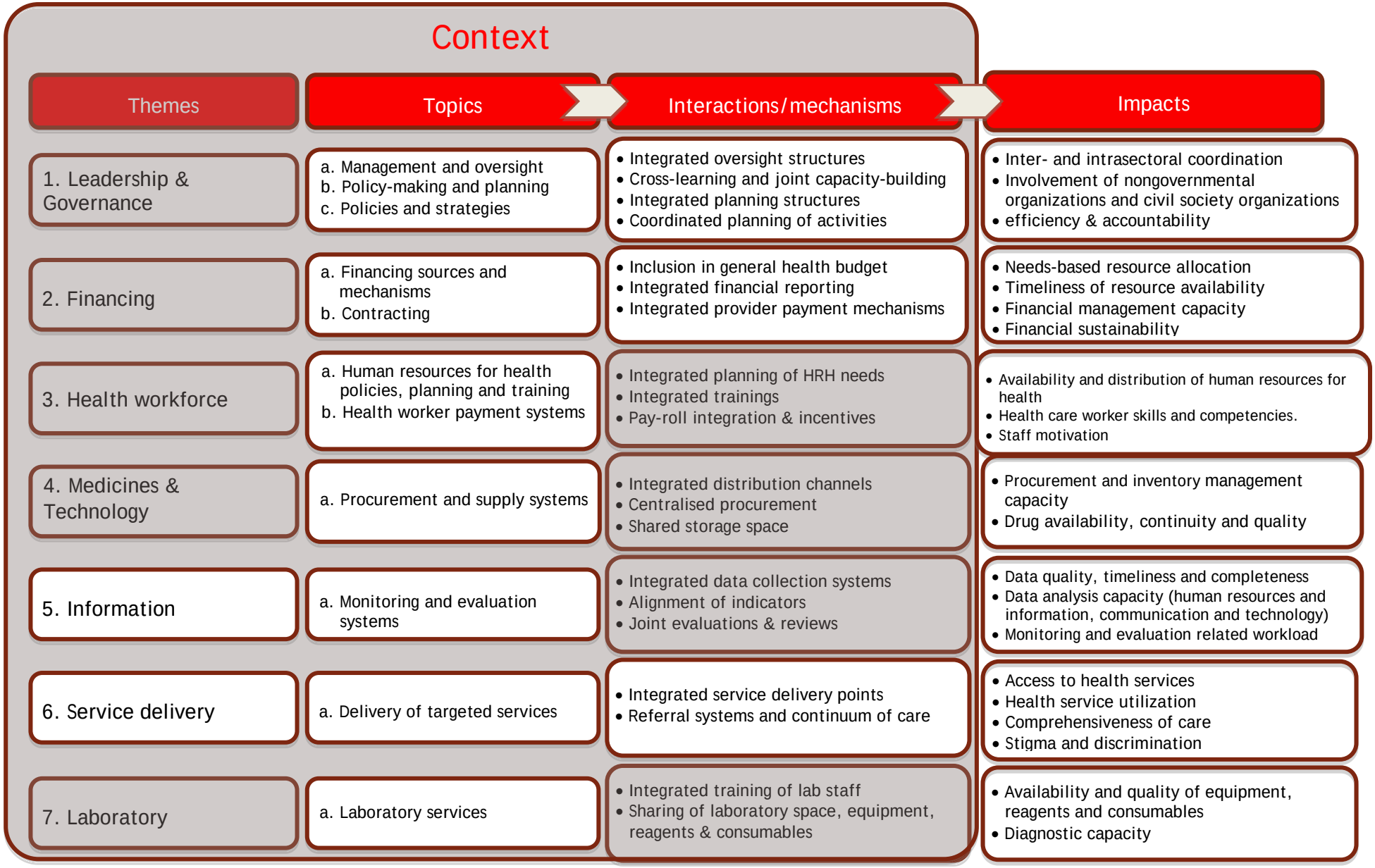


Figure 2. Analytical framework (to be refined during analysis)

Phase 5: Reporting

Based on the findings from the initial data analysis, the inputs from the steering committee, and the discussions from a synthesis and validation workshop, the lead expert, with assistance from the national consultant and the assessment working group, will prepare a first draft of the assessment report, following a pre-defined structure (see Annex 4). The draft report will be shared with WHO and the members of the Steering Committee for their input before it is finalized. The report will include the findings as well as the recommendations for action that emerged from the synthesis and validation workshop. The final report should be shared with all stakeholders, in particular those who participated in any stage of the assessment.

Interview guide

This interview guide is not designed for use as a rigidly structured questionnaire. Rather, it should be seen as a guidance document, which provides sample questions in each thematic area of interest and, as such, can be used in a relatively flexible manner. For most questions a list of prompts is provided. These lists do not aim to be comprehensive and other issues, not covered by the prompts, may come up in the discussion. It is, furthermore, not necessary to use all prompts.

Questions and prompts should be carefully selected and prioritized for each informant based on his/her interests and area of expertise. New questions can be formulated as deemed relevant for the study but this should be done with caution, as interview time is limited. Question series that are considered particularly relevant at the district or service delivery (health facility level) are indicated with ** at the end of the heading. These are found mainly in thematic modules 3, 4, 6 and 7.

Before the interview starts, the informant should be informed of the objectives of the assessment and expectations of confidentiality and anonymity should be discussed (see Phase 2). The informant must give his/her consent for audio (or video) recording of the interview before the recording device is turned on.

1. Leadership and governance

Please use **Diagrams 1 and 2** showing the organizational and decision-making structures to discuss the extent of their integration. If necessary, adjust these.

1.1 Programme management and oversight

1.1.1 How, if at all, is the **management and oversight** of the HIV programme integrated into the management structures of the general health system?

Prompts:

- Role of multi-sectoral National AIDS Committee in relation to role of Ministry of Health
- Role of nongovernmental organizations, private sector and development partners

1.1.2 What factors have influenced the current **level of integration** of the management and oversight structures[8]?

Prompts:

- Strengths/weaknesses of Ministry of Health management and oversight structures
- Donor requirements/initiatives
- Different financing sources for HIV or financial management mechanisms

1.1.3 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of the management structures?

Note: consider from perspective of the HIV programme AND from the health system perspective.

Prompts: Positive/negative effect on

[8] This refers to the integration of management and oversight structures for the HIV programme into the structures of the general health system.

- Coordination between Ministry of Health programmes on cross-cutting issues ownership of, and commitment to, HIV response
- Autonomy of Ministry of Health/National AIDS Control Programme (NAP) in decision making Effectiveness of decision making processes (bureaucracy)
- Transparency and accountability in health sector health system management capacity (skill building, numbers of personnel)
- Multi-stakeholder engagement and commitment
- Multisectoral involvement and coordination

1.1.4 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

1.2 Policy-making and planning

1.2.1 How, if at all, are the structures (e.g. committees, programme units, working groups, coordinating mechanisms) for policy-making and planning for the HIV programme integrated into the general health **policy-making and planning** structures and mechanisms?

Prompts:

- Role of National AIDS Committee and of National AIDS Control Programme, in relation to Ministry of Health
- Composition and role of Global Fund to fight AIDS, Tuberculosis and Malaria Country Coordination Mechanism
- Role of nongovernmental organizations and civil society organizations

1.2.2 What factors have influenced the current **level of integration** of the structures for policy-making and planning[9]?

Prompts:

- Strengths/weaknesses in existing policy-making and planning structures
- Need for multi-sectoral involvement
- Need for involvement of nongovernmental organizations and civil society organizations
- Donor requirements/initiatives

1.2.3 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of the structures for policy-making and planning?

Note: consider from perspective of the HIV programme AND from the health system perspective.

Prompts: Positive/negative effects on

- Harmonization and alignment of policy-making and planning processes
- Collaboration between programmes and/or departments
- Building leadership and management capacity across health sector
- Focus on HIV and competence with regard to HIV among those involved in policy-making and planning
- Involvement of stakeholders not otherwise involved in health policy-making and planning (e.g. civil society organizations)
- Coordination of stakeholders involved in policy-making and planning
- Efficiency of policy making processes and planning (e.g. avoidance of duplication of activities (e.g. number of meetings) and impact on workload

1.2.4 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

1.3 Policies and strategies

1.3.1 What are the **main** policies, strategies/plans currently affecting the national response to HIV?

[9] This refers to the integration of structures for policy-making and planning for the HIV programme into the general structures for health policy-making and planning.

Prompts:

- Multi-sectoral HIV/AIDS strategy and plan
- Health sector HIV/AIDS strategy and plan
- National HIV policy

1.3.2 How, if at all, are these HIV policies and plans integrated into other health and development policies and strategic plans?

Prompts:

- Inclusion in national growth and development plans
- Inclusion in national health sector policies and strategies
- Inclusion in reproductive health, child health and tuberculosis strategies

1.3.3 What factors have influenced the current **level of integration** of HIV policies and plans into other health and development policies and plans?

Prompts:

- Political prioritization of HIV response
- Epidemiological factors (e.g. overlapping epidemics)
- Cultural and social attitudes towards PLHIV (e.g. stigma)
- Legal frameworks
- Donor requirements/initiatives (e.g. poverty reduction strategy paper, Millennium Development Goals)
- Existing working relationships between programmes

1.3.4 How, if at all, has the current level of integration of HIV policies and plans[10] affected **coverage of HIV services**?

Prompts: Positive/negative effect on

- Equity in access for vulnerable and at-risk populations
- Focus on a) prevention, b) treatment, c) impact mitigation
- Coverage of particular services (e.g. prevention of mother-to-child transmission by integration into reproductive health policies, HIV testing through policies for provider-initiated testing)

1.3.5 How, if at all, has the current level of integration of HIV policies and plans[10] affected the **quality of HIV services**?

Prompts: Positive/negative effect on

- Care continuum for PLHIV (by more inclusive policies/plans)
- Emphasis on rights-based approach to HIV and health services
- Implementation of health and safety policies (e.g. use of gloves, disposable syringes)

1.3.6 How, if at all, has the current level of integration of HIV policies and plans affected **sustainability of HIV services**?

Prompts: Positive/negative effect on

- Government commitment and ownership
- Dependence on financial and technical support from donors and nongovernmental organizations

1.3.7 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of HIV policies and plans?

Note: consider from perspective of the HIV programme AND from the health system perspective.

Prompts: Positive/negative effects on

- Awareness of HIV policies and strategies with other (non-HIV) stakeholders
- Multi-sectoral involvement in, and ownership of, the HIV response

[10] This refers to the integration of HIV policies and plans into other health and development policies and plans.

- Clearly defined ownership and responsibility for development of HIV policies and plans
- Ability to build consensus on HIV-related policies among stakeholders

1.3.8 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

Note: Answer may include both actual opportunities and ideal scenarios (i.e. preferences)

2. Health financing

Please use **generic Diagram 3** on HIV and health sector financing to discuss the extent of integration of financing sources and mechanisms. If necessary, adjust the diagram.

2.1 Financing sources and financial management mechanisms for the HIV programme in the Ministry of Health

2.1.1 Is the budget for the Ministry of Health HIV programme integrated into other budget lines or does the HIV programme have a specific HIV budget line?

Questions 2.1.2 to 2.1.5 are relevant in countries that receive external financial support (e.g. GFATM or other donor support)

2.1.2 How is the management of the external funding sources for the HIV programme integrated into the general financial management mechanisms within the health sector?

Prompts:

- Extent of off-budget (donor) support and its integration in government financial management mechanisms

2.1.3 What factors have influenced the current level of integration[11]?

Prompts:

- Strengths/weaknesses in financial management mechanisms
- Donor requirements/initiatives (e.g. joint financing mechanisms)

2.1.4 In your opinion, what are the main **advantages and disadvantages** of the current level of integration?

Note: consider from perspective of the HIV programme AND from the health system perspective.

Prompts: Positive/negative effects on

- Alignment between resource allocation and health needs
- Government ownership of HIV response
- Potential for financing health system strengthening or cross-cutting activities
- Availability and predictability of funds for HIV
- Availability and predictability of funds for other health priorities
- Building of financial management capacity
- Financial accountability
- Efficiency of financial management for HIV services (e.g. high transaction cost of parallel systems)
- "Crowding out" effect of donor funds on public resources allocation for HIV (decreased public resource availability for HIV services by shifting to other health priorities)
- Resentment or envy between health programmes/departments over resources
- Distortion of routine revenue collection systems (e.g. if HIV services are free at point of delivery but non-HIV services are not)

2.1.5 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

[11] This refers to the integration of the external financing sources for the HIV programme into the general financial management mechanisms.

2.2 Mechanisms for provider-payment

2.2.1 Which HIV services (if any) are part of the national a) minimum/b) optional service package to be provided by national health services?

Prompts:

- HIV testing for antenatal care, tuberculosis, sexually transmitted infection patients
- Antiretroviral treatment
- CD4 count
- Tuberculosis diagnosis

2.2.2 Is this minimum/optional service package mandatory for private health services?

- Private for-profit
- Private not-for-profit

2.2.3 How, if at all, is the payment for HIV-related care and treatment services integrated into the payment systems for health services?

Prompts:

- Extent of inclusion of HIV-related services in government-subsidized service packages (see question 2.2.1 to 2.2.2)
- Extent of inclusion of HIV-related services in health insurance benefit package
- Exemption of VCT, ART and related services (e.g. treatment monitoring) from user fees
- Extent of requirement for household contributions (out-of-pocket payments; cost-sharing; informal payments) compared to other non-HIV related health services
- Differences between public and private sector
- Differences between different groups of service users (e.g. pregnant women)

2.2.4 What factors prevent and what factors can facilitate further integration of payment systems[12]?
Prompts:

- Availability of national resources in the public sector
- Government commitment to international declarations and targets (e.g. UN declaration to universal access)
- Donor initiatives (e.g. drug donation or subsidy programmes)
- Extent of health insurance coverage, including community health insurance
- Extent of the informal sector (i.e. workers without employer benefits)
- Role of public—private partnerships

2.2.5 How, if at all, has the current level of integration of the payment systems affected the **coverage of HIV services**?

Prompts:

- Increased coverage due to low cost for people living with HIV
- Limited coverage due to high cost for people living with HIV
- Limited coverage due to difficulties for providers to recover cost (insufficient cost coverage by government/insurance/users)
- Equitability of access to services
- Increased coverage due to de-stigmatization of HIV services if payment is integrated in usual payment systems (or opposite if not integrated)

2.2.6 How, if at all, has the current level of integration of the payment systems affected the **quality of HIV services**?

Prompts:

- Quality difference between services in the public vs. private sector (e.g. access to advanced diagnostics for treatment monitoring)

[12] This refers to the integration of the payment systems for HIV-related services into the payment systems for general health services.

2.2.7 How, if at all, has the current level of integration of the payment systems affected the **sustainability of HIV services**?

Prompts:

- Reliance on donor funds for free, or subsidized, provision of services vs. enabling partial cost-recovery if integrated in payment systems

2.2.8 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of the payment systems?

Note: consider from perspective of the client, the HIV programme AND from the health system perspective.

Prompts: Positive/negative effects on

- Anonymity and stigma reduction
- Service accessibility and affordability (e.g. from inclusion in health insurance package)
- Equity in access
- Service sustainability (e.g. through cost-recovery)
- Administrative burden

2.2.9 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

2.3 Public–private mix and contracting arrangements

2.3.1 How, if at all, do **contracting arrangements** between government and private providers/nongovernmental organizations include HIV services?

Prompts:

- Possibility of public sector to contract (i) private for profit and (ii) non-for profit organizations for delivering HIV services
- Possibility of private (for-profit/not-for-profit) organizations to leverage national/external funding for HIV service provision.

3. Health workforce

3.1 Human resources for health policies and planning

3.1.1 How, if at all, do national human resources for health (HRH) plans integrate **human resource needs for HIV service delivery** for e.g.:

a) Doctors
b) Nurses
c) Laboratory staff/technicians
d) Other personnel (e.g. counsellors)
e) Community health workers/volunteers

Prompts:

- Comprehensive estimation of, and planning for, numbers of HRH necessary to train, recruit and employ
- Collaboration/coordination between human resources planning of HIV programme and of the Ministry of Health

3.1.2 What factors have influenced the current **level of integration** of HRH planning for HIV service delivery into national HRH plans?

Prompts:

- Substantial workload associated with HIV service delivery

3.1.3 How, if at all, has the current level of integration of HRH planning[13] affected the **coverage of HIV services**?

[13] This refers to integration of human resources for health planning for HIV service delivery into national human resources for health plans.

Prompts:

- Adequacy of health work force allocated to HIV service provision

3.1.4 How, if at all, has the current level of integration of HRH planning affected the **quality of HIV services**?

Prompts:

- Impact on workload of health care workers and ability to spend sufficient time on delivery of HIV services

3.1.5 How, if at all, has the current level of integration of HRH planning affected the **sustainability of HIV services**?

Prompts:

- Ability to accommodate HIV service scale-up needs

3.1.6 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of human resources for health planning?

Note: consider from perspective of the HIV programme and from the health system perspective.

Prompts: Positive/negative effects on

- Availability of adequate human resources for HIV service delivery
- Allocation of national budget for human resources needed to provide HIV services
- Coordinated planning for human resources in the health sector
- Ability to use HIV funding for strengthening HRH
- Competition for HRH between health priorities
- Flexibility to respond to changing human resources for health needs for HIV programme

3.1.7 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

3.2 Human resources for health training

3.2.1 How, if at all, is **training on HIV service delivery** integrated into the national training curricula, for:

a) Health managers/leaders
b) Doctors
c) Nurses
d) Laboratory staff/technicians
e) Other personnel (e.g. counsellors)
f) Community health workers/volunteers

Prompts:

- Collaboration or coordination between HIV programme and other programmes within the Ministry of Health
- Pre-service education vs. in-service trainings and workshops

3.2.2 What factors have influenced the current **level of integration** of training on HIV service delivery into national training curricula?

Prompts:

- General **policy** of integration for in-service training
- General **status** of integration for in-service training in the country
- Donor requirements/initiatives (e.g. donor funded workshops)

3.2.3 How, if at all, has the current **level of integration** of training on HIV into national training curricula affected **coverage of HIV services**?

Prompts:

- Greater availability of HIV services due to more health care workers with training in HIV services
- Improved utilization of HIV services through referral as a result of increased HIV awareness among health care workers

- Reduction of stigma and fear of HIV by health care workers

3.2.4 How, if at all, has the current level of integration of training on HIV into national training curricula affected the **quality of HIV services**?

Prompts:

- More holistic, patient-centred approach by use of multi-skilled health care workers
- Reduction of stigmatization/discrimination of people living with HIV by health care workers
- Increased/decreased staff motivation and workload
- Impact of shifting HIV service delivery tasks to lower cadres of health care workers

3.2.5 How, if at all, has the current level of integration of training on HIV into national training curricula affected the **sustainability of HIV services**?

Prompts:

- Reliance on financial and technical partners for trainings
- health care workers mobility across services and/or between organizations ('brain drain')

3.2.6 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of training on HIV into national training curricula?

Note: consider from perspective of the HIV programme and from the health system perspective.

Prompts: Positive/negative effects on

- Transferability of skills acquired through training on HIV service delivery to other services, e.g. counselling and communication skills, chronic care, injection safety
- Quality of training on HIV service delivery
- General knowledge of health workers on HIV
- Adherence of health workers to clinical guidelines and standardized treatment protocols for HIV
- Staff motivation and sharing of workload
- Degree of specialization possible

3.2.7 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

3.3 Health worker payment systems

3.3.1 Who pays the basic salaries for health care workers who provide the following services?

- HIV care and treatment
- HIV counselling and testing:
- Outreach services to key populations at higher risk of HIV (e.g. injecting drug users, commercial sex workers)

Prompts:

- Ministry of Health/National AIDS Control Programme/nongovernmental organizations/development partner
- If there are multiple financiers, please provide an estimate of the percentage of health workers paid by each of the above

3.3.2 How, if at all, are payment mechanisms for health workers who provide HIV services integrated into general health worker payment mechanisms?

Prompts:

- Salary top-ups
- (Non-)monetary incentives and allowances
- Performance-based payments
- Per diems for attending trainings/meetings

3.3.3 What factors have influenced the current level of integration of payment mechanisms[14]?

[14] This refers to the integration of payment mechnisms for health workers providing HIV services into general health worker payment mechanisms.

Prompts:

- Different funding sources and/or financial management mechanisms
- Donor requirements/initiatives
- Integrated delivery of health services
- Involvement of nongovernmental organizations and private providers in service provision

3.3.4 How, if at all, has the current level of integration of payment mechanisms affected **coverage of HIV services**?

Prompts:

- Increased/decreased availability of general health workers to provide HIV services

3.3.5 How, if at all, has the current level of integration of payment mechanisms affected the **quality of HIV services**?

Prompts:

- Performance assessments and linkage to payment
- Ability to attract better qualified health care workers

3.3.6 How, if at all, has the current level of integration of payment mechanisms affected the **sustainability of HIV services**?

Prompts:

- Reliance on donor financing
- Government commitment to financing HIV service provision
- Financial resource availability within government

3.3.7 In your opinion, what are the main **advantages** and disadvantages of the current level of integration of payment mechanisms?

Note: consider from perspective of the HIV programme and from the health system perspective.

Prompts: Positive/negative effects on

- Brain drain (brain drain from general health services to HIV services; from public sector to nongovernmental organization or private sector or vice versa; prevented through payroll integration and payment equality; triggered by payment **inequality** if not integrated)
- Incentives to encourage HIV service delivery
- Envy and resentment between health care workers from payment **inequality** between services

3.3.8 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

4. Medicines and technology

Please use **Diagram 4** showing the procurement and supply systems for HIV-related commodities in relation to the general health sector procurement and supply systems to discuss the extent of integration. If necessary, adjust the diagram.

4.1.1 How, if at all, are the procurement and supply systems for the HIV programme integrated into the procurement and supply systems for the health system in general?

Note: Consider not only the central level but also regional and local levels.

Prompts:

- Centralized tendering and procurement systems
- Shared warehousing
- Integrated distribution channels to decentralized warehouses and dispensaries
- Integrated or linked inventory management systems

4.1.2 What factors have influenced the current **level of integration** of the procurement and supply systems for the HIV programme into the procurement and supply systems for the health system in general?

Prompts:

- Strengths/weaknesses of existing procurement and supply systems
- Donor requirements/initiatives
- Type of ownership (e.g. public vs. nongovernmental organizations/private) of health facilities

4.1.3 How, if at all, has the current level of integration of the procurement and supply systems for the HIV programme affected **coverage of HIV services**?

Prompts:

- Availability and continuity of ARVs (1st and 2nd line), HIV test kits and drugs for treatment of opportunistic infections ('stock-outs')
- Choice for specific drugs (e.g. WHO pre-qualification)

4.1.4 How, if at all, has the current level of integration of the procurement and supply systems for the HIV programme affected the **quality of HIV services**?

Prompts:

- Quality assurance of medicines and commodities (e.g. cold chain integrity, tracing of counterfeit drugs)
- Degree of transparency and accountability in the pharmaceutical sector

4.1.5 How, if at all, has the current level of integration of the procurement and supply systems for the HIV programme affected the **sustainability of HIV services**?

Prompts:

- Reliance on externally managed systems for procurement and/or storage
- Reliance on drug donations or subsidies

4.1.6 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of the procurement and supply systems for the HIV programme?

Note: consider from perspective of the HIV programme AND from the health system perspective.

Prompts: Positive/negative effects on:

- Use of most efficient systems (if not integrated)
- System-wide staff capacity-building
- ICT systems for forecasting and inventory management
- Warehousing capacity
- Competition over resources
- Government ownership over systems

4.1.7 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

5. Information

Please use **Diagram 5** showing the systems for monitoring and evaluation of the HIV response in relation the general systems for monitoring and evaluation in the health sector to discuss the extent of integration. If necessary, adjust the diagram.

5.1.1 How, if at all, is monitoring and evaluation of the HIV programme integrated with the general health management information system and/or with other systems within the health sector?

Note: There can be multiple monitoring and evaluation systems within the HIV response (e.g. for antiretroviral treatment, prevention of mother-to-child transmission, HIV counselling and testing).

Prompts:

- Integrated data collection systems (e.g. software, record books)
- Shared monitoring and evaluation staff
- Joint evaluations, reviews, or supervisory activities
- Alignment of indicators
- Linkages with tuberculosis, reproductive health and child health programmes

5.1.2 What factors have influenced the current level of integration of the monitoring and evaluation systems?
Prompts:

- General policy of integration of monitoring and evaluation systems
- Donor requirements/initiatives
- (Reduction of) transaction costs
- Strengths and weaknesses in existing monitoring and evaluation systems

5.1.3 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of the monitoring and evaluation systems[15]?

Note: consider from perspective of the HIV programme AND from the health system perspective.

Prompts: Positive/negative effects on

- Overall information system capacity for data collection and analysis (trainings, number of monitoring and evaluation staff, workload)
- Performance of monitoring and evaluation system for HIV
- Information, communication and technology infrastructure (hardware, software)
- Data quality, completeness and timeliness
- Emergence of monitoring and evaluation 'culture'
- Transaction costs
- Sharing of information across programmes and/or sectors
- Ministry of Health/service provider ownership

5.1.4 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

6. Service delivery**

Please use **Diagram 6** showing the organization of HIV services in relation to general health services organization to discuss the extent of integration. If necessary, adjust the diagram.

6.1 Health services management**

6.1.1 How, if at all, is the administrative **management** of HIV services integrated into the management of general health services?

Prompts:

- Responsibility of hospital managers or district health managers for HIV services
- Role of the National AIDS Programme
- Oversight of services that are managed by nongovernmental organizations, private health service providers

6.1.2 What factors have influenced the current **level of integration** of the management responsibilities for HIV services into the management of general health services?

Prompts:

- Inclusion/exclusion of HIV-related services in essential health services package
- Strengths/weaknesses of general health service management structures
- Different financing sources or financial management mechanisms for HIV
- Donor requirements/initiatives

6.1.3 How, if at all, has the current level of integration of management responsibilities[16] affected the **coverage of HIV services**?

Prompts:

- Impact of strengths/weaknesses of existing management structures (if integrated) on coverage

[15] This refers to the integration of monitoring and evaluation systems for the HIV programme into other health information systems
[16] This refers to the integration of management responsibilities for HIV services into the management of general health services.

- Impact of strengths/weaknesses of parallel management structures (if not integrated) on coverage

6.1.4 How, if at all, has the current level of integration of management responsibilities affected the **quality of HIV services**?

Prompts:

- Degree of government oversight on HIV activities provided by nongovernmental organizations, civil society organizations and community-based organizations
- Impact of strengths/weaknesses of integrated management on quality
- Impact of strengths/weaknesses of parallel management on quality

6.1.5 How, if at all, has the current level of integration of management responsibilities affected the **sustainability of HIV services**?

Prompts:

- Ownership of, and commitment to, HIV service delivery by the Ministry of Health and local health managers (e.g. district or facility level)

6.1.6 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of management responsibilities?

Note: consider from perspective of the HIV programme and from the health system perspective.

Prompts: Positive/negative effects on

- Coordination between service providers on cross-cutting health services
- Ownership of, and commitment to, HIV service delivery
- HIV–related stigma within health services
- Health worker performance
- Health system management capacity (skill building, numbers of personnel)
- Transparency and accountability in health sector (possibly linked to donor involvement in the HIV response)
- Ease and efficiency of information exchange through more direct lines of communication
- Complexity and efficiency of management and oversight procedures
- Transaction cost through duplication of structures and processes
- Systems strengthening
- Power balance between Ministry of Health and HIV oversight structures (e.g. National AIDS Commission)

6.1.7 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

6.2 Health service delivery

6.2.1 How, if at all, are HIV services targeting key populations at higher risk of HIV (e.g. sex workers, men who have sex with men, injecting drug users) integrated into the delivery of other health services?

Prompts:

- Stand-alone facilities or separate clinic hours vs. integrated package of health services
- Outreach activities
- Referral, coordination or collaboration between services
- Role of faith-based organizations, nongovernmental organizations and community-based organizations

6.2.2 What factors have contributed to the current level of integration of delivery of HIV services targeting key populations into other health services?

Prompts:

- Stigma and need for confidentiality
- Legal factors (e.g. criminalization of homosexuality and drug use)

6.2.3 How has the current level of integration of delivery of HIV services targeting key populations into other health services affected **coverage of HIV services**?

Prompts:

- Limited access because key populations at higher risk of HIV (specify) do not access other health services
- Increased access because key populations at higher risk of HIV (specify) utilize other (specify which) health services

6.2.4 How has the current level of integration of delivery of HIV services targeting key populations into other health services affected **quality of HIV services**?

Prompts:

- If integrated: improved quality because quality standards are ensured in these other health services (specify)
- If integrated: reduced quality because health services do not have adequate human and other resources to provide quality services
- If not integrated: improved quality because special quality assurance measures are taken for example due to donor's standards
- If not integrated: reduced quality because lack of government control over quality
- Role of stigma in service providers

6.2.5 How has the current level of integration of delivery of HIV services targeting key populations into other health services affected **sustainability of HIV services**?

Prompts:

- Donor dependence as opposed to government budget support

6.2.6 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of delivery of HIV services targeting key populations into other health services?

Note: consider from perspective of the HIV programme AND from the health system perspective.

Prompts: Positive/negative effects on

- Stigma reduction
- Comprehensiveness of services
- Access
- Cost

6.2.7 What opportunities do you see to improve the balance between the aforementioned advantages and disadvantages?

7. Laboratory

7.1.1 How, if at all, are HIV laboratory services integrated into the general health laboratory services?

Prompts:

- Sharing of laboratory space and/or staff
- Sharing of equipment and/or reagents
- Common systems for quality assurance (e.g. reference laboratories)

7.1.2 What factors have influenced the current level of integration HIV laboratory services into the general health laboratory services?

Prompts:

- Strengths/weaknesses of existing laboratory services
- General policy of laboratory service integration
- Donor requirements/initiatives

7.1.3 How, if at all, has the current level of integration of HIV laboratory services affected the **coverage of HIV services**?

Prompts:

- Number and distribution of HIV testing sites
- Number and distribution of facilities capable of providing antiretroviral treatment monitoring

7.1.4 How, if at all, has the current level of integration of HIV laboratory services affected the **quality of HIV services**?

Prompts:

- Systems for quality assurance of laboratory services
- Procurement and maintenance of general laboratory equipment
- Supervision of laboratory staff

7.1.5 How, if at all, has the current level of integration of HIV laboratory services affected the **sustainability of HIV services**?

Prompts:

- Role of nongovernmental organizations and donors in laboratory operations (e.g. procurement of equipment and reagents, maintenance)
- Inclusion in long-term laboratory system development

7.1.6 In your opinion, what are the main **advantages and disadvantages** of the current level of integration of HIV laboratory services?

Note: consider from perspective of the HIV programme and from the health system perspective.

Prompts: Positive/negative effects on

- Capacity-building of general laboratory technicians (training)
- Procurement of equipment and reagents useful for other health services
- Laboratory infrastructure renovation or building
- Work load for general laboratory staff
- Efficiency (e.g. duplication of systems and services, if not integrated)
- Competition over resources (e.g. human resources, equipment, space)
- Sustainability (if not integrated)

8. Concluding remarks

8.1 How, if at all, has participating in this assessment affected your understanding of the interactions between HIV programmes and health systems?

8.2 Do you have any suggestions for improvement of this assessment and/or the assessment tool?

8.3 Do you have any suggestions for other potential informants or sources of information for this assessment?

Annex 1. List of suggested key informants

The following list is non-exhaustive but offers some guidance regarding potential key informants within each of the thematic modules of the assessment instrument. The exact names of departments, job titles and responsibilities may vary from country to country. Discussions with the members of the Steering Committee and Assessment Working Group should provide a more comprehensive overview of relevant key informants.

Module 1: Leadership and governance

National level

- Ministry of Health: Director of the Department for Clinical Services (i.e. the Department overarching the HIV programme)
- Ministry of Health: Director of the Department for Hospital Services (if separate)
- Ministry of Health: Director of the Department for Policy and Planning
- Ministry of Health: Head of the National AIDS Programme (NAP)
- Ministry of Health: Head of the National Tuberculosis Control Programme
- Ministry of Health: Head of the Reproductive Health Programme
- Chair of National AIDS Commission (NAC)
- Chair of the Country Coordinating Mechanism
- UNAIDS Country Representative
- Health and/or HIV coordinators of bilateral and multilateral development partners
- Representative of umbrella organization for nongovernmental organizations. If no such organization exists: representative of most significant nongovernmental organizations

Regional/district level

- Regional/District health manager
- Regional/District HIV coordinator
- Regional/District tuberculosis and/or reproductive health coordinator

Module 2: Health financing

- Ministry of Finance: Programme officer for the health sector
- Ministry of Health: Health financing specialist
- Representative of the primary recipient(s) of GFATM grants
- Programme officer for grant management unit within the Ministry of Health
- Bilateral and multilateral development partners' representative
- Health insurance representative
- Provider representatives (e.g. hospital manager, private sector provider)

Module 3: Health workforce

National level

- Ministry of Health: Director of the Department for Human Resources
- National AIDS Control Programme, programme officer for human resources
- Representative from health worker training institute
- Representative of professional association for health care workers

District/facility level

- Director of health facility
- Various health care workers (e.g. doctors, nurses)

Module 4: Medicines and technology

National level

- Ministry of Health: Director of the Department for Procurement and Supply
- Director of the regulatory body for drug administration
- Representative of medical procurement agency (e.g. Central Medical Store)
- Representative of procurement agency for antiretroviral drugs

District/facility level

- Representative of regional/district level medical store
- Director of health facility (and/or visit to health facility pharmacy)

Module 5: Information

- Ministry of Health: Director of Health Information unit
- National AIDS Commission: monitoring and evaluation coordinator
- National AIDS Control Programme: monitoring and evaluation coordinator
- Monitoring and evaluation coordinators of tuberculosis and/or reproductive health programme
- Monitoring and evaluation coordinator of the principal recipients of GFATM grants
- Health and/or HIV coordinators of bilateral and multilateral development partners

Module 6: Service delivery

National level

- Director of National HIV Programme
- Programme managers within tuberculosis and/or reproductive health involved in HIV-related activities (e.g. tuberculosis HIV coordinator, prevention of mother-to-child transmission coordinator)
- Representative(s) of nongovernmental organizations working in service delivery to key populations at higher risk of HIV
- Representative(s) of association for people living with HIV

District/facility level

- District health manager
- Health facility managers

Module 7: Laboratory

National level

- Director of National Laboratory Services
- Representative of regulatory/accreditation body for laboratory services (e.g. national reference laboratory)

District/facility level

- Head of health facility laboratory services (and/or visit to health facility laboratory)

Annex 2. Desk review: documents and outline

List of suggested documentation

The following list is non-exhaustive but offers some guidance regarding documents that are likely to be of relevance to the desk review. Discussions with the members of the Steering Committee and Assessment Working Group should provide a more comprehensive overview of relevant documentation. In all cases, the most recent versions of these documents should be obtained.

Policies and strategic plans

- National growth and development plan (e.g. Poverty reduction strategy Paper)
- National health policy
- National health sector strategic plan (HSSP)
- National HIV (and sexually transmitted infection) policy
- National HIV (and sexually transmitted infection) strategic plan
- Individual HIV plans and policies (e.g. antiretroviral treatment scale-up plan, tuberculosis HIV policy)
- National reproductive health strategy
- National tuberculosis strategy
- National human resources for health strategic plan
- National health information system strategic plan

Grant applications

- HIV, tuberculosis, health system strengthening or community systems strengthening (components of) grant applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria
- Health system strengthening and civil society organizations grant applications to the GAVI Alliance

Programme reviews and evaluations

- Millennium development goal country progress report
- UNGASS country progress report
- Annual health sector review
- Health sector strategic plan mid-term review
- Annual HIV programme report
- Public expenditure review
- Health sector and/or HIV programme evaluations by development partners
- Grant performance reports
- National health accounts

In addition, relevant information on epidemiological, demographic, socioeconomic and health sector indicators can be found in the online databases of the World Health Organization (http://www.who.int/gho/), World Bank (http://databank.worldbank.org/) and UNAIDS, among others. Although “grey” literature (e.g. newspaper articles, blog postings) can provide useful contextualization of information, such sources should be used with caution as they are characterized by an increased risk of bias.

Desk review outline

The desk review will provide the background information necessary for the data collection and analysis phases of the assessment. Specifically, it should provide an overview of:

- the demographic, political, socioeconomic and health profile of the country, essential for contextualizing the assessment findings;
- the key organizations and stakeholders in the country’s health system and in the HIV response. in addition to its relevance in clarifying the organizational structure of the health system, this information will inform the identification of key informants and the preparation of the organizational diagrams;
- the main policies and reforms in the national health system;

- the key strengths and weaknesses of the national health system, as well as past and ongoing health system strengthening efforts;
- the main elements of the national response to HIV and its stakeholders therein;
- the main points of interaction between the HIV programme and elements of the general health system.

The desk review should focus on the most relevant information in each of the thematic areas of the assessment but does not need to provide a comprehensive in-depth analysis. Ideally, the desk review should not exceed approximately 15 pages. Elements of the desk review will be incorporated into the findings from the primary data analysis to produce the final assessment report. It is, however, also a product that can be read independently from the assessment report and, as such, should have a clear structure. A suggested outline and length for the report is the following:

1. Introduction (0.5 page)

Summary of the objectives and outline of the desk review.

2. Country profile (1–2 pages)

Overview of the country's demographic, political, socioeconomic and health profile. Include key indicators and trends over time.

3. Health system (3 pages)

- Review of main health sector policies and reforms (e.g. decentralization) in past 10–15 years;
- Overview of basic structure of the health system and its key actors (e.g. governmental, nongovernmental and development partners);
- Overview of main financing sources, and financing agents ('purchasers') in the health sector, including trends over time;
- Review of main strengths and weaknesses in the health system, with particular attention to the thematic areas of the assessment.

4. HIV response (2 pages)

- HIV epidemiological profile (e.g. HIV prevalence, number of people living with HIV; key populations), including trends over time;
- Description of the national response to HIV (including financing sources) and its evolution;
- Overview of the key service providers in the HIV response;
- Overview of service coverage (e.g. antiretroviral treatment, voluntary counselling and testing, prevention of mother-to-child transmission, harm reduction programmes, treatment of sexually transmitted infections and opportunistic infections) and trends over time;
- Review of main strengths and weaknesses of the HIV response.

5. Interactions between the HIV programme and the health system (2—3 pages)

- Overview of the main points of interaction between the HIV programme and elements of the health system, with particular consideration for interactions with reproductive health, family health and tuberculosis programmes;
- Overview of impacts of HIV programme on strengthening of the health system;
- Review of past and on-going discussions in the country around the desirability and feasibility of integration of HIV and other health services, and relevant policy developments.

6. Conclusions (1–2 pages)

Synthesis of main findings of the desk review. Special attention should be given to the identification of areas of particular interest for the primary data collection phase of the assessment.

References

Annex 1: Bibliography

Overview of all the documents reviewed and how these were identified. If other relevant documents were identified but could not be obtained, these should be mentioned as well.

Annex 3. Sample organizational diagrams

Diagram 1: Organizational chart of the national health system and interactions with national HIV programme

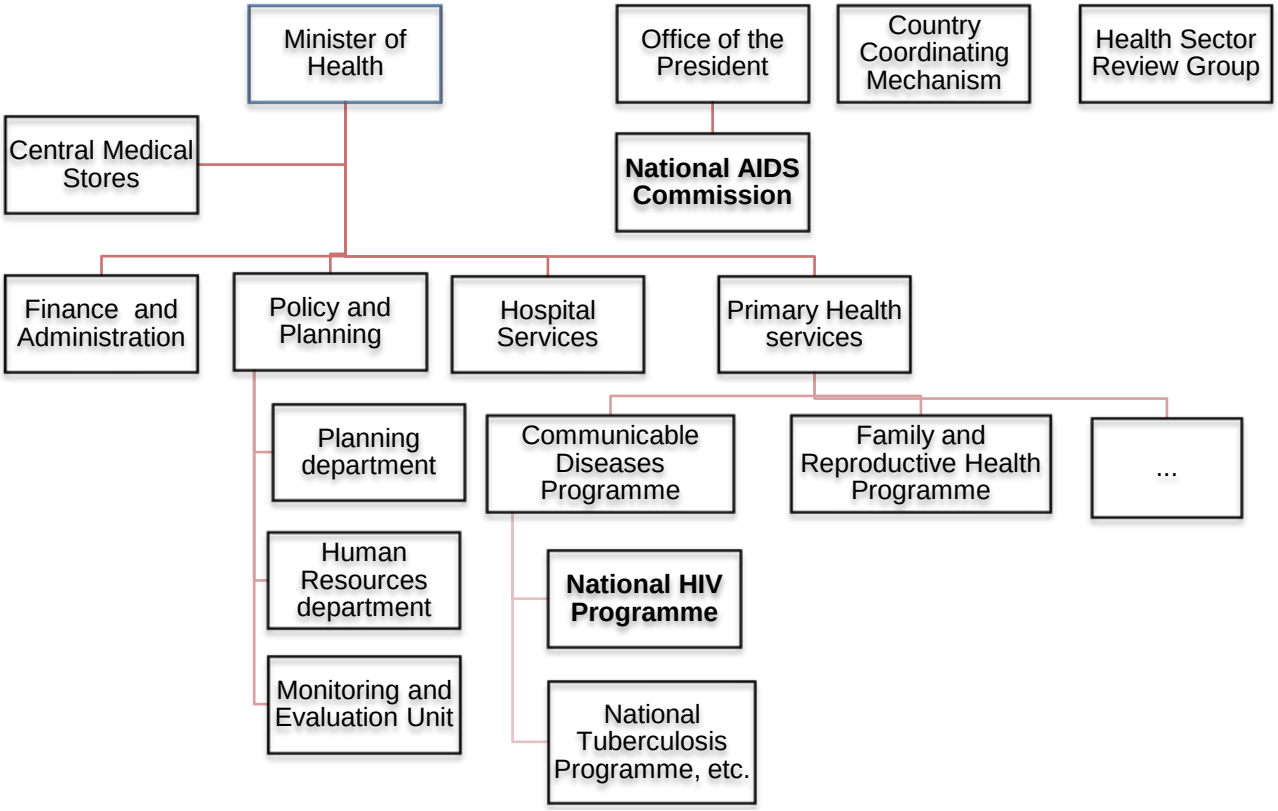


Diagram 2: Decision-making and reporting structures in the national health system and the HIV response

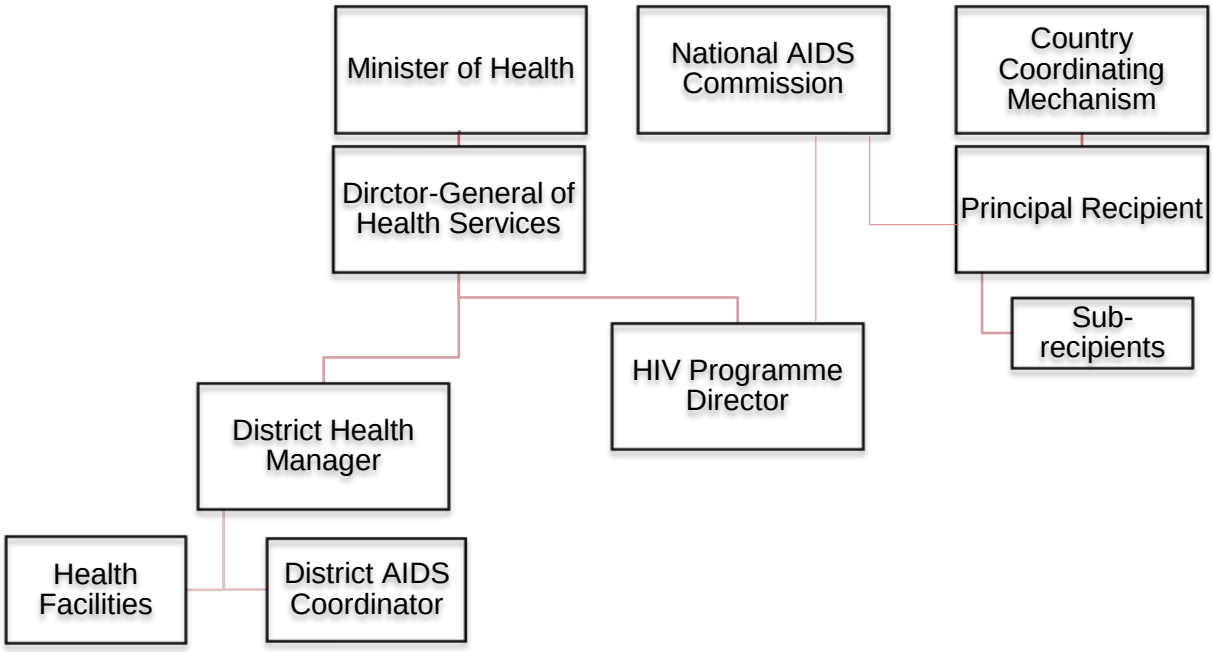


Diagram 3: Health sector and HIV financing

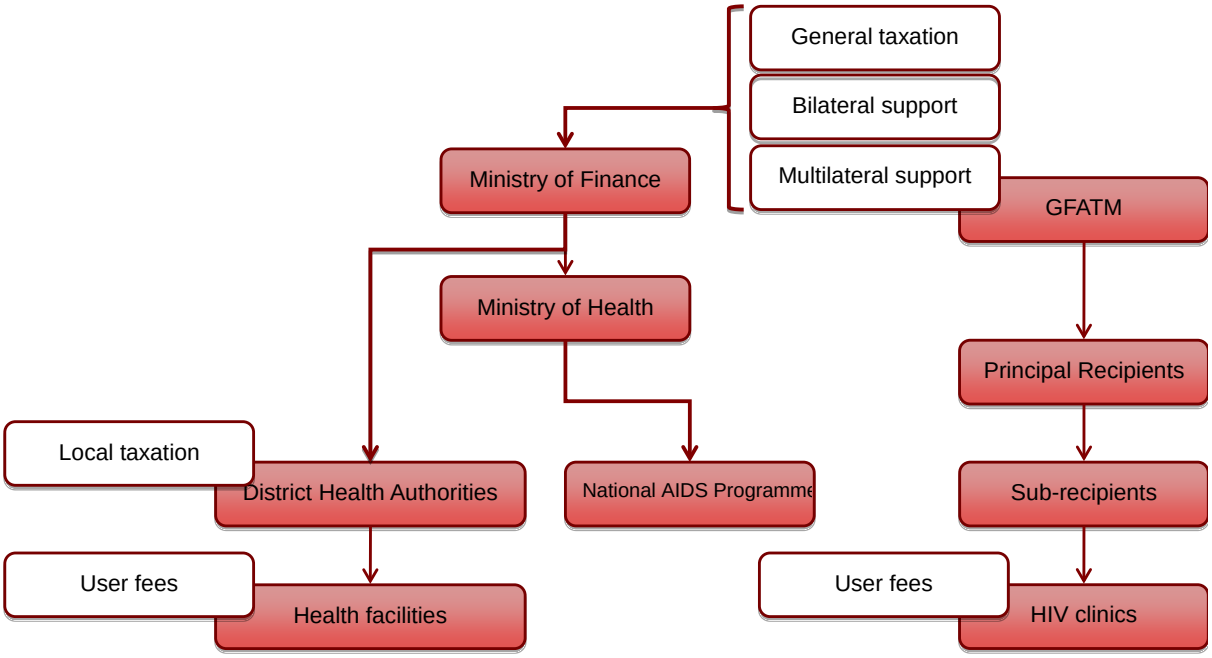


Diagram 4: Procurement and supply systems for HIV and non-HIV medicines and technologies

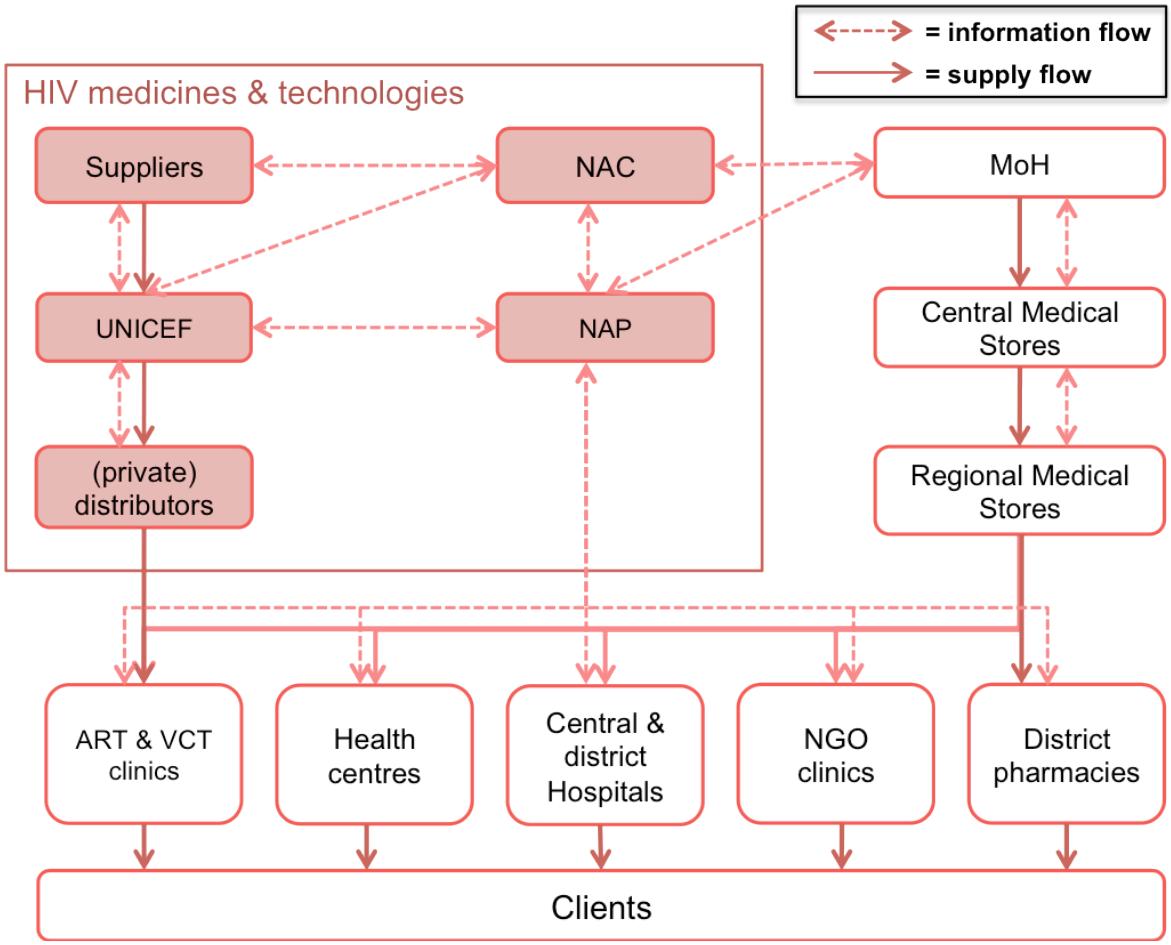


Diagram 5: Monitoring and evaluation systems for HIV response and health sector

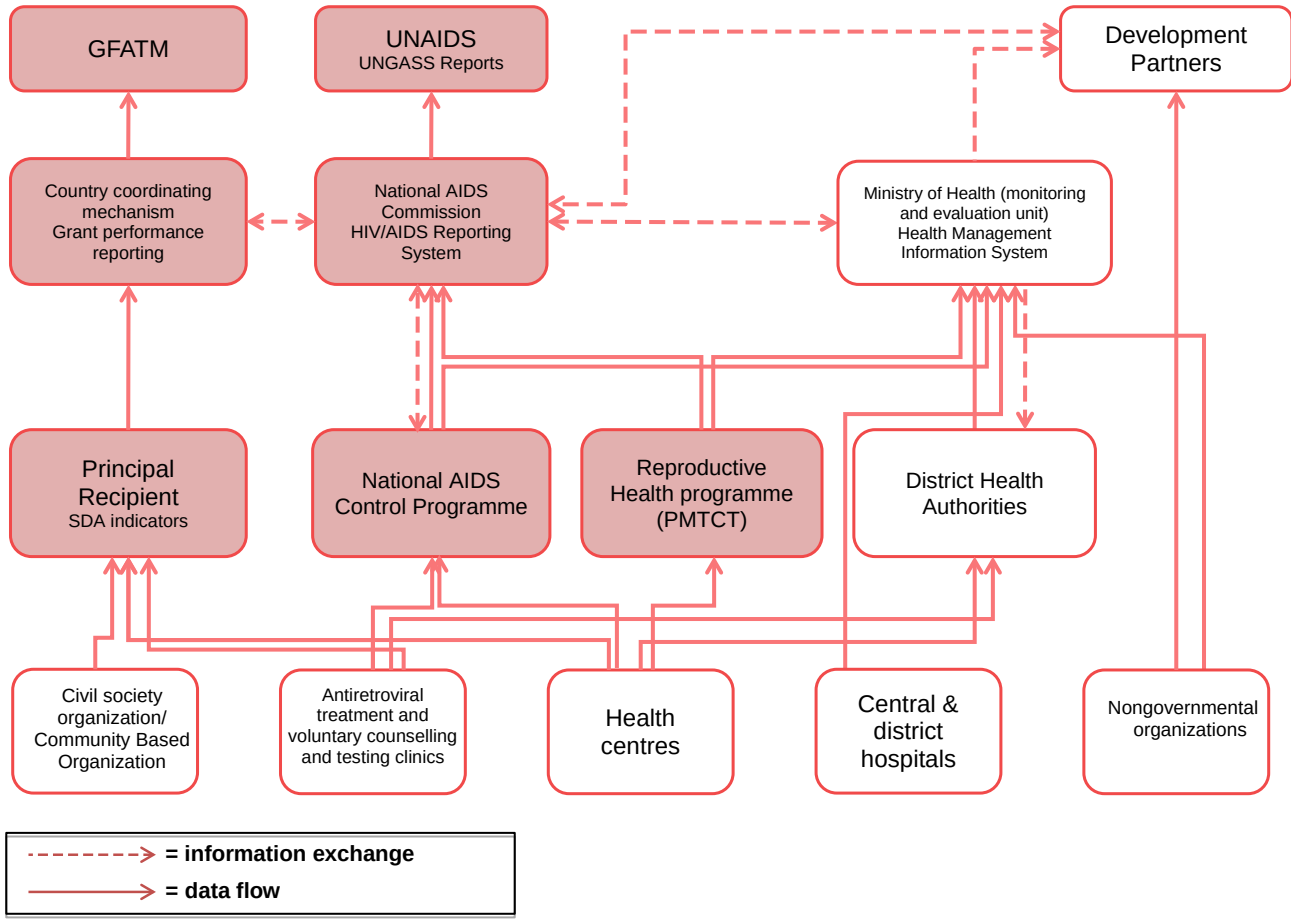
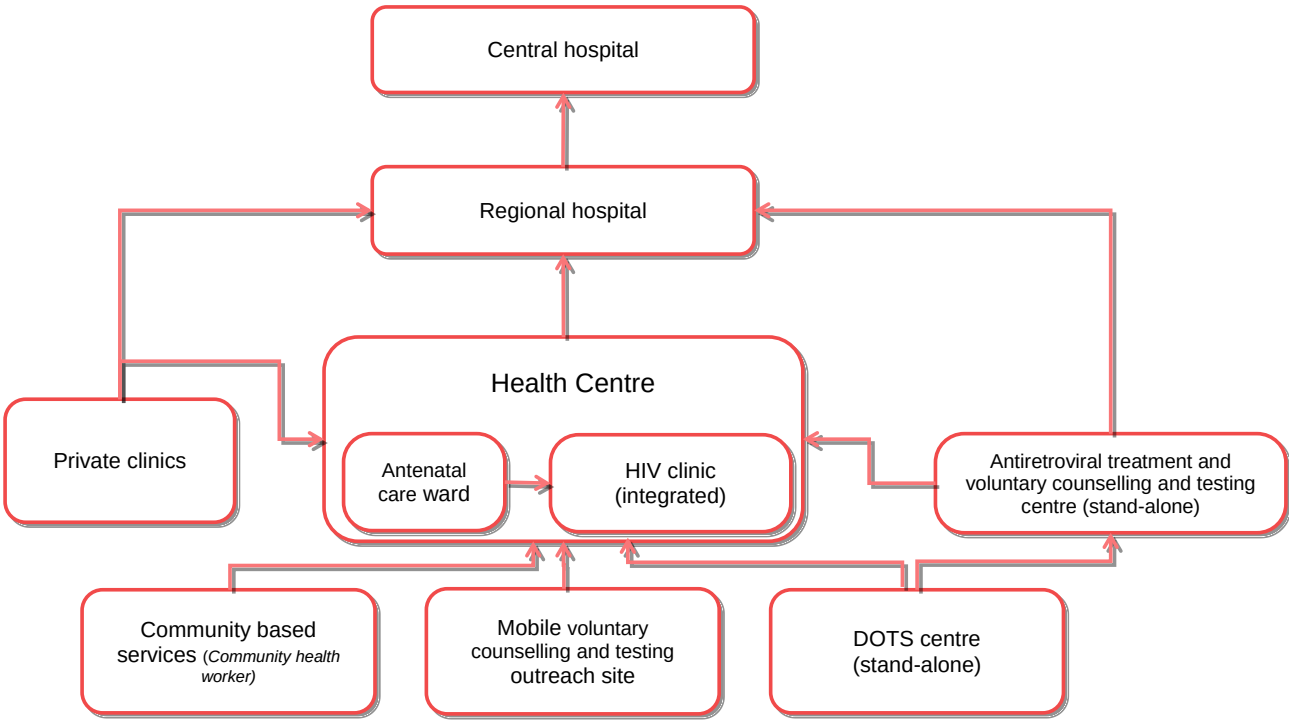


Diagram 6: Patient flow in HIV services in relation to the health care delivery system



Annex 4. Interview summary sheet

<table>
<tr><th colspan="6">Interview Summary Sheet</th></tr>
<tr><td>Country</td><td colspan="5"></td></tr>
<tr><td rowspan="2">Interview ID</td><td colspan="3">Interview Number</td><td colspan="2">Audio file name</td></tr>
<tr><td colspan="3"></td><td colspan="2"></td></tr>
<tr><td rowspan="2">Date of interview</td><td>Day</td><td colspan="2">Month</td><td colspan="2">Year</td></tr>
<tr><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td rowspan="2">Time of interview
(Use 24 hour clock e.g. 13:20)</td><td colspan="2">Start</td><td colspan="3">End</td></tr>
<tr><td>Hour:</td><td>Min:</td><td>Hour:</td><td colspan="2">Min:</td></tr>
<tr><td rowspan="2">Name of Interviewer(s)</td><td>First name</td><td colspan="2">Surname</td><td colspan="2">Title</td></tr>
<tr><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td rowspan="2">Name of Informant(s)</td><td>First name</td><td colspan="2">Surname</td><td colspan="2">Title</td></tr>
<tr><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Position/Title of Informant(s)</td><td colspan="5"></td></tr>
<tr><td>Institution/Department of Informant(s)</td><td colspan="5"></td></tr>
<tr><td rowspan="2">Contact information of Informants(s)</td><td colspan="3">E-mail</td><td colspan="2">Phone</td></tr>
<tr><td colspan="3"></td><td colspan="2"></td></tr>
<tr><td>Language of interview</td><td colspan="5"></td></tr>
<tr><td colspan="6">Interview observations (e.g. noise; interruptions; presence of anyone other than informant(s) and interviewer(s); interviewer’s impression of informant(s))</td></tr>
</table>

Annex 5. Assessment report outline

The assessment report will collate the findings from the desk review and the primary data analysis. Its purpose is to initiate discussions in the assessment country, as well as internationally, on the desirability and feasibility of integration of HIV responses into the health system, and to inform planning and policy-making processes. In order to achieve these objectives the report will require a clear structure, outlining the main findings, viewed in the country context, and summarizing key stakeholders' opinions and preferences. The suggested outline for the report is therefore as follows:

Executive summary

1. Introduction

2. Country profile

- 2.1. Demographic and socioeconomic situation
- 2.2. Political and legal environment

3. Health system

- 3.1. Health profile
- 3.2. Policies and strategies
- 3.3. Organizational structure
  - 3.3.1. Government and Ministry of Health
  - 3.3.2. Nongovernmental organizations and private sector
  - 3.3.3. Civil society
  - 3.3.4. Development partners
- 3.4. Health financing
- 3.5. Service delivery
- 3.6. Health system strengths and weaknesses

4. HIV response

- 4.1. Epidemiology
- 4.2. Policies and strategies
- 4.3. Organizational structure
- 4.4. Health financing
- 4.5. Service delivery
- 4.6. HIV response strengths and weaknesses

5. HIV programme and health system interactions

Describe here not only the status of integration of HIV programme functions in the respective health system functions, but also (a) what factors determine this current status and (b) its advantages and disadvantages.

5.1 Administrative integration

- 5.1.1. Policies and planning
- 5.1.2. Management and oversight
- 5.1.3. Information

5.2. Financial integration

- 5.2.1. Funding and resource allocation
- 5.2.2. Financial management mechanisms
- 5.2.3. Contracting arrangements

5.3. Operational integration

- 5.3.1. Service delivery
- 5.3.2. Health workforce
- 5.3.3. Laboratory services
- 5.3.4. Medicines and technology

Annex 6. Sample consent form

[INSTITUTIONAL LETTER HEAD]

Informed Consent Form for stakeholders in the national health system and/or HIV response who have been invited to participate in the project *Rapid Assessment of Interactions between HIV programmes and Health Systems*

Principle Investigator: XXXXX

This Informed Consent Form has two parts:

- **Part I: Information Sheet (to share information about the study with you)**
- **Part II: Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form

Part I: Information sheet

Introduction

I am/we are xxx (and xxx), working for YYY. I am/we are doing assessment on the interactions between HIV programmes and health systems. I am/we are going to give you information and am/are inviting you to be part of this assessment. This consent form may contain words that you do not understand. If this is the case, please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them.

Purpose of the assessment

HIV programmes can influence health systems in many ways, some of which are positive and others negative. Effective, functioning health systems, in turn, are important to support an effective response to HIV. This assessment seeks to find out how the existing health system and HIV programmes interact with each other. This information may help to improve policies, programmes and services.

Participation in the assessment and participant selection

The assessment involves guided interviews with different people who have a role in the health system or the response to HIV in this country. You are being invited to take part in this assessment because we feel that your experience with working in the health system or the response to HIV can contribute much to our understanding and knowledge of the interactions between health systems and HIV programmes.

Voluntary participation

Your participation is voluntary, and if you choose not to participate in any way this will not have any negative consequences for you personally, or for the organization that you work for. You may change your mind about participating at any time and stop, even if you agreed earlier. You also do not have to answer all questions, if you so wish, and may stop the interview at any time.

Procedures

If you accept the invitation to participate, I/we will ask you a number of questions that have been selected based on your professional experience and expertise. If you do not wish to answer any of the questions during the interview, you may say so and I/we will move on to the next question. No one else will be present unless you would like someone else to be there. The information recorded is confidential, and no one else, except [name of person(s)], will have access to the information documented during your interview. If you agree, the entire interview will be recorded. The recorded information will be stored on a password-protected device. This recording will remain confidential, and no one else, except [name of person(s)], will have access to it. All recordings will be destroyed after _____number of days/weeks.

Duration

The assessment will take place over a period of approximately 3 months in total. We will be doing the interviews over a period of around 2 weeks. The interview itself will take between 45 and 60 minutes.

Risks

In general, this assessment does not seek personal information from you. However, there is a risk that you may share some personal or confidential information by chance. If that happens, you can say so and we will make sure that the information is not used in the assessment. It is also possible that you would feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the discussion/interview if you feel the question(s) make you uncomfortable.

Part II: Certificate of Consent

I have been invited to participate in an assessment of the interactions between HIV programmes and health systems

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent to be a participant in this study

Print name of participant _____

Signature of participant _____ Date _____/_____/_____

Day/month/year

Statement by the investigator/person taking consent:

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that he/she will be asked questions that will help to better understand interactions between HIV programmes and the health system in this country.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this form has been provided to the participant.

Print name of investigator/person taking consent _____

Signature of investigator/person taking consent _____

Date ____/_____/_____

Day/month/year

Annex 7. Terms of reference

- Steering Committee
- Assessment Working Group
- National consultant
- lead consultant

Terms of reference: Steering Committee

As part of the project [insert title of project] we aim to gain better insight into the interactions between HIV programmes and health systems and into stakeholders' views on determinants of integration and its effects on programme and health system performance. The implementation of this project will be guided by a Steering Committee to ensure high-level support by the national authorities concerned for the assessment. The Steering Committee will, furthermore, be instrumental in carrying forward assessment findings into future policy-making and planning processes.

Composition

The guiding role of the Steering Committee requires that its members are stakeholders who have a significant influence on policy-making and planning processes regarding health and HIV services. It is therefore recommended that the Steering Committee comprises the following (or similar):

- Minister's assistant
- WHO Country Representative
- Chair of country coordinating mechanism
- Under-secretary for Preventive Affairs
- Director of Planning
- National AIDS Control Programme manager
- Representative from umbrella organization for nongovernmental organizations involved in HIV health sector interventions (or, if no umbrella organization exists, of the largest nongovernmental organization involved in HIV service delivery).

Roles and responsibilities

The Steering Committee will play a guiding role throughout the entire assessment process, spanning a period of approximately 3 months. In particular, the Steering Committee will:

- review the assessment objectives and methodology and, if necessary, provision of input to the Assessment Working Group (AWG) for their adaptation to the country context;
- advise the assessment working group on selection of key informants;
- review the assessment report prepared by the lead consultant at the preliminary stage (for identification of potential data gaps and to provide contextual input relevant for further analysis) and at the final stage;
- provide input on an action plan developed during a synthesis and validation workshop for taking forward assessment findings

It is anticipated that the Steering Committee will meet with the Assessment Working Group on three separate occasions.

- **Pre-assessment meeting**: This meeting will precede the primary data collection by the consultants contracted by WHO Regional Office for the Eastern Mediterranean. During this meeting WHO Regional Office for the Eastern Mediterranean, the consultants and the assessment working group and the Steering Committee will jointly discuss the assessment objectives, particularly in their relation to the country context. The meeting is designed to ensure a broad base of support for the assessment processes itself and to create commitment to take forward its key findings.
- **Debriefing meeting**: At the end of the data collection, the members of the assessment working group will report the assessment progress and key preliminary findings to the Steering Committee.

This meeting is designed to identify potential data gaps and provide contextual input useful to the data analysis and to consult on the contents of the synthesis and validation workshop.

- **Post-assessment meeting**: The assessment working group will present the assessment findings and the outcomes of the synthesis and validation workshop to the Steering Committee in a final meeting.

Terms of reference: Assessment Working Group

As part of the project [insert title of project] we aim to gain better insight into the interactions between HIV programmes and health systems and into stakeholders' views on determinants of integration and its effects on programme and health system performance. The implementation of this project will be facilitated by an Assessment Working Group (AWG).

Composition

The assessment working group will comprise:

- an international lead consultant
- National AIDS Control Programme manager
- a national consultant
- 1 staff member working for the National AIDS Programme; this expert will have good knowledge of the activities of the National AIDS Control Programme and will be in a position to facilitate interview appointments with key informants working within the national HIV response
- 1 staff member working for the Ministry of Health who has broad knowledge of the national health system; preferably this staff member works in an area of the Ministry of Health where activities cut across all programmatic areas, e.g. policy and planning, human resources, health systems strengthening.

Roles and responsibilities

The assessment working group will coordinate the day-to-day activities essential to implementation of the assessment. As such, it will be responsible for the following tasks:

- organizing a pre-assessment meeting to orient the Steering Committee on the assessment objectives and methodology.
- if necessary, adapting the assessment tool to the local context, taking into account the input from the Steering Committee.
- preparing an initial list of key informants (KIs).
- developing initial versions of organizational charts, as described in the assessment methodology.
- organizing a debriefing meeting after completion of primary data collection and analysis to inform the Steering Committee of assessment progress and preliminary findings and consult with the Steering Committee on the programme for a synthesis and validation workshop with a broader audience of key stakeholders.
- organizing a synthesis and validation workshop with key stakeholders during which assessment findings and their implications are discussed.
- organizing a post-assessment meeting with the Steering Committee to discuss assessment findings, outcomes of the workshop and next steps in country.

In addition, the other members of the assessment working group will assist the consultants with:

- obtaining relevant secondary data for a desk review;
- facilitating interview appointments with the key informants and arranging interview logistics (e.g. transport);
- validation and contextualization of findings, based on personal experience and knowledge;
- providing feedback on draft and final versions of reports.

Duration

The assessment working group will facilitate the implementation of the assessment throughout the entire process. On average, the national members of the assessment working group will be expected to invest approximately 3 hours per week, whereby the weight of the work will be mostly on the preparation and final phases of the assessment.

Terms of reference: National consultant

As part of the project [insert title of project] we aim to gain better insight into the interactions between HIV programmes and health systems and into stakeholders' views on determinants of integration and its effects on programme and health system performance. For the implementation of this project [insert name of lead organization(s)] will select and appoint a national consultant who will assist in the various stages of the assessment.

Skills and expertise

The national consultant will require the following skills and expertise:

- close familiarity with the health system of the assessment country and its key stakeholders
- good knowledge of HIV programming
- fluent spoken English and French (if first international language of the country is French)
- good writing skills in English (and French, if first international language of the country is French)
- fluent local language

Roles and responsibilities

The consultant will be a member of the Assessment Working Group (AWG) and will work in close collaboration with the lead consultant. The consultant will be independently responsible for the following tasks:

- translation of the assessment tool to the language of the assessment country;
- conducting a desk review of documentation relevant to the assessment (e.g. national policies and strategic plans, grant applications, evaluation reports);
- coordinating the activities of the assessment working group;
- conducting interviews with key informants, jointly with the lead consultant;
- assisting the lead consultant in the analysis of primary data;
- assisting the lead consultant in the preparation of draft and final assessment reports;
- preparing meeting reports of steering committee meetings;
- preparing a draft report of the synthesis and validation workshop for review and finalization by the international lead consultant.

Furthermore, as a member of the assessment working group, the consultant will be involved in:

- review and, if necessary, revision of the assessment tool and methodology
- preparation and facilitation of Steering Committee meetings and the synthesis and validation workshop

Deliverables

- Translation of the assessment tool into the language of the assessment country
- A desk review report summarizing key findings relevant to the assessment objectives. The report will outline the general structure of the health system and identify the key actors therein. It will include a description of the main health sector policies and reforms. The report will, furthermore, provide an overview of the national response to HIV. In particular, it will focus on the interactions between the health system and the HIV programme. A detailed description of the objectives and desired outline for the desk review report will be provided in the assessment methodology.

- Draft meeting report of the synthesis and validation workshop, summarizing stakeholders' opinion regarding the assessment findings presented and suggested action points.

Duration

The consultant will be involved in all steps of the assessment, which will span a period of around 3 months. It is anticipated that the consultant will spend approximately 34–36 working days on the assignment and that these will be distributed as follows:

- translation of the methodology: 2 days (If applicable)
- desk review: 8 days
- data collection (interviews): 15 days
- support to international lead consultant during data analysis and reporting: 5 days
- assessment working group coordination activities: 3 days
- synthesis and planning workshop planning and write-up: 3 days

Terms of reference: Lead consultant

As part of the project [insert title of project] we aim to gain better insight into the interactions between HIV programmes and health systems and into stakeholders' views on determinants of integration and its effects on programme and health system performance. For the implementation of this project [insert name of lead organization(s)] will select and appoint a lead consultant to lead and participate in the various stages of the assessment. Depending on the availability of adequately experienced experts in country the lead consultant will be recruited nationally or internationally.

Skills and expertise

The lead consultant will require the following skills and expertise:

- good knowledge of health system organization and donor architecture
- good knowledge of HIV programming and its potential health system impacts
- good project and team management skills
- fluent spoken English, French (in countries with French as official language); preferably fluent in local language
- good writing skills (English)
- record in leading similar assessments of HIV programmes and/or health systems

Roles and responsibilities

The lead consultant will be responsible for the following tasks:

- conducting interviews with key informants
- data analysis
- preparation of draft and final assessment reports
- coordination of the activities of the Assessment Working Group (AWG).

The lead consultant will be assisted in these tasks by a national consultant selected by WHO with the Ministry of Health. Furthermore, as a member of the assessment working group, the lead consultant will provide technical oversight to and participate in:

- review and, if necessary, adaptation of the assessment methodology
- debriefing meeting with the Steering Committee
- synthesis and validation workshop

Deliverables

- Audio recordings and/or interview notes from key informant interviews
- Draft and final report of the assessment findings. The report will follow the outline presented in the assessment methodology. The final report will incorporate the outcomes of the synthesis and

validation workshop and the feedback of WHO Regional Office for the Eastern Mediterranean on the draft report.

Duration

The lead consultant will be involved in all steps of the assessment, which will span a period of around 2–3 months. It is anticipated that the consultant will spend approximately 60 working days on the assignment and that these will be distributed as follows:

- preparation stage: 3 days
- data collection (interviews): 15 days
- data analysis: 10 days
- reporting: 10 days
- other: 4 days

This publication provides guidance and a tool for assessing interactions of HIV programmes with national health systems. The purpose of such assessment is to explore to what degree and how HIV programme functions are integrated into national health systems and to study the positive and negative aspects of these interactions in view of HIV programme and health system performance. Assessment aims to promote thinking and discussion on these issues among key stakeholders, namely government, private sector and civil society leaders involved in public health, and representatives of beneficiaries. The results should inform national planning and the preparation of grant proposals for HIV programme and health systems strengthening.

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