

Integrating HIV/AIDS Components into Existing Gender-Based Health Programmes

There are several reasons to integrate HIV/AIDS components into existing gender-based health programmes. First, the narrow focus of purely HIV/AIDS programmes has failed to mobilise communities for effective control and prevention of the disease. In many countries HIV/AIDS is not perceived as a top priority as compared to more common health problems such as malaria.

Another reason for integrating HIV/AIDS components into ongoing gender-based health programmes is the need to ensure sustainability of prevention efforts. Due to the economic challenges that developing nations face, as well as the limits of funding from donor agencies and organisations, the integration of HIV/AIDS activities into existing programmes may be the most viable opportunity for controlling the pandemic.

Integrated health programmes that deliver a wide range of services can be more effective and attract support from many segments of society. In many communities, tackling AIDS through a direct approach can be a difficult task because of opposition or scepticism. In such contexts, integrated health programmes offer the best alternative for the implementation of HIV/AIDS activities. For example, HIV/AIDS activities can easily be integrated into maternal and child health programmes, which are often multi-faceted (i.e., they often include responsible sexual behaviour, safe maternal care, safe delivery, family planning, and child care components).

Steps To Effective Integration

Integration can be conducted effectively by following a number of logical steps. Establishing an HIV/AIDS component is similar to the development of an independent HIV/AIDS prevention programme. The steps discussed here presuppose that existing gender-based health programmes are ongoing, functional, receive regular funding and can accommodate an HIV/AIDS component with no significant increase in costs. Where applicable, the steps address issues specific

The term "gender" is used to describe the various characteristics assigned to women and men by a given society. The term "sex" refers to biological characteristics. Gender is socially constructed, learned, and can vary from culture to culture, generation to generation, and over time due to societal changes. Gender roles reflect the behaviours and relationships that societies believe are appropriate for an individual based on his or her sex.

Summary:

This module has been compiled to provide HIV/AIDS/STI programme developers and health care practitioners with concrete steps on how to integrate HIV/AIDS components into existing gender-based health programmes. The steps outlined explain how such an integration can occur and provide examples of successful programme integration. This module is a component of the *UNAIDS Resource Packet on Gender & AIDS*, which includes additional modules, fact sheets, and an almanac.



Goal:

To provide a guideline for integrating HIV/AIDS components into existing gender-based health programmes.



Intended Audience:

Programme Developers
Health Educators
Community- and Clinic-Based Health Practitioners

Integrating HIV/AIDS Components into Existing Gender-Based Health Programmes

to community-based health programmes and/or clinic-based programmes. Community- and clinic-based programmes are not mutually exclusive and aspects of each can coexist within one programme.

Step 1: Establish staff for the HIV/AIDS component.

Because the early phases of the integration will be time consuming, staff time should be devoted to designing and implementing the new HIV/AIDS component. In addition, staff members should be responsible for establishing goals, objectives, and a timeline for implementation. Such development activities should be informed by a needs assessment process described below. Staff members assigned to the new component should also have enough decision-making authority within the entire programme. For example, staff members who are responsible for including HIV/AIDS education and counselling should have access to clients, the same referral mechanisms as other staff, and the ability to make decisions regarding clients' care. Minimum requirements for staff members should include having an HIV/AIDS background and a good knowledge of gender issues.

Step 2: Conduct needs assessments.

In order to design and implement a successful HIV/AIDS component, you must first be informed about the community you wish to serve. The results of your research will help determine the type and level of services needed, as well as when and where the services should be offered. Studying the needs of various groups can help programmes begin to develop a proactive policy to attract underserved groups.

Needs assessments can allow programmes to explore:

- myths, beliefs and taboos about sex and HIV/AIDS;
- relationships between men and women;
- knowledge, attitudes, and practices in HIV/AIDS prevention;
- populations in need of services;

- level of community interest in the programme; and
- types of services needed.

Questionnaires and focus groups are ways to assess specific information on HIV/AIDS knowledge, health seeking behaviour, partner information and notification, use of condoms, knowledge on availability of services, etc. This information can be coupled with epidemiological surveys of HIV/AIDS prevalence. Obtain input from leaders and members of the community (e.g., headmasters, women and youth groups, commercial sex workers, truck drivers, etc.) to validate the information collected from the needs assessment.

Needs assessments also should include demographic information on the target population such as sex, age, area of residence, and service utilisation. By including demographic information, needs assessments can investigate such questions as: why the majority of clients are women; from where men receive sexually transmitted infection (STI) counselling and treatment; and in which sections of towns and cities clients reside.

In Quezon City, Philippines, a group of physicians, lawyers, and business people were deeply dissatisfied with existing health services for women.¹ They decided to set up the Women's Health Care Foundation (WHCF), which delivers integrated health services, including services for HIV/STIs, for women of all ages and conditions. The Foundation conducted an assessment of its existing health care services in order to develop appropriate strategies that effectively addressed the needs of the clients. The Foundation found that providers favoured married women of reproductive health age and had negative attitudes toward young and single women who sought family planning advice and other reproductive health services.

Integrating HIV/AIDS Components into Existing Gender-Based Health Programmes

Studies have shown that clinic operation hours can have a serious impact on who utilises the services. In some situations, women may first have to secure food and prepare meals for the whole family or collect money from small businesses in the market place before they are able to visit clinics. Keeping the clinic open an extra hour, for example, can increase the number of clients who seek services.

After conducting a thorough needs assessment, the WHCF developed several strategies to increase accessibility to services.¹ In addition to low cost services and staff training, one of the main strategies has been to keep clinics open after the normal hours, long after government clinics had closed. This has increased the number of clients by 50%. Another approach was to set up clinics in strategic locations to attract potential clients who can walk in at any time.

- Cubao Clinic, a modest centre with a small reception area, an even smaller laboratory and a screen-off examination room, attracts a considerable number of patients because it is within walking distance of the commercial district.
- Alanbang Clinic, located in a poor suburban area, attracts clients from the neighbouring communities and serves as a base for clients who cannot afford transportation fees or are too busy to visit a clinic in the city.
- Quezon Avenue Clinic, situated in a business and commercial establishment area, serves employees from nearby offices.

In addition to women, adolescents comprise another category of clients who are not adequately served by traditional service delivery approaches. Embarrassment and fear about staff judgements may prevent adolescents from discussing sexual health issues. In addition, adolescents may be less likely to

return to clinics to collect results of their STI or HIV tests. In such cases, innovative means to encourage follow-up visits and/or, where feasible, rapid testing procedures should be implemented.

“Adolescents are reluctant to go to clinics because of cultural barriers and even if they go, they are not well received, because providers don’t want to give them what they need,” says Christine Nare, president of CEFÉVA in Senegal.² “From a social and cultural perspective, if a woman is not married, people believe that they should not have sexual intercourse. If an unmarried young woman goes to a clinic to look for methods, it suggests that she is having sex. This is something girls generally do not want people to know, and they do not want people to see them going to a clinic.”

Because of the perception that certain programmes target only women and children, men too may experience discomfort in accessing services. Clinic spaces which require men and women to convene in joint waiting rooms may be problematic, as men and women do not sit together in many societies. Men, like women, want affordable and high-quality services, privacy, confidentiality and clinic hours compatible with work schedules. Service providers in Australia have achieved some success in attracting more men to reproductive health services (including screening for prostate cancer) by opening clinics at night.³

Step 3: Obtain community input and involvement.

It is important to include the community in programme design and implementation. Due to the sensitive nature of sexual health programmes, community involvement and support may be essential for programme effectiveness. Networking with community leaders and influential groups about newly-planned activities may help improve community reception of the activities. For example, clinics that seek to organise outreach activities,

Integrating HIV/AIDS Components into Existing Gender-Based Health Programmes

such as home care and health education, should work with community leaders and influential partners, as social mobilisation becomes an essential activity in such a context.

An additional way to involve the community is to recruit community volunteers to participate as peer educators. The volunteers can increase the number of programme staff. In addition, the volunteers will have a more intimate understanding of the community and its members and may therefore be able to adapt educational materials to better fit their needs.

As a guiding principle, the WHCF programme decided that it should reach out to community members not only to inform them about basic reproductive health care but also to train them as community volunteers.¹ The programme recruited respected community leaders to become distributors of contraceptives, such as pills and condoms. Trained community volunteers learned to organise small discussion groups that became a regular and integral part of the outreach programme.

Step 4: Train programme staff.

The main objectives of staff training are to:

- provide a clear understanding of the HIV/AIDS epidemic and its impact on affected communities and families;
- teach staff how to protect themselves and their clients from HIV infection;
- develop skills to discuss topics related to sex and sexuality;
- raise gender awareness by highlighting the roles that men and women play in the spread of the virus;
- develop effective skills for HIV/AIDS counselling, home care, referral, behavioural change communication and community mobilisation;

- provide clarification of the differences between STI risk assessment and clinical approach to diagnosis and treatment of STIs; and
- provide formal guidelines, protocols or service manuals to assist staff in implementing the integrated activities.

In the process of providing comprehensive health services to women, the WHCF in the Quezon City project trained its staff to perform multiple tasks.¹ Nurses and midwives had to learn to take medical histories, which were normally done by doctors; provide perinatal and family planning information and methods (including Intra Uterine Devices); and perform simple laboratory tests. In recognition of the increased workload, the project tried to staff clinics with an established minimum number of nurses, midwives, laboratory technicians, and consulting physicians.

Gauging programme staff and service providers' knowledge and attitudes of HIV/AIDS is the first step in developing training sessions. Because of the social stigma associated with HIV/AIDS, it is important to identify attitudes which may hinder the delivery of HIV/AIDS services. The training required for programme staff will depend on their current level of knowledge and attitudes. The training may require extra sensitivity as some attitudes may be linked to religious beliefs. Training on the psychological preparation required for addressing issues of HIV/AIDS illness and death may also be necessary.

In Tanzania, a needs assessment survey explored the HIV-related beliefs, attitudes and prejudices of health workers (e.g., their fear of infection, discomfort with sensitive topics such as sex and death).⁴ The survey found that staff's HIV-related knowledge, attitudes and practices are linked to their educational backgrounds and amount of HIV/AIDS training and retraining opportunities. The programme then developed

Integrating HIV/AIDS Components into Existing Gender-Based Health Programmes

an independent training course that focused on the following areas:

- Basic facts about HIV;
- Common thoughts and worries about HIV;
- Translating acquired knowledge into action;
- Exploring AIDS in the community;
- HIV infection and AIDS counselling; and
- Infection control in health units.

In societies where men provide services to men and women to women, the number of staff of both sexes must also be given special attention. Gender sensitivity may comprise a major portion of the training. The way that programme staff and service providers interact with adolescents, commercial sex workers, and other groups who have traditionally been neglected by reproductive health services also calls for special attention. Programme management will need to get a clear understanding of relevant factors before designing an adequate training curriculum for awareness raising and the improvement of service delivery.

Training is more effective if it is based on policies which are clearly stated and incorporated into implementation protocols.

Policy and procedure development can be used as an effective way to train staff on core concepts. The Jamaica Family Planning Association has successfully applied this approach to improve its reproductive health services when trying to integrate HIV/STI services into the traditional family planning services.⁵ They defined a set of policies and procedures on a syndromic approach, which consists of recognising STI symptoms and selecting appropriate treatment and referring clients as necessary. They then trained the staff to apply these policies. This development of procedures

and training enabled the Jamaica Family Planning Association to successfully integrate HIV/STI services and reach out to men who were not interested in the previously existing health services.

Step 5: Integrate HIV/AIDS-specific activities with routine programme activities.

HIV/AIDS-specific activities (such as condom distribution, counselling, referral, health education, home care, initiation of behaviour change communication) should be designed in such a way that they fit logically into the existing programme routine. For example, condom use might be paired up with family planning and HIV/STI might be discussed with child survival. Programme staff should be able to actively provide and promote a broad range of services. A woman who enters the programme because of a sick child or for other health services could be offered and encouraged to use a range of STI/HIV services such as:

- risk assessment;
- counselling;
- voluntary testing;
- screening;
- treatment;
- awareness/education for behavioural communication and partner notification; and
- referral.

In Mwanza, Tanzania, it was found that Commercial Sex Workers (CSWs) were not using the existing health services.⁴ In an effort to control STIs and limit the spread of HIV, the health authorities decided that new approaches were needed to attract the CSWs. Clinic activities were expanded to offer a broad range of other services to the

Integrating HIV/AIDS Components into Existing Gender-Based Health Programmes

CSWs in addition to health education and condom distribution. The CSWs were also encouraged to bring in their children for child health services. As CSWs were integrated into the normal health system, private and government clinics began to target CSW clients as well as others for STI treatment.

The integration of HIV/AIDS components into existing programmes should not overburden programme staff. Staff support is critical to the success of integration. Activities which programme staff perceive as irrelevant will be rejected by those very individuals who are supposed to provide services. Integration may also require the hiring of additional staff to increase organisational ability to handle additional services. To the extent possible, programmes should avoid distinguishing the new HIV/AIDS components from other services. For example, administering the new component through a completely different set of staff members may hinder an organisation's ability to create acceptance and solidarity among staff.

Step 6: Monitor and evaluate.

Full consideration must be given to monitoring and evaluation from the onset of the programme. Management should develop indicators to measure programme performance as well as methods for measuring those indicators. The following are some of these indicators:

- age at first intercourse for youth oriented programme;
- number of sexual partners;
- use of condoms;
- self-reported prevalence of STIs;
- proportion of STIs among selected clients;
- functioning of referral system;
- utilisation by gender, profession, and residence;

- client satisfaction; and
- supply stocks (medicine for STIs and HIV opportunistic infections, HIV test kits, etc.).

The above indicators may take different forms depending on whether the programme is community-based or clinic-based. For example, clinic-based programmes may have a greater capacity to diagnose clients with STIs, while community-based programmes may have to rely on self-reporting.

The amount of money available for monitoring and evaluation will determine the type of data collection and analysis that a programme can carry out. This may vary from measuring a few indicators to setting up a full scale Behavioural Surveillance System. In countries with low prevalence rates in the general population, systematic and periodic surveys of groups with high-risk behaviour can provide programme management with information on the evolution of risky behaviours. In countries where risk is evenly distributed in the general population, collecting data periodically from random household samples may be more appropriate.

The Mwanza Project in Tanzania organised a participatory approach to evaluate a mobile STI clinic.⁴ The goal of the project was to strengthen the sense of ownership of the programme by CSWs. Two project staff and four peer educators were selected to monitor the perception of the programme by the CSWs. Questionnaires were developed, and peer educators interviewed a total of 47 CSWs. Project staff and peer educators met to discuss problems and analyse the answers given by the respondents. The facilitators conducted an analysis of the mobile clinic records. The full evaluation team met to discuss the conclusions, which were later shared with all the peer educators. Findings were used to develop new messages for health education and for improving clinic service utilisation.

Case Study

The following case study reflects the steps needed to integrate HIV/STI components into existing health services successfully.

Sexual and Reproductive Health Integration in Bangladesh

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and the Bangladesh Rural Advancement Committee (BRAC) joined forces to integrate sexual health interventions and education into existing rural health services.⁶ The goal of the joint project was to improve the sexual and reproductive health of the rural poor in Bangladesh, especially women and adolescent girls. In an effort to reach this goal, the project:

- Conducted a needs assessment (interviews and focus groups) within the community to identify the socio-cultural factors contributing to the need for sexual and reproductive health services among community members.
- Identified and trained community members interested in becoming peer educators and counsellors.
- Trained community health workers to integrate sexual and reproductive health education into their work. The workers began to discuss sexual and

reproductive health issues with their clients during their regular visits, regardless of the nature of the visit (i.e., birth attendants, pharmacists, and traditional healers added sexual health education to their regular routine). Community members began to view the health providers as resources on sexual problems in addition to their existing roles.

- Created educational materials based on the results of their needs assessment. The materials included picture stories containing information about physical development, reproduction, STIs, and hygiene. The materials were used to train the health workers and peer educators.
- Conducted an evaluation of the integrated health services.

Through the project's efforts, 68 health workers and 1,890 community members were trained to integrate sexual and reproductive health services into their work. The trained personnel talked to hundreds of community members, providing them with information and resources to deal with sexual health problems in addition to the regular services provided. The project is an example of a successful integration of sexual and reproductive health services into existing rural health programmes.

Integrating HIV/AIDS Components into Existing Gender-Based Health Programmes

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[back to Module Table of Contents](#)